



NZBA

Baby Friendly Aotearoa
New Zealand

BABY FRIENDLY HOSPITAL INITIATIVE

PART TWO

The New Zealand Criteria

New Zealand Breastfeeding Alliance

UNICEF & WHO

Part Two
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The New Zealand Criteria

1 Introduction

The BFHI criteria for Aotearoa New Zealand are based on the *UNICEF/WHO Baby Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care (2009)* guidelines. The global assessment tool forms the basis of the audit and accreditation procedure for all countries.

The BFHI documents for New Zealand are in **7 parts**:

Part 1: Background and Baby Friendly Implementation in Aotearoa New Zealand.

Part 2: The New Zealand Criteria for BFHI.

Part 3A: Information for Services

Part 3B: Pre-Audit Questionnaire. (*Primary, Secondary and Tertiary*)

Part 4: Resources for Aotearoa New Zealand.

Part 5: BFHI Annual Survey. (*Primary, Second and Tertiary*)

Part 6: BFHI Guide for External Auditors.

Part 7: BFHI Audit Summary. (*Primary, Secondary and Tertiary*)

The intent in Aotearoa New Zealand is to encourage consistent evidence-based culturally-appropriate infant feeding practices at all maternity facilities and where initiation of breastfeeding occurs acknowledging:

- the Treaty of Waitangi / te Tiriti o Waitangi is an integral part of BFHI in Aotearoa New Zealand;
- New Zealand has a unique system where women choose their Lead Maternity Carer (LMC) for their antenatal, birth and post-natal care.
- Self-employed LMCs utilising maternity facilities also have a key role in practising in line with BFHI principles and promoting these in the community;
- Consultation on the policy with community service providers and consumers is mandatory.

The New Zealand Ministry of Health requires all maternity facilities in New Zealand to attain, and then maintain Baby Friendly Hospital Accreditation.

These documents have been accepted as the New Zealand BFHI accreditation criteria, adapted from the International BFHI documents following extensive consultation, to reflect the Treaty of Waitangi / te Tiriti o Waitangi, meet New Zealand legislation and reflect our unique maternity system.

**2 New Zealand
Criteria for Baby
Friendly
Hospital
Initiative
Implementation**

The New Zealand Criteria for the Baby Friendly Hospital Initiative serves as the recognised standard, measuring adherence to each of the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions.

Additional required criteria are listed regarding the Treaty and the care of the non-breastfeeding mother.

**3 BFHI Audit
Criteria for
Infant Feeding
Data**

Infant feeding data from maternity facilities must show that at least 75% of the babies discharged from maternity facilities in the last year have been exclusively breastfed or exclusively fed expressed breastmilk from birth to discharge. Sound, documented clinical reasons or evidence of mothers' informed decisions are required for at least 80% of the breastfed babies who have been given a breastmilk substitute.

All babies discharged with their mothers from the maternity facility must be included in the breastfeeding data.

**4 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.

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.

* Prescribed as per the Medicines Act, 1981.

From *Breastfeeding Definitions for Monitoring the National Health Outcome Targets in New Zealand*, MOH. New Zealand, February 1999.

Ever Breastfed:

The World Health Organisation requires countries to report on the percentage of infants that initiated breastfeeding: Infants who

received any breastmilk, whether directly at the breast or expressed, fall into the category of 'ever breastfed'.

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.

5 Ethnicity and Breastfeeding Status Data Collection

Collecting high quality ethnicity data that is then linked to breastfeeding status will help to determine if strategies to improve breastfeeding rates are effective.

The MOH and NZBA require ethnic breakdown of the breastfeeding statistics, at discharge, from maternity facilities to enable the accurate calculation of breastfeeding rates. Ethnicity data collection is governed by protocols set by the Ministry of Health¹.

The Mother's Ethnicity will determine the ethnic groups that should be included in the consultation process for a facility's Breastfeeding Policy. Baby Friendly standards require that consultation takes place in the local community and with ethnic groups that represent over 5% of the clientele accessing the maternity facility.

Mothers must identify their own ethnicity (self-identification). The person recording ethnicity data must not 'guess' ethnicity on behalf of the respondent, transfer the information from another form, or limit the number of ethnicities to be given.

