# BFHI Policy Draft

**Beirut, December 2018**

## Step 1a: Fully comply with the law 47/2008

## Rationale:

The Lebanese law 47/2008 adopts all provisions of the International Code for Marketing of Breast Milk Substitutes, issued by the World Health Organization (2013) for Organizing the Marketing of Infant and Young Child Feeding Products and Tools. The aim is to protect families during the entire prenatal, perinatal and postnatal periods from commercial pressure.

## Implementation:

The healthcare facility and healthcare staff uphold the Lebanese law 47/2008 by declining to:

- Accept or receive any gift, contribution, benefit, money, or the like, no matter what the value may be, from the manufacturer or distributor of a designated product, or from their representative, or any other person.
- Accept, receive, or give any sample of a designated product to anyone.
- Clarify or explain the instructions of use of a designated product to anyone except individually to the mother or family members who needs them. In this case, they shall give a clear and full explanation of the risks of improper or unnecessary use of the designated product with the information stipulated in chapter II of the law related to information and education.
- Conduct any kind of professional assessment, research, or activity related to a designated product in health care facilities without a pre-issued written approval from the National Breastfeeding Committee.
- Allow the employees of manufacturers or distributers of a designated product to promote any of their products at health care facilities:
    - ✓ The employees of manufacturers or distributers of a designated product should not have any direct or indirect contact or communication with pregnant women and mothers.
    - ✓ They should not perform any educational function related to pregnant women or mothers or infants and young children.

To know more about prohibited promotional practices refer to chapter III article 8 and 9 of the law (1)

Designated Product refers to any of:

- ✓ infant formula
- ✓ follow-up formula
- ✓ any other product marketed or otherwise represented as suitable for feeding infants and young children up to the age of three years
- ✓ feeding bottles, teats, and pacifiers
- ✓ Any product that the Ministry of Health may, after consultation of the National Committee and by notice in the official Gazette, declare to be a "designated product" for purposes of this Law.

**Global standards:**

- All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies.
- The facility has no display of designated products covered under the law or items with logos of companies that produce infant formula, feeding bottles and teats, or names of designated products covered under the law.
- The facility policy describes how it abides by the law, including procurement of designated products, not accepting support or gifts from producers or distributors of products covered by the law and not giving samples of Infant formula, feeding bottles or teats to mothers. (2)

## Step 1b: Have a written infant feeding policy that is routinely communicated to staff and parents.

### Rationale:

Policy drives practice.
Policies help to sustain practices over time and communicate a standard set of expectations for all health workers.

### Implementation:

- Facilities providing maternity and newborn services should have a clearly written breastfeeding policy that is routinely communicated to staff and parents.
- A facility breastfeeding policy may stand alone as a separate document, be included in a broader infant feeding policy, or be incorporated into a number of other policy documents.
- However, organized, the policy should include guidance on how clinical steps should be implemented in the facility, to guarantee that appropriate care is equitably and consistently provided to all mothers and babies and is not dependent on the preferences of each care provider.
- It should also spell out how the management procedures should be implemented, preferably via specific processes that are institutionalized.

### Global standards:

- The health facility has a written infant feeding policy that addresses the implementation of all eight key clinical practices of the ten steps, law implementation, and regular competency assessment.
- The policy is visible to pregnant women, mothers and their families.
- A review of all clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with Baby Friendly Hospitals Initiative (BFHI) standards and current evidence-based guidelines.
- At least 80% of clinical staff who provide antenatal, delivery and/or newborn care can explain at least two elements of the infant feeding policy.

## Step 1c: Establish ongoing monitoring and data-management systems.

## Rationale:

Facilities providing maternity and newborn services need to integrate recording and monitoring of the clinical practices related to breastfeeding into their quality-improvement/monitoring systems. (1)

## Implementation:

- Two clinical indicators are considered as "sentinel indicators":
  - ✓ Early initiation of breastfeeding.
  - ✓ Exclusive breastfeeding during hospital stay.

