WHO / UNICEF

Baby Friendly Hospital Initiative

Part One

Background and Baby Friendly Implementation in New Zealand

• Introduction
• Towards the Baby Friendly Hospital Accreditation
• The Baby Friendly Hospital Designation Process
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### Glossary

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<td>Artificially Feeding</td>
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<tr>
<td>Anniversary Date</td>
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<tr>
<td>BF</td>
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<tr>
<td>BFCI</td>
<td>Baby Friendly Community Initiative</td>
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<td>BMS</td>
<td>Breastmilk substitute</td>
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<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GSIYCF</td>
<td>Global Strategy Infant and Young Child Feeding</td>
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<td>LBW</td>
<td>Low Birth Weight</td>
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<td>LMC</td>
<td>Lead Maternity Carer</td>
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<td>MOH</td>
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<td>NICU</td>
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<td>New Zealand Breastfeeding Authority</td>
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### Acknowledgements:

The New Zealand Breastfeeding Authority would like to acknowledge the input of the people and organisations that have contributed to the review of this framework.
Part One:
Introduction

The New Zealand Breastfeeding Authority (NZBA) is a not for profit non-government organisation that is the coordination group for the Baby Friendly Initiative in New Zealand.

The Baby Friendly Hospital Initiative (BFHI) has two main goals:

- To encourage and facilitate the transformation of hospital facilities in accordance with the WHO and UNICEF Ten Steps to Successful Breastfeeding.
- To end the practice of distribution of free and low-cost supplies of breastmilk substitutes to hospitals and health care facilities in accordance with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions hereafter referred to as The Code.

NZBA is contracted by the Ministry of Health to:

- Implement and administer the Baby Friendly Hospital Initiative (BFHI) and the Baby Friendly Community Initiative (BFCI);
- Conduct assessments and reassessments for BFHI and BFCI;
- Work to improve breastfeeding rates for Māori; and
- Develop materials and resources to support the Baby Friendly Initiative as listed on NZBA website.

Kia U Ki Te Pai

As a mother’s milk provides nourishment
Let us embrace all that is good

The Treaty of Waitangi
The New Zealand Breastfeeding Authority is committed to the Treaty of Waitangi and will work through:

Partnership, by working with whanau, hapu and iwi to develop appropriate policies and procedures that will improve breastfeeding rates and services in New Zealand.

Participation, by involving Māori in decision making, planning, development and implementation of the Baby Friendly Initiative.

Protection, by working in a manner that will protect and preserve Māori traditional breastfeeding practices.

The BFHI assessment standards are in accordance with the UNICEF / WHO global criteria:

- maternity facilities are required to achieve at least a 75% exclusive breastfeeding rate at discharge;
- compliance with the Ten Steps; and
- adherence to the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions.
Note: The following standards are only relevant for the Baby Friendly Hospital Initiative.

The criteria for a Baby Friendly Hospital are relevant in all countries.

The 2002 WHO/UNICEF Global Strategy for Infant and Young Child Feeding (GSIYCF) calls for renewed support – with urgency – for exclusive breastfeeding as expressed in the foreword by Gro Harlem Bruntland, the Director-General of the World Health Organisation (WHO) and Carol Bellamy, the Executive Director of the United Nations Children’s Fund (UNICEF).

“WHO and UNICEF jointly developed the Global Strategy for Infant and Young Child Feeding to revitalize world attention to the impact that feeding practices have on the nutritional status, growth and development, health and thus the very survival of infants and young children.

The Global Strategy is based on the evidence of nutrition’s significance in the early months and years of life, and of the crucial role that appropriate feeding practices play in achieving optimal health outcomes. Lack of breastfeeding – and especially lack of exclusive breastfeeding during the first half-year of life – are important risk factors for infant and childhood morbidity and mortality, that are only compounded by inappropriate complementary feeding. The life-long impact includes poor school performance, reduced productivity, and impaired intellectual and social development.

The Strategy is the result of a comprehensive two-year participatory process. The aim, from the outset, was to move towards formulating a sound approach to alleviating the tragic burden borne by the world’s children – 50 to 70% of the burden of diarrhoeal disease, measles, malaria and lower respiratory infections in childhood are attributable to undernutrition – and to contribute to a lasting reduction in poverty and deprivation.