Where more than one ethnic group is identified, the ethnicity of the respondent is determined by default in the following order:

- Māori
- Pacific peoples
- Asian
- Other groups except NZ European *and*
- NZ European².

¹ *Ethnicity Data Protocols for the Health and Disability Sector*, Ministry of Health, Wellington, 2004.

² Refer to *Ethnicity Data Protocols for the Health and Disability Sector*, Ministry of Health, Wellington, 2004, page 19.

<http://www.health.govt.nz/publication/hiso-10001-ethnicity-data-protocols-health-and-disability-sector>

6 Ten Steps to Successful Breastfeeding

Step One Have a written Breastfeeding Policy that is routinely communicated to all health care staff.

Step One:
Breastfeeding Policy

The health facility has a written breastfeeding policy that addresses all of the Ten Steps to Successful Breastfeeding and protects breastfeeding by adhering to the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA Resolutions.

This policy is developed in consultation with groups that comprise of 5% or more of the clientele accessing the maternity facility, consumer organisations and other providers using the maternity facility. The Treaty is acknowledged and integrated throughout the policy.

The person(s) responsible for midwifery or nursing services can at any time locate a copy of the policy and describe how all new staff are orientated and made aware of it.

The policy is available so that all staff and independent practitioners who take care of mothers and babies can refer to it. Summaries of the policy are visibly posted in all areas of the health care facility which pregnant women, mothers, infants, and/or children access. These areas include the labour and birthing area, antenatal care in-patient wards and clinic/consultation rooms, post-partum wards, infant care areas, and any neonatal infant care units or special care baby units. The summaries are displayed in the language(s) and with wording most commonly understood by mothers and staff.

The policy must be reviewed at least every three years.

❖ 100% compliance to all criteria, as documented above, must be achieved to pass Step One.

Step Two Train all health care staff in skills necessary to implement this policy.

Step Two:

Training & Professional Development

The person(s) responsible for midwifery or nursing services can report that all staff employed by the facility, who have any contact with pregnant women, mothers and/or babies, have received orientation and education on the implementation of the breastfeeding policy. This person can describe how the education is delivered and confirm that it meets the standards.

A copy of the curricula or course session outlines, for educating various types of staff in breastfeeding promotion and support (including breastfeeding and lactation management where applicable), is available for review. An Education Schedule for new employees is available.

The person(s) responsible for midwifery or nursing services reports that all staff caring for women and babies have participated in education on breastfeeding protection, promotion and support (and breastfeeding and lactation management if applicable), or if new, have been orientated to the breastfeeding policy, on arrival, and scheduled for education within six months. They can also confirm that Level 3 Specialist staff are available to offer breastfeeding support, on-site, 24 hours per day.

The education criteria for the **four levels** of staff are described below. These are the minimum hours required for the designations identified. The facility coordinator will consider, on an individual basis, how much daily contact staff have with pregnant women and mothers and/or babies.

Once assessed, their education requirements must align with one of the levels identified below. To assist a facility in determining the level of education required for applicable staff, an education classification is provided in the *Appendix: Education Classifications* section of this document.

It is an expectation, that all facility staff, irrespective of designation, receive orientation to the Breastfeeding Policy at commencement of employment and at each policy review.

Note: A variation in the hours of infant feeding education may occur and diversity of practice within some health professions is recognised.

Anaesthetists

The requirement for anaesthetists who regularly* work with women during labour and birth is:

- Orientation to the maternity facility's breastfeeding policy with focus on Step Four. Emphasis must be given to the importance of immediate skin-to-skin contact³ between mother and baby and the potential effect of medications⁴, administered during labour and birth, on the newborn and the initiation of breastfeeding⁵.

At the time of audit evidence must be provided to demonstrate that a **minimum of 80% of anaesthetists**, for whom this is applicable, have completed this education on employment and at each Breastfeeding Policy review.