  They should be routinely tracked for each mother–infant pair
- Recording of information on these "sentinel indicators" should be incorporated into the medical charts and collated into relevant registers.
- Additional indicators for monitoring adherence to the eight key clinical practices have to be documented as well; these additional indicators are particularly important during an active process of quality improvement and should be assessed monthly.
- If the level of the "sentinel indicators" falls below 80% (or below national standards), it will be important to assess both the clinical practices and all management procedures to determine where the bottlenecks are and what needs to be done to achieve the required standards.
- Two alternative methods for verification are proposed:
  - ✓ Newborn registries
  - ✓ Maternal discharge surveys: two questions addressing the sentinel indicators
    - ➢ Was your baby exclusively breastfed?
    - ➢ When was the first time you breastfed your newborn baby after birth?
- Facilities are not expected to use both methodologies at the same time; the choice will depend on what is more practical and feasible to the facilities.



## Global standards:

- A minimum of 80% compliance for all process and outcome indicators, including early initiation of breastfeeding and exclusive breastfeeding.
- The facility has a protocol for an ongoing monitoring and data-management system to comply with the eight key clinical practices.

- Clinical staff at the facility meet at least every 6 months to review implementation of the system. During concentrated periods of quality improvement, monthly review is needed to monitor progress.

## Step 2: Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

### Rationale:

Training of health staff enables them to develop effective skills, give consistent messages, and implement policy standards.

### Implementation:

- The National BFHI committee is responsible to plan a TOT, a 20 hours breastfeeding training course, a BFHI assessor workshop and other breastfeeding seminars based on the assessed needs.
- A copy of the curriculum or course session outlines for all trainings in breastfeeding promotion and support for various types of staff is available for review.
- The National BFHI committee is responsible to review and update the training of trainers' (TOT) curriculum and the 20 hours breastfeeding material as needed.
- The curriculum revision should be carried out by the individuals with appropriate training and skills.
- Training at all levels should address the 10 steps and the Lebanese law 47/2008.
- The TOT, the 20 hours breastfeeding training course, and the BFHI assessor workshop are provided by the National Expert Team, with the help of a consultant from WHO for the assessor course.
- Training of trainers (TOT):
  At least one health staff from the breastfeeding committee at each health facility working on the BFHI program has to attend the TOT program, which provides the attendees with a high level of lactation knowledge and allows them to give the

20 hours breastfeeding training course at their own place at work, supervised for the first time by a skilled person from the National program

- The BFHI assessor workshop:
  - ✓ The focal point of the health facility working on BFHI program have to attend the assessor workshop.
  - ✓ This workshop focuses on developing the assessor skills in the use of the assessment tools as presented in the WHO/UNICEF assessment training course and in reporting.
- The 20 hours breastfeeding training course:
  - ✓ A minimum of 20 hours breastfeeding training on breastfeeding, lactation management and the role of staff in upholding the Lebanese law 47/2008 for midwives and nurses who have contact with pregnant women and mothers and/or provide infant feeding services. It also includes 3 hours of observing clinical practice with pregnant women and new mothers.
  - ✓ A new staff member joining a health facility participating in the BFHI must be trained within 6 months of employment.
  - ✓ The 20 hours breastfeeding training could be organized by the national program or by the health facility BFHI committee, or acquired through on – line course that covers all the 10 steps and the Lebanese law 47/2008.
- Training for the other health facility staff participating in the BFHI:
  - ✓ A one-day seminar (minimum of 3 hours) for obstetricians and pediatricians could be organized by the national program or by the health facility.
  - ✓ A minimum of one hour for other clinical and non-clinical staff such as health workers, clerical housekeeping given by a health facility committee member.
- Considering education as on-going process at the national and hospital level:
  - ✓ Staff will be yearly educated and updated on the implementation of the health facility BFHI policy.
  - ✓ A refreshment breastfeeding course for midwives and nurses who have direct contact with pregnant women and mothers and/or provide infant feeding services every 2-3 years could be organized by the national program or by the health facility participating in the BFHI.