This exercise provided an exceptional opportunity to re-examine critically, in light of the latest scientific and epidemiological evidence, the fundamental factors affecting feeding practices for infants and young children. At the same time, it renewed commitment to continuing joint action consistent with the Baby Friendly Hospital Initiative, the International Code of Marketing of Breast-milk Substitutes, and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.

The Strategy is intended as a guide for action; it identifies interventions with a proven positive impact, it emphasizes providing mothers and families the support they need to carry out their crucial roles, and it explicitly defines the obligations and responsibilities in this regard of governments, international organizations and other concerned parties.”

http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/
NZBA Baby Friendly Quality Cycle

BFHI focuses on Initiation of breastfeeding

Establishes standards for service provision by maternity services which are measurable and can be monitored, and evaluated.

The standards are based on current scientific evidence and set guidelines for best practice.
The Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

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 a half-hour of birth.

   Is now interpreted as:
   *Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed*.

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

6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.

7. Practise rooming-in - 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.

From: Protecting, Promoting and Supporting Breastfeeding:
    The Special Role of Maternity Services

   A Joint WHO/UNICEF Statement 1989

Published by the World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland

*Revised international BFHI documents 2009
New Zealand Ministry of Health Breastfeeding Definitions

Exclusive breastfeeding: The infant has never, to the mother’s knowledge, had any water, formula or other liquid or solid food. Only breastmilk, from the breast or expressed, and prescribed* medicines have been given from birth.

* Prescribed as per the Medicines Act 1981

Fully breastfeeding: The infant has taken breastmilk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.

Partial breastfeeding: The infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours.

Artificial feeding: The infant has had no breastmilk but has had alternative liquid such as infant formula with or without solid food in the past 48 hours.

From: Breastfeeding Definitions For Monitoring The National Health Outcome Targets In New Zealand. MOH. New Zealand. Feb 1999

Ever Breastfed:

The World Health Organisation requires countries to report on the percentage of infants that initiated breastfeeding: in other words ‘ever breastfed’ or received any breastmilk.

To gain this figure:
Add together the number of infants who at discharge were exclusive, fully or partially breastfed, and include the infants who have breastfed, or received breastmilk, even just once, but are discharged artificially feeding
Compliance with the International Code of Marketing of Breastmilk Substitutes\(^1\)

**Statement**
The International Code of Marketing of Breastmilk Substitutes and the subsequent relevant World Health Assembly (WHA) resolutions will hereby be referenced as The Code in this document.

The following section is an excerpt from: UNICEF/WHO Baby-Friendly Hospital Initiative Revised, Updated and Expanded for Integrated Care – Section 1 Background and Implementation 2009

**What is the Code?**
The Code was adopted in 1981 by the World Health Assembly to promote safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breastmilk substitutes, when these are necessary. One of the main principles of The Code is that health care facilities should not be used for the purpose of promoting breast-milk substitutes, feeding bottles or teats. Subsequent WHA resolutions have clarified The Code and closed loopholes.

**How is the Code relevant to the Baby-friendly Hospital Initiative?**
In launching the BFHI in 1991, UNICEF and WHO were hoping to ensure that all maternity facilities would become centres of breastfeeding support. In order to achieve this, hospitals must avoid being used for the promotion of breast-milk substitutes, bottles or teats, or the distribution of free formula. The Code, together with the subsequent relevant resolutions of the World Health Assembly, lays down the basic principles necessary for this. In addition, in adopting The Code in 1981, the World Health Assembly called upon health workers to encourage and protect breastfeeding, and to make themselves familiar with their responsibilities under The Code.

**Which products fall under the scope of the Code?**
The Code applies to breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast-milk; feeding bottles and teats.

Since exclusive breastfeeding is to be encouraged for 6 months, any food or drink shown to be suitable for feeding a baby during this period is a breast-milk substitute, and thus covered by The Code. This would include baby teas, juices and waters. Special formulas for infants with special medical or nutritional needs also fall under the scope of The Code.

Since continued breastfeeding is to be encouraged for two years or beyond, any milk product shown to be substituting for the breast-milk part of the child’s diet between six months and two years, such as follow-on formula, is a breast-milk substitute and is thus covered by The Code.

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\(^1\) UNICEF/WHO Baby-Friendly Hospital Initiative Revised, Updated and Expanded for Integrated Care – Section 1 Background and Implementation 2009– Adapted for NZ context.
What does The Code say?