***Note:** Regular involvement is deemed to be those working in Obstetric Care, at least one shift every month.

Anaesthetists Interview Requirements

At least 80% of the randomly selected **Anaesthetists** can:

- confirm that they have received the described education or, if they have been in the maternity facility less than six months, have at least received orientation to the breastfeeding policy and what their role is in implementing this policy.
- show awareness of the Ten Steps to Successful Breastfeeding including the importance of skin-to-skin baby-mother contact.
- describe the advice they would give to a mother about the effects of drugs given during labour, birth and following a general anaesthetic.
- state three practices in the maternity service that support breastfeeding.

³ *Understanding the Breast Crawl*, Amanda Henderson, *Nursing for Women's Health*, Vol.15, Issue 4, Aug-Sept, 2011.

⁴ Departments of Pharmacology & Obstetrics and Gynecology University of Michigan & S. E. Domino, MD, Department of Obstetrics and Gynecology, University of Michigan; M.S. Morris, E. F. Domino, S. E. Domino,

⁵ Estimation of infant dose and exposure to pethidine and norpethidine via breast milk following patient-controlled epidural pethidine for analgesia post caesarean delivery. Al-Tamimi Y, Ilett KF, Paech MJ, O'Halloran SJ, Hartmann PE. Department of Anaesthesia and Pain Medicine, Joondalup Health Campus. Int J Obstet Anesth., 2011 Mar 11.

Level One: Awareness (*no clinical or a limited clinical role*)

These are classified as staff, who are employed by the maternity facility in a **non-clinical or a limited clinical role**, and who are in regular contact with pregnant women, mothers and their babies. e.g. cleaning staff, reception staff, general theatre staff and phlebotomists.

At the time of audit evidence must be provided to demonstrate that a **minimum of 80% of Level One: Awareness** staff have completed the equivalent of one hour of **education, which encompasses the mandatory subjects, every year since employment**. If employed for **three years this must equate to three hours** in the previous **three years**.

For non-clinical / limited clinical staff, the education must include:

- orientation to the facility's breastfeeding policy
- the Importance of Breastfeeding
- the Ten Steps to Successful Breastfeeding
- the protection of breastfeeding which includes the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions.

Ongoing Education

Ongoing breastfeeding education for **Level One: Awareness** staff, between audits should equate to a **minimum of one hour annually**.

Level One Interview Requirements

At least 80% of the randomly selected **Level One Awareness** staff can:

- confirm that they have received the described education or, if they have been in the maternity facility less than six months, have at least received orientation to the breastfeeding policy and what their role is in implementing this policy.
- describe at least three reasons why exclusive breastfeeding to six months is important.
- state three practices in the maternity service that support breastfeeding.
- answer correctly four out of five questions on issues relating to the promotion, protection and support of breastfeeding.

Level Two: Generalist

These are classified as staff who have contact with the mother/baby dyad and, who have a **limited clinical role in infant feeding**, but are able to refer to an on-site Level 3 specialist for breastfeeding assistance. The Generalist **does not usually include** midwifery, nursing or support staff who have direct contact with the antenatal/postnatal women. Generalist staff may include obstetricians, paediatricians, registrars, house surgeons, junior doctors, dietitians, speech and language therapists.

Generalist staff must have education that covers:

- orientation to the Breastfeeding Policy
- the importance of breastfeeding
- acceptable sound clinical reasons for supplementation
- the implications of unnecessary supplementation
- the Ten Steps to Successful Breastfeeding
- the protection of breastfeeding which includes the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions
- the effect of medications administered during labour and birth on the newborn and initiation of breastfeeding (for medical practitioners only)
- the importance of referral to a Specialist Level 3 or 4 staff member when a breastfeeding situation arises beyond their scope of practice.

At the time of the audit evidence must be provided to demonstrate that a **minimum of 80%** of **Level Two: Generalist** staff have completed **two hours** of infant feeding education, which encompasses the mandatory subjects, every year since employment. If employed for three years this must equate to six hours in the previous **three years**.

Ongoing Education

Once six hours of breastfeeding education has been achieved within three years, which covers the mandatory subjects, the ongoing breastfeeding education for a **Level Two Generalist** staff member must show a **minimum of one hour three-yearly which includes** a review of the Breastfeeding Policy and any relevant policies relating to infant feeding.