**Global standards:**

- Documentation of trainings- indicates that 80% or more of the clinical staff members who have contact with mothers and/or infants have received training, either at the hospital or prior to arrival that covers all 10 Steps, and the Lebanese law 47/2008.
- Documentation of trainings also indicates that other clinical and non-clinical staff members have received training that is adequate, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants.

**Step 3: Antenatal information; Discuss the importance and management of breastfeeding with pregnant women and their families.**

**Rationale**:

- All pregnant women and their families must have basic information about breastfeeding, in order to make informed decisions.
- Pregnancy is a key time to inform women about the importance of breastfeeding, support their decision making and pave the way for their understanding of the maternity care practices that facilitate its success.
- Mothers also need to be informed that birth practices have a significant impact on the establishment of breastfeeding.



**Implementation:**

Breastfeeding education must be provided free of conflicts of interest. In line with the WHO guidance on ending the inappropriate promotion of foods for infants and young children, published in 2016 and endorsed by the world health assembly (WHA)
The personnel providing information must have counselling skills to consider the social and cultural context of each family.

- What are the topics to be discussed in antenatal education?
  - ✓ The importance and benefits of breastfeeding.
  - ✓ The importance of early initiation of breastfeeding.
  - ✓ Global recommendations on exclusive breastfeeding for the first 6 months.

- ✓ The risks of giving infant formula and the fact that breastfeeding continues to be important after 6 months when other foods are given.
- ✓ The importance of immediate and sustained skin to-skin contact.
- ✓ The importance of rooming-in.
- ✓ The basics of good positioning and attachment.
- ✓ Recognition of feeding cues.
- ✓ Management of engorgement.
- ✓ Conditions that might influence milk production.
- ✓ Practical skills such as: positioning and attachment, on-demand feeding

- How is the antenatal information provided:
  - ✓ Printed material.
  - ✓ Online information.
  - ✓ Video or demonstration.
  - ✓ Educational material takes into consideration illiterate parents.
- Who is responsible to provide antenatal information:
  - ✓ The facility where the delivery will take place.
  - ✓ In case the facility doesn't provide antenatal care, coordination with antenatal community services or physician's clinics will ensure that pregnant women will receive essential antenatal information before 32 weeks of pregnancy.
- When antenatal information should be provided:
  - ✓ During the first or second antenatal visit, so there is time to discuss any challenges, if necessary; at or after 12 weeks of gestation, and preferably not later than 32 weeks of pregnancy.
  - ✓ Women at increased risk for preterm delivery or birth of a sick infant (e.g. pregnant adolescents, high-risk pregnancies, known congenital anomalies) must begin discussions with knowledgeable providers as soon as feasible concerning the special circumstances of feeding a premature, low-birth-weight or sick baby.



**Global standards:**

- At least 80% of mothers who received prenatal care at the facility report having received prenatal counselling on breastfeeding.
- At least 80% of mothers who received prenatal care at the facility are able to adequately describe what was discussed about two of the topics mentioned above.
- Protocol of antenatal education along with the material can be defined by at least 80% of the facility personal.

**Step 4: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.**

This step implies that a skin-to-skin contact should be initiated for all healthy newborns, immediately after normal vaginal delivery and cesarean section (C/S) with local anesthesia or as soon as the mother is sufficiently able to respond after a general anesthesia, for at least one hour or until the baby has attached and fed at the breast (if this takes longer). Mothers should have the opportunity for early skin-to-skin contact.

**Rationale:**

Mothers who are supported to initiate breastfeeding soon after the baby is born are more likely to have a successful breastfeeding experience.