The main points in The Code include:

• no advertising of breast-milk substitutes and other products to the public;
• no free samples to mothers;
• no promotion in the health services;
• no donations of free or subsidized supplies of breast-milk substitutes or other products in any part of the health care system;
• no company personnel to contact or advise mothers;
• no gifts or personal samples to health workers;
• no pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
• information to health workers should only be scientific and factual;
• information on artificial feeding should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding;
• unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Who is a “health worker” for the purposes of The Code?

According to The Code, any person working in the health care system, whether professional or non-professional, including voluntary and unpaid workers, in public or private practice, is a health worker. Under this definition, ward assistants, nurses, midwives, social workers, dietitians, counsellors, in-hospital pharmacists, obstetricians, administrators, clerks, etc are all health workers.

What are a health worker's responsibilities under The Code?

1. **Encourage and protect breastfeeding.**

   Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under The Code, and be able to explain the following:
   - the importance of breastfeeding;
   - maternal nutrition, and the preparation for and maintenance of breastfeeding;
   - the negative effect on breastfeeding of introducing partial bottle-feeding;
   - the difficulty of reversing the decision not to breastfeed; and
   - where needed, the proper use of infant formula, whether manufactured industrially or home-prepared.

   When providing information on the use of infant formula, health workers should be able to explain:
   - the social and financial implications of its use;
   - the health hazards of inappropriate foods or feeding methods; and
   - the health hazards of unnecessary or improper use of infant formula and other breastmilk substitutes.

2. **Ensure that the health facility is not used for the display of products within the scope of The Code,** or placards or posters concerning such products. Ensure that packages of breast-milk substitutes and other supplies purchased by the health facility are not on display or visible to mothers.

3. **Refuse any gifts offered by manufacturers or distributors associated with products that are in the scope of the Code.**
4. **Refuse samples** (meaning single or small quantities) of infant formula or other products within the scope of The Code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.

5. **Never pass any samples to pregnant women, mothers** of infants and young children, or members of their families.

6. **Disclose any contribution made by a manufacturer or distributor** for fellowships, study tours, research grants, attendance at professional conferences, or the like to management of the health facility.

7. **Be aware that support and other incentives for programmes and health professionals working in infant and young-child health should not create conflicts of interests.**

**Frequently Asked Questions:**

**Does The Code ban all free and low-cost supplies of infant formula and other breast-milk substitutes (including follow-on formula) in health facilities?**

Yes. Although there were some ambiguities in the wording of Articles 6.6 and 6.7 of The Code, these were clarified in 1994 by World Health Assembly Resolution (WHA 47.5) which urged Governments: “to ensure that there are no donations of free or subsidized supplies of breast-milk substitutes and any other products covered by the International Code of Marketing of Breast-milk Substitutes in any part of the health care system”. Breast-milk substitutes should be obtained through “normal procurement channels” so as not to interfere with the protection and promotion of breastfeeding. Procurement means purchase.

**Should free supplies be donated for pre-term and low birth weight infants?** Some argue that these infants need early supplementation, and therefore free supplies should be permitted.

No. The prohibition applies to all types of infant formula, including those for special medical purposes. In any case, breast-milk is the medically indicated feeding of choice for almost all pre-term and low birth weight babies. Obtaining free supplies for these babies encourages bottle (artificial) feeding, which further threatens their survival and healthy development. Moreover, once free supplies are available in the maternity facilities and nurseries, it is extremely difficult to control their distribution and misuse.

**Should the prohibition extend to Maternal Child Health, primary health, and rural clinics?**

Yes. The Code defines the health care system as: “governmental, non-governmental or private institutions or organizations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice”.

**Why not permit free supplies in paediatric wards, since older infants may already be using feeding bottles?**

Because free supplies to paediatric services or other special services for sick infants can seriously undermine breastfeeding. The WHO/UNICEF guidelines suggest, in paragraph 50:

“There will, of course, always be a small number of infants in these services who will need to be fed on breastmilk substitutes. Suitable substitutes, procured and distributed as part of the regular

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2 See WHO/UNICEF “Guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on breast-milk substitutes (WHO, A39/8 Add. 1, 10 April 1986). The 1986 World Health Assembly based its adoption of WHA 39.28 on this document.
inventory of foods and medicines of any such health care facility, should be provided for those infants.