Level Two Interview Requirements

At least 80% of the randomly selected **Level Two: Generalist** staff can:

- confirm that they have received the described education or, if they have been in the maternity service less than six months, have at least received orientation on the breastfeeding policy and their role in implementing this policy.
- answer correctly four out of five questions on breastfeeding promotion and support, and breastfeeding management.
- describe two breastfeeding issues that should be discussed with a pregnant woman.
- describe the support services available for mothers in the community, and how mothers are informed of this support.
- recognise the importance of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions in the protection of breastfeeding and its application to practice.

Level Three: Specialist

These are classified as clinical staff who are working in the maternity facility. These may include midwives, nurses, childbirth educators and in some cases support staff who work in a clinical capacity with mothers and their babies.

At the time of audit evidence must be provided to demonstrate that a **minimum of 80%** of **Level Three: Specialist** staff have completed the **mandatory requirement of 21 hours** of infant feeding education and, following this, ongoing education should equate to a **minimum of four hours** of infant feeding education annually. This ongoing annual education includes a minimum of **one hour** of clinical education. A **30-minute** Breastfeeding for Māori Women education session must be attended during a three to four-yearly ongoing education period.

The initial 21 hours of education must at least include:

- orientation to/review of the Breastfeeding Policy
- the importance of breastfeeding
- acceptable sound clinical reasons for supplementation
- the implications of unnecessary supplementation
- the Ten Steps to Successful Breastfeeding
- the protection of breastfeeding including the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions
- the Artificial Feeding Policy and the care of the non-breastfeeding mother and her infant
- the effect of medications administered during labour and birth, on the newborn and the initiation of breastfeeding
- safe and unsafe sleep practices
- one hour Breastfeeding for Māori Women which incorporates the Treaty
- three hours of supervised clinical education as stipulated below.

The supervised one-on-one clinical tuition must include:

- all practical aspects of positioning, aligning and latching of baby for breastfeeding
- the teaching of hand expressing breastmilk
- cup feeding technique
- safe and hygienic preparation, feeding and storage of breast-milk substitutes.

Level Three Interview Requirements

At least 80% of the randomly selected **Level Three Specialist** staff can:

- confirm that they have received the described education or, if they have been in the maternity service less than six months, have at least received orientation on the breastfeeding policy and their role in implementing this policy.
- answer correctly four out of five questions on breastfeeding promotion and support, and breastfeeding management.
- describe two breastfeeding issues that should be discussed with a pregnant woman.
- prove competence in guiding a breastfeeding mother to confidently feed her baby.
- describe the support services available for mothers in the community, and how mothers are informed of this support.
- recognise the importance of *the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions* in the protection of breastfeeding and its application to practice.
- prove competence in guiding a non-breastfeeding mother to safely prepare and feed her baby a breastmilk substitute.

Level Three: Specialist (continued)

Individualised evidence must be provided to demonstrate that Level Three staff (who have clinical contact with mothers and/or infants and have been on the staff six months or more) have received the required education, either at the facility or prior to arrival. This documentation will also identify the date and hours of the instructional orientation to the facility's breastfeeding policy, clinical and practical assessment and attendance at any ongoing breastfeeding education sessions.

Staff employed within the preceding six months are required to have been orientated to the policies and have been placed on the first available breastfeeding education session, unless they have provided documentation confirming that the required education had been received elsewhere.

Ongoing Education:

Ongoing breastfeeding education for **Level Three: Specialist** staff should be shown to equate to a **minimum of four hours annually which includes one hour of supervised clinical tuition annually, over the previous three or four years.**

Note: The ongoing breastfeeding education programme will also include cultural education focusing on **Breastfeeding for Māori Women** for a minimum of 30 - 40 minutes **every three to four years.**



Level Four: Expert

These are classified as staff who have specialist expertise in infant and young child feeding. It is expected that these staff would be an International Board Certified Lactation Consultant (IBCLC) and employed in a designated lactation position. This person would be employed by the facility in a clinical role may also educate staff at all levels on infant feeding.

A Level Four staff member needs to:

- receive orientation to the Breastfeeding Policy and Artificial Feeding Policy on employment
- attend a half-hour session on Breastfeeding for Māori Women every three years

There must be documented evidence demonstrating that the facility has arranged or supported appropriate ongoing annual education for this staff member to ensure 75 Continuing Education Recognition Points (CERPs) can be earned over a five-year period enabling recertification.