**Implementation:**

- All babies should be well dried, given to their mothers to hold skin-to-skin and covered, whether or not they have decided to breastfeed.
- Place baby on mother's chest in skin-to-skin contact with their mothers immediately following birth. Note: Laying a baby on top of mother's gown or on top of a towel does NOT count as skin-to-skin.
- Place babies for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.
- Let the baby start suckling when ready. Do not hurry or interrupt the process. Feeding cues from the infant may be apparent within the first 15–20 minutes after birth, or may not be apparent until later.
- Keep mother and baby together.
  - ✓ Routine procedures, such as weight, measurement, and baby eye drops, need to be delayed.
  - ✓ Other routine baby procedures (APGAR scores, assessment, placing the ID bracelet) need to be done on the mother's chest
  - ✓ Bathing needs to be delayed, with priority given to the skin-to-skin time

- Mothers with C-section or complications should be assisted to breastfeed as soon as possible. Few tips can help:
  - ✓ The mother's heart monitor stickers need to be placed on her sides, to leave a spot open on her chest for the baby
  - ✓ The mother's gown needs to be placed so that it easily opens for the baby to lay on her bare chest
  - ✓ The mother's blood pressure cuff and IV needs to be placed on the non-dominant arm
  - ✓ The mother's oxygen monitor needs to be put on her toe instead of her finger
  - ✓ The baby needs to be dried and covered with multiple warm blankets and a cap
  - ✓ If the skin-to-skin time is done very early (in the OR), the baby may need to be laid cross-wise across the mother's upper chest, above the blue drape
  - ✓ Mothers who are not able to initiate breastfeeding during the first hour after delivery should still be supported to breastfeed as soon as they are able.
- Skin to skin in special situations:
  - ✓ HIV positive mothers: Since HIV is not transmitted by mothers while they are holding their newborns, mothers need to be encouraged to hold and feel close and affectionate towards their newborn babies. HIV-positive mothers should be supported in using the feeding option of their choice. They shouldn't be forced to breastfeed, as they may have chosen to replacement feed without knowledge of the delivery room staff.
  - ✓ If the mother is not capable of holding the baby due to nausea or other reasons, another family member should be encouraged to do skin-to-skin with the baby.
  - ✓ Intermittent skin to skin can be practiced in sick and premature infants as young as 26 weeks gestation, when the condition of the infant permits. Despite apparent physiologic stability during skin-to-skin care, it is prudent that infants in the NICU have continuous cardiovascular monitoring and that care be taken to monitor correct head positioning for airway patency as well as the stability of the endotracheal tube, arterial and venous access devices, and other life support equipment. Both parents are encouraged to practice skin to skin. Parents should be monitored for skin infections and might need cleansing of the skin before infant contact. Some experts consider infants

with open lesions (e.g., open neural tube defects, abdominal wall defects) to be particularly at risk.

**Global standards:**

- At least 80% of mothers in the maternity ward who have had normal vaginal deliveries or caesarean delivery with local anesthesia, report that their babies were placed in skin-to-skin contact with them immediately or within 5 minutes after birth and that this contact lasted 1 hour or more, and that they were offered help by a staff member to initiate breastfeeding.
- At least 80% of mothers who have had caesarean deliveries with general anesthesia report that as soon as they were sufficiently able to respond, they were given their babies to hold with skin contact, and were offered help by a staff member to initiate breastfeeding.

## Step 5: Support mothers to initiate and maintain breastfeeding and manage common difficulties

Helping mothers to breastfeed effectively with a good technique is a vital step. If infants are separated from their mothers, or are unable to suckle, their mothers need to express their milk.

**Rationale:**

Supporting mothers to initiate and maintain breastfeeding and manage common difficulties is needed because:

- Many mothers do not know how to breastfeed
- Mothers may lack support from their environment
- It is associated with increased milk supply: The baby's sucking and milk removal stimulate the production of milk
- It is associated with an increase in duration of breastfeeding
- Less maternal morbidity related to breastfeeding
- Better infant health
- Builds caring and nurturing relationship between mother and infants
- Increases mothers' confidence in themselves, in breastfeeding and in their infant's growth and development

**Implementation:**

Nursing staff should offer further assistance with breastfeeding within six hours of delivery;