Is there a working definition for “low-cost” supplies?
Yes. There is a general agreement that ending “low-cost” or “low-price” sales means ending sales at prices below the wholesale price or lower than 80% of the retail price, in the absence of a standard wholesale price. The reason for stopping low price sales is that low prices lead to the overuse of breast-milk substitutes.

Is The Code still relevant in view of the HIV pandemic and the increased need for formula?
Yes. Indeed The Code is even more important in the context of HIV, since The Code and resolutions:
• encourage governments to regulate the distribution of free or subsidized supplies of breastmilk substitutes to prevent “spillover”; 
• protect children fed on replacement foods by ensuring that product labels carry necessary warnings and instructions for safe preparation and use; and 
• ensure that a given product is chosen on the basis of independent medical advice.

The Code is relevant to, and fully covers the needs of, mothers who are HIV-positive. Even where The Code has not been implemented, its provisions still apply.
**Key points from The Code**

1. Products should not be advertised or otherwise promoted to the public.
2. Mothers and pregnant women and their families should not be given samples of products.
3. Health care providers should not be given free or subsidised supplies of products and must not promote products.
4. People responsible for marketing products should not try to contact mothers or pregnant women or their families.
5. The labels on products should not use words or pictures, including pictures of infants, to idealise the use of their products.
6. Health workers should not be given gifts.
7. Health workers should not be given samples of products, except for professional evaluation or research at the institution level.
8. Material for health workers should contain only scientific and factual information and must not imply or create a belief that bottle-feeding is equivalent or superior to breastfeeding.
9. All information and educational materials for pregnant women and mothers, including labels, should explain the benefits and superiority of breastfeeding, the social and financial implications of its use, and the health hazards of the unnecessary or improper use of formula.
10. All products should be of a high quality and take account of the climate and storage conditions of the country where they are used.

Towards a Baby Friendly Hospital Accreditation

Introduction
The Baby Friendly Hospital Initiative (BFHI) has been launched by WHO and UNICEF to encourage hospitals, health care facilities, and particularly maternity wards, to adopt practices that fully protect, promote and support exclusive breastfeeding from birth.

Becoming a Baby Friendly Hospital is a process that starts with a self-appraisal (Refer Part 3 - Pre-Assessment Questionnaire by the maternity facility. This initial self-appraisal will lead to analysis of the practices that encourage or hinder breastfeeding; this analysis will determine the necessary actions needed to make the changes required. It thus follows the triple-A sequence (Assessment, Analysis, and Action) which characterises other UNICEF Programme developments.

After a maternity facility is satisfied that it can meet the standards required to become a Baby Friendly facility; the maternity facility’s ability to achieve this accreditation is confirmed objectively by using internationally agreed standards for maternity care which protects, promotes and supports breastfeeding.

An external assessment is carried out which determines if the maternity facility has attained the level required and can be awarded Baby Friendly Hospital accreditation along with a BFHI Certificate to celebrate and recognise the facility’s success.

Breastfeeding rates
The Baby Friendly Hospital Initiative (BFHI) seeks to provide mothers and babies with a good start for breastfeeding, increasing the likelihood that babies will be breastfed exclusively.

The number of women breastfeeding exclusively from birth to discharge usually serves as an indicator of whether protection, promotion, and support for breastfeeding are adequate in that facility. Annual statistics that show at least 75% of the mothers are exclusively breastfeeding or exclusively feeding their babies human milk from birth to discharge is expected. When the figure is lower than 75%, the facility should study their Part 3 - Pre-Assessment Questionnaire results, consider Part 2: The New Zealand Criteria carefully, and work through the Triple A process of assessment, analysis, and action, to increase their exclusive breastfeeding rates. External assessment should be arranged once the 75% exclusive breastfeeding goal has been achieved.

The BFHI cannot guarantee that women who start out breastfeeding exclusively will continue to do so for the recommended six months. By establishing a pattern of exclusive breastfeeding during the stay, maternity facilities are taking an essential step towards longer durations of exclusive breastfeeding after discharge.

If facility staff recognise antenatal care provided elsewhere contributes to a rate of less than 75% exclusive breastfeeding after birth, or that community practices need to be more supportive of breastfeeding, they may consider how to work with the antenatal caregivers to improve antenatal education on breastfeeding and with breastfeeding advocates to improve community practices (See section 1.5, UNICEF / WHO BFHI Materials: revised, Updated and Expanded for Integrated Care 2009, for a discussion of strategies for fostering Baby Friendly communities).

http://www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse_s1/en/
Supplies of Breastmilk Substitutes

Part 3 - Pre-Assessment Questionnaire includes questions that will help the maternity facility to determine how well they comply with The Code and what actions are needed to achieve full compliance.