- Programs with instruction specific to lactation are awarded L-CERPs. (a minimum of 50 are required).
- Education on topics about the ethics of practice for IBCLCs is awarded E-CERPs. (a minimum of five are required).
- R-CERPs can be earned from professional education that is related to the work of an IBCLC, but is not specifically about breastfeeding. (20 can be R CERPs).

Continuing Education Recognition Points (CERPs) can be earned not only by attending Conferences or seminars but also by preparing, researching and presenting education sessions at a level appropriate for IBCLC education. One (1) CERP is equivalent to sixty (60) minutes of instructional or preparation time.

Level Four Interview Requirements

See *Part 6: BFHI Audit Manual Co-ordinator Interview – page 16:*



Refer to *Appendix: Education Classifications* (page 36) for examples of the collation of education requirements for all levels of staff in maternity facilities.

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

If the health facility is the provider of primary care, breastfeeding classes, antenatal classes or handover of care during pregnancy the following standards, in **Section A**, are applicable for these services.

If the facility has pregnant women who are referred for obstetric consultation only, the standards for this particular service or clinic which are documented in **Section B** are applicable.

(NOTE: Some facilities may be assessed by both Section A and Section B criteria).

Section A:

The person(s), responsible for midwifery or nursing services reports that breastfeeding is discussed and information is given to pregnant women using those antenatal services, either individually or in a group.

The facility has a written description of the topics discussed in the antenatal education programme (pertaining to BFHI and breastfeeding) and this is available for review along with the printed materials that support the topics being discussed. The breastfeeding education content and information covers the Ten Steps to Successful Breastfeeding and other relevant information.

This includes:

- the facility Breastfeeding Policy
- the importance of breastfeeding
- the importance of exclusive breastfeeding for the first six months
- the implications of formula feeding
- that breastfeeding continues to be important after six months when other foods may be introduced
- the effect of drugs, used in labour, on both the newborn and the initiation of breastfeeding
- the importance of early skin-to-skin contact
- early initiation of breastfeeding
- rooming-in on a 24-hour basis, safe and unsafe sleeping practices
- responsive (cue-based or baby-led) feeding
- frequent feeding to help ensure enough breastmilk
- good positioning and attachment
- the implications of giving water, formula or other supplements to a baby in the first six months
- the implications of using pacifiers, teats and bottles on the establishment of breastfeeding
- breastfeeding support services in the community.

Step Three:

Antenatal
Communication

80% of the randomly selected pregnant women who have completed the antenatal education or are at least **32 weeks or more** gestation who are using the antenatal service can:

- confirm that a staff member has either, discussed the importance of exclusive breastfeeding with them, or ensured that another health professional has discussed, the importance with them and can list at least two implications of giving a breastmilk substitute to a baby under six months of age
- identify at least two of the following reasons breastfeeding is important:
 - optimal nutrition for baby
 - bonding
 - protection, including the importance of colostrum.
 - health of the baby
 - health of the mother.
- confirm that a staff member has discussed breastfeeding management with them or ensured that another health professional has discussed this with them and they were able to adequately describe what was discussed about two of the following topics:
 - importance of skin-to-skin contact
 - importance of rooming-in 24 hours a day, safe and unsafe sleep practices
 - positioning and attachment of baby to the breast
 - importance of responsive (cue-based or baby-led) feeding
 - how to initiate and maintain a good milk supply
 - implications of using pacifiers, teats and bottles on the establishment of breastfeeding.

For All Services where Step Three - Section A is applicable:

Additionally, at least 80% of these pregnant women can confirm that they have not received group education or any written promotional materials on the preparation or brands of infant formula, and that all information given to them was free from advertising in compliance with The Code.

Information provided to pregnant women, should be ethnically and culturally appropriate and relevant to specific needs.

Section B:

These facilities must provide the following:

- positive conversations around breastfeeding
- good resources promoting and supporting breastfeeding
- a Baby Friendly environment
- identification of maternal risk factors that may impact on breastfeeding
- contribution to breastfeeding care planning/referral to appropriate support services
- an environment which is compliant with The Code.