- Teach mothers how to position and attach their babies for breastfeeding, and how to recognize that the baby is well attached on the breast and breastfeeding effectively.
- Teach mothers the supply and demand principles behind maintaining optimal milk supply, how to stimulate the milk ejection reflex, how to hand express their breast milk and how to maintain lactation if they are separated from their baby.
- Support mothers to respond in a variety of ways to behavioral cues for feeding, comfort or closeness. Ways to respond to infant cues include breastfeeding, skin-to-skin contact, cuddling, carrying, talking, singing and so forth.
- Teach how to recognize when their baby is ready to feed, and how frequently to breastfeed: On demand 8 – 12 times /day, to stimulate milk production. If infants are sleeping during the first days wake them after 4 hrs.
- Mothers should be taught how to express their milk, and when they might need to do so. Mothers will be taught how to store their milk and how to make it ready for feeding.
- Mothers with babies in special care should be helped to initiate and maintain lactation by frequent expression of breast milk soon after birth, skin to skin care and recognize their infants' behavior cues.
- For HIV positive mothers: They are to be counseled on locally available feeding options and the risks and benefits of each, so they can make informed infant feeding choices.
- Staff is well trained on dealing with common early breast problems: nipple cracking, engorgement, mastitis…



**Global standards:**

- At least 80% of mothers received assistance with breastfeeding within six hours of delivery and throughout their stay.
- At least 80% of mothers received education regarding feeding in response to infant cues and methods of expressing and storing breast milk.
- Staff routinely assesses mother/baby comfort and effectiveness of feeding and suggests changes as needed.
- Mothers of preterm or ill babies are educated about collecting their milk.

- Mothers of preterm or ill babies are encouraged to place their infant skin to skin when possible

**Step 6: Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.**

**Rationale:**

- Healthy newborns on breast do not need any fluids or food other than their mother's milk. Giving newborns any foods or fluids other than breast milk in the first few days after birth interferes with the establishment of breast-milk production. Babies who are supplemented prior to facility discharge have been found to be twice as likely to stop breastfeeding altogether in the first 6 weeks of life
- Foods and liquids may contain harmful bacteria and carry a risk of disease. Supplementation with infant formula significantly alters the intestinal microflora
- There are **rare exceptions** during which the infant may require other fluids or food in addition to, or in place of, breast milk. The feeding program of these babies will be determined by qualified health professionals on an individual basis.

**Implementation:**

Breast milk is the only food or fluid to be given to the newborn baby, unless medically indicated (3). **All the details will be documented in the medical file** of the mother and/or the infant.



- **Mothers who may need to avoid breastfeeding permanently are:**
  - ✓ Mothers who have HIV infection, if replacement feeding is AFASS (Affordable, Feasible, Acceptable, Sustainable, and Safe).
  - ✓ Mothers who are positive for human T-cell lymph trophic virus type I or II should not breastfeed nor provide expressed milk to their infants.

  Issues to consider while implementing this step in relation to feeding recommendations for children of **HIV-infected** mothers and for settings with high HIV prevalence (4):
  - ✓ Staff members should find out whether HIV-positive mothers have made a feeding choice and make sure they don't give babies of breastfeeding mothers any other food or drink.
  - ✓ Being an HIV-positive mother and having decided not to breastfeed is a medical indication for replacement feeding.

- ✓ Staff members should counsel HIV-positive mothers who have decided to breastfeed on the risks if they do not exclusively breastfeed. Mixed feeding brings both the risk of HIV from breastfeeding and other infections.

Even if many mothers are giving replacement feeds, this does not prevent a hospital from being designated as baby-friendly, if those mothers have all been counseled and offered testing and made genuine choices.