Support for non-breastfeeding mothers

This assessment includes specific questions related to the training facility staff have received on providing support to “non-breastfeeding mothers” and what support these mothers have received. The inclusion of these questions does NOT mean that the BFHI is promoting formula feeding, rather, that the Initiative wants to help ensure that ALL mothers, regardless of feeding method, get up-to-date evidenced based, commercial free information about infant feeding and the support they need.

Mother Friendly care

In New Zealand

New Zealand has a unique maternity system which has a clear focus on ensuring best practice and mother-focused care. There are national policies in place to ensure labour and birthing practices and procedures are holistic and mother/baby focused.

The standards specified by WHO/UNICEF for “mother-friendly care” (see following section) are already incorporated into our maternity practice. In New Zealand the requirements for maternity services around birth practices are monitored by the Ministry of Health. **NZBA will not be including the monitoring of the Mother Friendly standards in maternity services as part of BFHI assessment.**

These standards include:

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights Regulation 1996

Covers the following:

1. Right to be treated with respect
2. Right to freedom from discrimination, coercion, harassment, and exploitation
3. Right to dignity and independence
4. Right to services of an appropriate standard
5. Right to effective communication
6. Right to be fully informed
7. Right to make an informed choice and give informed consent
8. Right to support
9. Rights in respect of teaching or research
10. Right to complain

Facility Policies include:

- The New Zealand Maternity Standards
- **Standard 1**: Maternity services provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies
- **Standard 2**: Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage
- **Standard 3**: All women have access to nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women

- **New Zealand Clinical indicators**
  - focused on the labour and birth period
- Referral guidelines
- A Quality and Safety plan

These indicators are reported on to the Ministry of Health and the data monitored with benchmark performance data. These indicators will be used to increase the degree of national consistency and sharing of national information.

**Internationally**
The UNICEF/WHO BFHI Revised Updated and Expanded for Integrated Care (2009) Section One included a section which introduced Mother-Friendly Care standards for assessment of maternity facilities. The international BFHI documents provide an added component related to mother-friendly care. Mother-friendly labour and birth practices are important, in their own right, for the physical and psychological health of the mothers themselves, and also have been shown to enhance infants’ start in life, including breastfeeding.

There has been strong interest, worldwide, in finding ways to advocate mother-friendly practices that are both helpful for the mothers’ psychological and physical health and of benefit to their infants, helping to ensure successful breastfeeding.

The addition of this “mother-friendly care” component within BFHI was a very useful first step in helping to ensure an optimal continuum of care for both mother and child from the antenatal to postnatal period. Since many facility staff may not have the knowledge and skills needed to offer fully “mother-friendly care”, WHO recommended that these criteria be implemented gradually, with maternity facilities only required to pass on this component after facility staff have received the necessary training.

(Refer: UNICEF/WHO BFHI Section 1: Background and Implementation (2009) p.58)

A mother-friendly facility:

1. Provides or refers for antenatal care, including vitamin/iron/folate supplementation, HIV-testing, monitoring for danger signs, and referral where appropriate
2. Offers all birthing mothers:
   - Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends
   - Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula or labour-support professional
   - Access to the best available care, preferably skilled assistance and access to timely referral as needed
- The freedom to walk, move about, and assume the positions of her choice during labour and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy position
3. Maintains records to allow for external and self-assessment and reporting purposes
4. Provides culturally competent care - that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion
5. Has clearly defined policies and procedures for:
   - Hygienic techniques
   - Delayed cord clamping
   - Placenta removal and disposal
   - Collaboration, consultation and referral with other maternity services, including maintaining communication with all caregivers when referral/transfer is necessary
   - Linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support
6. Has a review process for the following practices and procedures which can impact on breastfeeding:
   - Induction of labour
   - Episiotomy
   - Caesarean section
7. Has best practice guidelines for trial of labour following a previous caesarean section
8. Educates staff in non-drug methods of pain relief and does not promote the use of analgesic or anaesthetic drugs not specifically required to correct a complication
9. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions
10. Has training in haemorrhage control, both manual and medical
11. Strives to achieve the WHO-UNICEF *Ten Steps to Successful Breastfeeding*

**HIV and Infant Feeding**

Currently the Ministry of Health recommend that HIV-infected mothers in New Zealand do not breastfeed their children. Safe and effective alternatives to breastfeeding are available in New Zealand (Ministry of Health 2006). Infant mortality rates are low compared to developing countries where the nutritional and health benefits of breastfeeding outweigh the risk of transmitting HIV.

*Refer:*
The Baby Friendly Hospital Accreditation Process

The maternity facility should:

- Obtain Part 2 - The New Zealand Criteria and Part 3 – the Pre-Assessment Questionnaire and follow through the steps recommended by NZBA
- Appraise (assess) its practices using Part 3 – the Pre-Assessment Questionnaire
- Develop an action plan and implement the necessary changes in areas identified in the self-appraisal
- Apply to NZBA for BFHI assessment
- Undergo the BFHI assessment

Once accreditation is achieved the facility must:

- Complete and return to NZBA, a BFHI Annual Survey report (Part 5).
- Be reassessed every three years to maintain accreditation or every four years for services who meet the additional criteria. (see page 22)

Refer

UNICEF / WHO Baby Friendly Hospital Initiative Revised, Updated and Expanded for Integrated Care, Section 1 Background and Implementation 2009
The Baby Friendly Hospital Designation Process Flow Chart

1 The maternity facility appraises its own practices, using Part Three Pre-Assessment Questionnaire and studying Part Two The New Zealand Criteria.

Either:
2(a) Meets standards, as indicated by the self-appraisal, and has at least 75% exclusively breastfeeding from birth to discharge.

Or:
2(b) Does not meet standards but recognises need for improvements.

3(a) Maternity facility requests pre-assessment by NZBA to help determine if the facility is ready, and to assist with any final improvements needed.

Either:
3(b) Maternity facility studies the New Zealand Criteria, analyses deficiencies and develops plan of action to become Baby Friendly, in consultation with NZBA.

Or:
4(b) Maternity facility does not meet the New Zealand Criteria, and has at least 75% exclusively breastfeeding from birth to discharge.

5(a) Maternity facility meets the New Zealand Criteria for a Baby Friendly hospital.

Or
5(b) Maternity facility does not meet the New Zealand Criteria for a Baby Friendly hospital.

6(a) NZBA Board awards the maternity facility the WHO/UNICEF Global BFH Certificate.

Or
6(b) Maternity facility meets the New Zealand Criteria within six months.

7(a) Maternity facility monitors practice and works to maintain standards evidenced by completing the BFHI Annual Survey.

Or
7(b) Maternity facility analyses problem areas and schedules further action to become Baby Friendly, in consultation with NZBA.

8(a) After 3 or 4 years reassessment is required, using the BFHI Documents for Aotearoa New Zealand.

Or
8(b) Maternity facility implements plan of action until Baby Friendly practices become routine, then invites external assessment. Go to 4(a)

9(a) Maternity facility meets the New Zealand Criteria and receives reaccreditation.

Or
9(b) Maternity facility does not meet the New Zealand Criteria and does not receive reaccreditation.

Notes:

1. The New Zealand Criteria represent the UNICEF/WHO Global Criteria with adaptations appropriate for Aotearoa New Zealand.
2. An external assessment team does not designate a hospital as Baby Friendly. The NZBA Board (moderation panel) makes the final decision, after checking that the assessment results are accurate.
3. A maternity facility that attains Baby Friendly status may consider immediate action to expand the New Zealand Criteria based on needs of the community and in conjunction with BFCl.
4. The criteria for a four year accreditation are given in Part One page 22.
Process for BFHI Assessment

New Zealand Breastfeeding Authority (NZBA) notifies the maternity manager approximately six months prior to expiry of their accreditation.