- **Mothers who may need to avoid breastfeeding temporarily**:
  - ✓ Mothers with severe illness that prevents them from caring for their infant.
  - ✓ Mothers on certain medications (sedating psychotherapeutic drugs; diagnostic or therapeutic radioactive isotopes or exposure to radioactive materials, for as long as there is radioactivity in the milk; antimetabolites or chemotherapeutic agents or a small number of other medications until they clear the milk...)
  - ✓ Mothers who are using drugs of abuse ("street drugs").
  - ✓ Mothers who have herpes simplex lesions on a breast (infant may feed from the other breast if clear of lesions).
  - ✓ Mothers with untreated active tuberculosis (wait until mother is no longer infectious; minimum of 2 weeks on treatment). Expressed milk can be used.
  - ✓ Mothers who have untreated brucellosis should not breastfeed nor provide expressed milk to their infants.
  - ✓ Maternal varicella if started 5 days before through 2 days after delivery. Separate mother from infant. Give expressed breast milk.
  - ✓ Acute infection with H1N1 influenza. Isolate mother until afebrile. Give expressed breast milk.
  - ✓ CMV seropositive mother, when the infant is < 1500g.

- **Mothers who intend to "mix-feed":**
  - ✓ Will be counseled on the importance of exclusive breastfeeding in the first few weeks of life, and how to establish a milk supply and to ensure that the infant is able to suckle and transfer milk from the breast.
  - ✓ Supplementation can be introduced at a later date if the mother chooses.

- **Mothers who have chosen not to breastfeed:**
  - ✓ Will be counseled on the importance of breastfeeding, and the risks of infant formula for the newborn.
  - ✓ If they still do not wish to breastfeed, feeding with infant formula will be given.
  - ✓ Mothers will be given information about various feeding options and helped to decide what is suitable in their circumstances.

- ✓ Mothers will be taught about safe preparation and storage of infant formula and how to respond adequately to their child's feeding cues. They will be asked to demonstrate what they have learned.
- ✓ Mothers will be taught how to care for their breasts, since they planned not to breastfeed.
- ✓ All these details will be documented in the mothers' medical file.

**The policy of feeding the infants in the Nursery Intensive Care Unit (NICU) will be known to all the medical and paramedical staff, and fully applied. This policy will be clearly displayed in the NICU unit.**

**Infants** who **should not** receive breast milk or any infant formula except specialized infant formula are those who have one of these inborn errors of metabolism diseases:

- ✓ Classic galactosemia.
- ✓ Maple syrup urine disease.
- ✓ Phenylketonuria: (Some breastfeeding is possible, under careful monitoring).

Some other infants, for whom breast milk remains the best feeding option, **may need** infant formula or breast milk additives in addition to breast milk **for a limited period**. These include:

- ✓ Very low birth weight infants (less than 1500g).
- ✓ Very preterm infants (less than 32 weeks gestational age).
- ✓ Newborn infants at risk of hypoglycemia.

Infants will be assessed for signs of inadequate breast milk intake and supplemented when indicated. **Lack of resources, staff time or knowledge will not be a justification for the use of early additional foods or fluids.**



**Infants in the NICU** will be fed breast milk;

- ✓ Whenever they can teat directly the breast, they will be put on breast as much as needed.
- ✓ If the infant cannot teat the breast, or the mother is not present, expressed breast milk will be given to the infant by NG tube or by cup if he is able to feed by cup. The mother is taught how to express her milk, how to conserve it, and bring it to the NICU whenever is possible.

**Methods of feeding low birth weight babies:**

- ✓ Before 30 weeks gestational age: Nasogastric tube.
- ✓ Between 30-32 weeks: Cup feeding. The feeding can be continued by NG tube, if the infant is not able to complete his feed by cup only.

- ✓ > 32 Weeks, ± 1300g: Breastfeeding is possible. The feed can be completed by cup or NG tube with expressed breast milk if necessary.
- ✓ > 36 Weeks, ± 1800g: Breastfeeding is well coordinated; when necessary, the feed could be completed by cup using expressed breast milk.

- ✓ No Infant Formula, no bottles, no teats, no pacifiers will be present in the NICU. If these products are needed for a specific baby, they will be brought under medical prescription.
- ✓ Supplementation, if necessary, will be temporary, until the newborn is capable of breastfeeding and/or the mother is available and able to breastfeed.
- ✓ Mothers will be supported and encouraged to express their milk to continue stimulating production of breast milk, and to prioritize use of their own milk, even if direct breastfeeding is challenging for a period of time.
- ✓ Reasons for supplements will be documented in the newborn file.

**Before leaving the NICU**, the staff will make sure that:

- ✓ The infant is able to breastfeed.
- ✓ The mother recognizes the infant's feeding cu
- ✓ The mother knows how to breastfeed; she will demonstrate it before the baby leaves the NICU. The staff will make sure that the mother has acquired all the skills needed.
- ✓ The mother knows how to express breast milk, if needed.
- ✓ The mother knows how to feed the baby by cup, if an extra feed with expressed breast milk is needed.



**Global standards:**

- At least 80% of infants (preterm and term) received only breast milk throughout their stay at the facility.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them decide what were suitable in their situations.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the safe preparation, feeding and storage of infant formula.
- At least 80% of term breastfed babies who received supplemental infant formula have a documented medical indication for supplementation in their medical record.

- At least 80% of mothers with babies in special care report that they have been offered help to start their breast milk coming and to keep up the supply, within six hours of their babies' births.

## Step 7: Enable mothers and their infants to remain together and to practice Rooming-in 24 hours a day.

### Rationale:

- Rooming-in is necessary to enable mothers to practice responsive feeding, as mothers cannot learn to recognize and respond to their infants' cues for feeding if they are separated from them.
- Rooming-in allows mothers and their babies to stay together day and night to bond and to establish breastfeeding.

### Implementation:

- Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practice Rooming-in throughout the day and night except for periods of up to an hour for hospital procedures.
- Rooming-in involves keeping mothers and infants together in the same room immediately after vaginal birth or caesarean section, or from the time when the mother is able to respond to the infant, until discharge.
- Rooming in should start no later than one hour after normal vaginal deliveries. Normal postpartum mothers should have their babies with them in cots by their bedside unless separation is indicated.
- Rooming-in may not be possible in circumstances when infants need to be moved for specialized medical care. If preterm or sick infants need to be in a separate room to allow for adequate treatment and observation, efforts must be made for the mother to recuperate postpartum with her infant. (3)



### Global standards:

At least 80% of mothers of term infants report that their babies stayed with them since birth, without separation lasting for more than 1 hour. (3)

## Step 8: Support mothers to recognize and respond to their infants' cues for feeding

### Rationale:

- Breastfeeding involves recognizing and responding to the infant's display of hunger and feeding cues and readiness to feed, as part of a nurturing relationship between the mother and infant.
- Breastfeed on demand is: no restrictions on the frequency or length of the infant's feeds, and mothers are advised to breastfeed whenever the infant is hungry or as often as the infant wants. Scheduled feeding, which prescribes a predetermined, and usually time-restricted, frequency and schedule of feeds is not recommended.

### Implementation:

- Mothers should be supported to recognize and respond to their infants' cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options.
- Breastfeeding often, when baby gives feeding cues at least every 1½ to 3 hours. This helps make milk and can prevent and decrease engorgement. Newborns should not go longer than 2 to 3 hours during the day or 4 hours at night without a feeding because their stomachs are small
- When the mother and baby are not in the same room for medical reasons (mother's illness, preterm or sick infant), the facility staff needs to support the mother to visit the infant as often as possible, so that she can recognize feeding cues.
- Mothers of infants admitted to the neonatal intensive care unit should be sensitively supported to enable them to have skin-to-skin contact with their infants, recognize their infants' behavior cues, and effectively express breast milk soon after birth.

**The mother should look for the following feeding clues to ensure her baby is feeding at the right time.**

- ✓ Eye movement under closed lids (rapid eye movement).
- ✓ Increased alertness, awakening or changes in facial expression.
- ✓ Movement of arms or legs.
- ✓ Tossing, turning or wriggling.
- ✓ Mouthing.
- ✓ Rooting (opening their mouth and searching to suck on contact).
- ✓ Clicking or tongue sucking.
- ✓ Hand movements to their mouth and sucking on hands
- ✓ Squeaking noises or light fussing.