- NZBA offers a pre-assessment discussion with the BFHI Coordinator where the assessment process and any issues are covered.
- Date or dates for assessment are agreed between management and NZBA. This date must be prior to when their accreditation period expires. In special circumstances this can be negotiated with NZBA.
- The maternity facility is required to send to NZBA, at least six weeks prior to the assessment, the following (ideally on a USB stick or by email):
  - A completed Part Three Pre-Assessment Questionnaire.
  - Annual breastfeeding data / ethnicity data.
  - Copies of the Breastfeeding Policy with consultation documentation and the Artificial Feeding Policy
  - Facility staff education records
  - Other associated policies and information for mothers (if available electronically)
  - Antenatal and/or postnatal mother consents
  - A site map
- The maternity facility manager/BFHI Co-ordinator will inform NZBA of the name of the person who will meet the team and where they will meet. The Lead Assessor may contact the BFHI coordinator/maternity manager and confirm the time and place to meet
- NZBA also need to be informed if there is to be a formal welcome. If this is to be a Māori welcome (powhiri or mihi whakatau) then NZBA may request a cultural support person/Kaumatua to support the assessment team.
- The maternity facility is invoiced for the assessment fee which needs to be paid prior to the assessment. Refer to NZBA website.
- Assessments cannot be cancelled after dates for assessment have been confirmed, without incurring additional costs; this will equate to 25% of the assessment fee.

The maternity facility will have the following available for the assessment team:

- Name of a site liaison contact person for the BFHI assessment team
- Arranged time for the BFHI assessment team to meet the facility management
- The security requirements of the maternity facility (especially after hours) and safety procedures (e.g. fire exits)
- A secure room for assessors to work in and to keep documents (lockable), ideally within the maternity unit, or in close proximity to the ward(s)
- Phone access in a room where interviews can be performed in private
- A staff duty roster. A complete list of all facility staff at the maternity facility
- A list of mothers with the type of birth and the method of feeding
- Copies of any information sheets and completed consent forms given out by the maternity facility
- The maternity facility will need to begin collecting informed consent from mothers and forwarding them to NZBA, at least three to four months prior to the assessment (this will depend on the size of the facility). This is especially important for smaller maternity facilities and consents may need to be collected and sent many months prior to the assessment for an adequate sample of a minimum of ten
mothers. The consents collected need to be forwarded to NZBA soon after collecting. Ideally these interviews need to be completed by NZBA at least six weeks prior to assessment.

The Assessment team:
- Will conduct the assessment and the lead assessor will provide feedback on the findings to management and facility staff.
- A suitable time will be arranged for the feedback session.

Following the assessment:
- NZBA sends the maternity facility an Assessment Feedback form for the facility to complete and return.
- The lead assessor completes the assessment write up and sends it to NZBA for review.
- If the findings show that the maternity facility is required to complete further follow-up work to meet the requirements of the assessment, then a letter will be sent to maternity facility management outlining the follow-up required.
- The maternity facility has six months from the date of the letter requesting further follow-up to meet the requirements outlined in the preliminary report.
- When the requirements have been completed the report goes to the NZBA moderation panel (consisting of selected NZBA board members) to be reviewed.
- The NZBA moderation panel makes the decision as to whether to award BFHI accreditation to the maternity facility.
- The maternity facility is contacted, informing them of the moderation panel's decision, and is sent the completed documents

a) If the maternity facility does not meet all of the criteria:
- The maternity facility has a period of six months following receipt of the report, to fulfil the requirements
- The maternity facility will be invoiced by NZBA for additional time (over and above that required for a straightforward assessment) and costs incurred following the initial site visit (This may include additional staff or assessor time, travel, meals, accommodation, administration, telephone calls and postage)
- If after meeting the standards the NZBA Board is not satisfied that the maternity facility will maintain the BFHI standards (e.g. it takes nearly the full six months to meet the BFHI standards, or the maternity facility has to be assessed a number of times for some components before passing) the maternity facility may be given a Provisional Pass (i.e. the maternity facility must undergo a further review administered by a BFHI assessor at the time of the BFHI Annual Survey and must pass to achieve full accreditation). Note: The maternity facility will be invoiced for the costs of this visit.
- If, following a reassessment, the service is unable to meet the standards required for BFHI accreditation, i.e. within the six month time given to address their issues, the designation as a BFHI facility is withdrawn. The certificate must be removed from view and NZBA will notify the Ministry of Health.
- Where a facility fails to undertake reassessment within six months from the due recertification date the designation as a BFHI facility will be withdrawn. The certificate must be removed from view and NZBA will notify the Ministry of Health. In some instances the reason for reassessment delay may be due to
extraordinary circumstances (i.e. moving to a new premises, earthquakes, etc) and in these instances NZBA will work with the service on an individual strategy.

b) If the maternity facility passes the assessment:

- An accreditation ceremony may be arranged by the maternity facility with NZBA
- An NZBA staff / board member will formally present the maternity facility with a BFHI certificate if a formal presentation is planned or the certificate will be couriered to the service.

Accreditation is for a period of three years or if the service meets additional criteria the accreditation may be granted for four years (refer to ‘Four Yearly Accreditation’ below)

All maternity facilities will be required to undergo a BFHI reassessment within the designated time.

A BFHI Annual Survey report is to be completed by the anniversary date on the facility’s BFHI certificate and sent to NZBA.

**BFHI Annual Survey**

All BFHI accredited services must complete and submit to NZBA their Annual Survey. This is *Part Five: BFHI Annual Survey* of the BFHI Documents for Aotearoa New Zealand 2014.

**Process for BFHI Reassessment**

The Ministry of Health requires all maternity facilities to be BFHI accredited and it is important that maternity facilities do not allow their accreditation to lapse.

**NZBA will be in touch with the maternity facility at least six months prior to the anniversary date to prepare for reassessment**

- The NZBA Executive Officer offers a pre-assessment discussion/visit.
- During the pre-assessment the assessment process and any issues are discussed.
- Following this, the request for assessment is initiated by the maternity facility. The maternity facility sends to NZBA the:
  - BFHI Assessment Request form
  - a completed *Part 3 Pre-Assessment Questionnaire*
  - annual breastfeeding / ethnicity data
  - copies of the Breastfeeding Policy, consultation documentation and Artificial Feeding Policy
  - facility staff education records

**The Assessment Process for Reassessment is the same as that for Assessment (See Page 20)**

During the reassessment the team will review the previous assessment report and recommendations made to see if these have been implemented.

**Four Yearly Accreditation**

Services will be considered for four yearly accreditation if they have:

- maintained accreditation through regular assessment every three years
- been accredited a minimum of three times
- submitted their BFHI annual survey each year, on time
• consistently maintained the BFHI criteria to a high standard

The Certificate
• The maternity facility will be awarded a certificate for each subsequent reassessment.
• The certificate will be dated with the anniversary date of the previous BFHI presentation, i.e. three years after the previous presentation. This is the case even if the maternity facility takes a considerable amount of time to achieve all of the standards, or if the maternity facility has delayed reassessment.
• The certificate can be couriered to the service or in special instances an NZBA staff / Board member will formally present the maternity facility with a BFHI certificate.

Resolution Procedure
NZBA provides an effective and efficient resolution process which deals with complaints or grievances in a professional manner with consideration given to cultural and ethnic sensitivities. If a maternity facility or provider wishes to make a complaint or register a grievance in relation to the BFHI assessment process, the NZBA Executive Officer should be contacted.

Contact details:
New Zealand Breastfeeding Authority (NZBA)
Unit 1, First Floor, 16 Sheffield Crescent,
P O Box 20-454
Bishopdale
Christchurch 8543
Phone: 03 3572 072
Fax: 03 3572 074
Email: info@nzba.co.nz
Basic Principles of the Baby Friendly Hospital Initiative in Aotearoa New Zealand

1. The Treaty of Waitangi is an integral part of BFHI in Aotearoa New Zealand.

2. The Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA Resolutions are non-negotiable. They are the minimum standard of hospital and maternity practices required to be Baby Friendly.


4. Facility staff interviews will be conducted face-to-face.

5. Mothers are to be interviewed because they are an important source of information on the breastfeeding practices within the facility. Informed consent must be obtained.

6. Elimination of free and low-cost supplies of infant formula to the hospital or maternity facility seeking designation is an essential precondition for attaining Baby Friendly status.

7. Assessment tools must cover all aspects of Part Two: The New Zealand Criteria. NZBA requires facilities to complete Part Three: The Pre-Assessment Questionnaire and a BFHI Assessment Request form.

8. In New Zealand the Ministry of Health requires maternity facilities to achieve BFHI Accreditation.

9. Once accredited a BFHI Annual Survey (Part 5) of the BFHI Documents for Aotearoa New Zealand 2014, must be completed and forwarded to NZBA each year each year; this is a requirement for ongoing reassessment.

10. Reassessment is required 3 or 4 yearly. NZBA may revoke a maternity facility's BFHI status for failure to apply for reassessment within the designated period of accreditation.

11. NZBA observes strict confidentiality regarding assessment information and the final report, which is shared only with the maternity facility.