**Global standards:**

At least 80% of breastfeeding mothers of term infants can describe at least two feeding cues.



**Step 9: Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.**

**Rationale**:

- Proper guidance and counseling of mothers and other family members enable them to make informed decisions on the use or avoidance of pacifiers and/or feeding bottles and teats until the successful establishment of breastfeeding.
- Feeding bottles, teats and pacifiers contribute to nipple confusion when used too early, and interfere with milk transfer and breast milk supply (5).
- There are a number of reasons for caution about the use of feeding bottles, teats and pacifiers, including hygiene, oral formation and recognition of feeding cues.

**Implementation:**

**In the maternity ward:**

- Breastfeeding is the method of choice for feeding newborns, and suckling on the breast is the only method of suckling proposed to the newborn.
- Breastfed babies are not given pacifiers or dummies.
- No bottles or teats or pacifiers will be present in the maternity ward.
- If the newborn is to be given some other fluid or food for medical reasons, it will be by syringe or by cup, and not in a bottle or teat.
- The maternity staff will not become reliant on teats as an easy response to suckling difficulties; instead they should be counseling mothers and enabling them to attach their babies properly and to suckle effectively.
- For the mothers who do not wish to breastfeed, the maternity staff will inform mothers and family members of the hygiene risks related to inadequate cleaning of feeding utensils, so they can make an informed choice of the feeding method.
- The maternity staff will discuss with the mothers the cautions about the use of feeding bottles, teats and pacifiers, including oral formation and recognition of feeding cues.
- Pacifiers may be used in few situations such as reducing pain during procedures when breastfeeding or skin-to-skin contact are not possible; but they should not replace suckling on the breast.



**In the NICU:**

- Premature babies before 30 weeks of gestation will be fed, when possible, by nasogastric tube.
- Between 30-32 weeks, cup feeding is possible. Since feeding bottles with teats interfere with learning to suckle at the breast (6), the infant will be given expressed breast milk by cups or spoons.
- For preterm infants who are unable to breastfeed directly, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established. Non-nutritive sucking or oral stimulation could involve the use of pacifiers, a gloved finger or a breast that is not yet producing milk.

**Global standards:**

At least 80% of breastfeeding mothers of preterm and term infants report that they have been taught about the risks of using feeding bottles, teats and pacifiers.

## Step 10: The parents and their infants have timely access to ongoing support and care after discharge

### Rationale:

Mothers need sustained support to continue breastfeeding; their milk supply has not been fully established after discharge.

Breastfeeding support is needed in the first weeks especially when mothers go through different phases of breast milk production, and their infant passes through growth spurts.

Maternity facilities must know about and refer mothers to the variety of resources that exist in the community.

### Implementation:

- Each mother should be linked to lactation-support resources in the community upon discharge. Mothers and babies are recommended to be seen by a health professional between 1-2 weeks, to assess the feeding situation**.** Babies who are expected to have breastfeeding problems or for whom breastfeeding is not well established need to be seen earlier within the first week after discharge**.**
- Facilities providing maternity and newborn services have the responsibility to provide mothers with:
    - ✓ A number to call upon in case of breastfeeding questions or difficulties
    - ✓ The National free breastfeeding hotline (1214) that has been established by the MOPH.
    - ✓ Contact details of primary health-care with a trained nurses and midwives on breastfeeding management.
    - ✓ Names and contacts numbers of skilled professional lactation consultant available in the community.
    - ✓ Mother-to-mother support groups if available, However, this should not substitute an active follow-up care by a skilled professional.

- Contact details of professional and voluntary support should be regularly updated by MOPH to ensure correct information is given to mothers.
- The hospital can support mothers over phone calls or through home visits.

**Global standards:**

- At least 80% of mothers of preterm and term infants report that a staff member has informed them where they can access breastfeeding support in their community.
- The facility can demonstrate that it coordinates with community services that provide breastfeeding/ infant feeding support, including trained primary health care center and mother-to-mother support. [1]

**References:**


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