Step Four Help mothers initiate breastfeeding within half an hour of birth.

This Step is 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.

Step Four:
Skin-to-skin: Initiating Breastfeeding

At least 80% of the randomly selected clinical staff can explain how skin-to-skin contact between a mother and her baby at birth is implemented and the importance of this practice.

At least 80% of the randomly selected mothers in the facility who have had vaginal births, or caesarean section births without general anaesthesia, can confirm:

- that their babies were in skin-to-skin contact with them immediately or within five minutes after birth and that this contact continued for at least an hour, except for brief bed-transfer interruption or if there were clinically justifiable reasons for separation.

(It is preferable that babies be left even longer than an hour, if feasible, as they may take longer than 60 minutes to breastfeed).

Step Four:
Skin-to-skin: Initiating Breastfeeding

- that they were encouraged to look for signs for when their babies were ready to breastfeed during this first period of contact and offered help with breastfeeding, if needed.

(The baby should be supported to breastfeed, when ready and not forced to do so. If necessary staff can assist the mother with placing her baby so he/she can move to her breast and latch when ready).

The time and length of skin-to-skin contact following birth is recorded in the mother/baby's clinical record.

If any of the randomly selected mothers have had caesarean section births with *general anaesthesia*, at least 80% should report that their babies were in supervised skin-to-skin contact with them as soon as they are able to respond, and that this contact continued for at least an hour or more, except for brief bed-transfer interruption or if there were medically justifiable reasons.

Facility records show that in at least 80% of cases, babies are with their mothers, in skin-to-skin contact, immediately or within five minutes of birth, for at least 60 minutes. These mothers can confirm they were shown how to recognise the signs that their babies are ready to breastfeed and offered help, if required.

At least 80% of the randomly selected *mothers with babies in special care*, report that they have had opportunities to hold their babies in skin-to-skin contact or, if not, the staff could provide justifiable reasons why they could not.

NOTES: Recognising the practice of delayed cord clamping, the wording of this step has been amended. 'Skin-to-skin' contact does not necessarily always mean 'chest to chest' therefore maintaining skin-to-skin contact can occur from birth even if it is initially thigh-to-baby – as long as baby maintains skin-to-skin contact with its mother.

Step Five Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants.

Step Five:

Breastfeeding
Management

The person(s) responsible for midwifery or nursing services reports that mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support in the postpartum period.

At least 80% of the randomly selected clinical staff can:

- teach mothers how to position, align and attach their babies for breastfeeding and are able to demonstrate correct techniques
- teach mothers how to hand express and can describe or demonstrate an acceptable technique for this
- identify signs of effective suckling and milk transfer
- explain how to store expressed breastmilk.

At least 80% of the randomly selected mothers who are breastfeeding can:

- report that maternity staff offered further assistance with the next breastfeed within six hours of birth or when they were able to respond to their babies
- report that a Level Three staff member offered them support with positioning and attaching their babies for breastfeeding
- demonstrate or describe correct positioning, alignment, attachment and effective suckling and milk transfer
- report that they were shown how to express their breastmilk by hand and offered written information on breastmilk storage. In addition, mothers report that they were encouraged to express sufficient milk for comfort if ever their breasts are overfull and the baby is disinterested in breastfeeding
- report that they have access to breastfeeding support, 24 hours a day, should it be required.

At least 80% of the randomly selected mothers with babies in special care, who are breastfeeding or intending to do so:

- report that they have been supported to initiate lactation within six hours of birth
- report that they have been shown how to express their breastmilk by hand
- can adequately describe (or demonstrate) how they were shown to express their breastmilk by hand
- report that they have been told that over every 24-hour period, they need to breastfeed or express their milk eight times or more, with no longer than six hours between any two of these sessions, to establish and maintain their supply
- report that they were given information on the storage of breastmilk and that this was discussed with them.

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

Step Six:

Medical Indications

Maternity facility data indicate that at least 75% of the babies discharged with their mothers from the maternity unit in the last year have been exclusively breastfed or exclusively fed breastmilk from birth to discharge.

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 BFHI standards and current evidence.

No materials that recommend breastmilk substitutes or infant foods or drinks (other than breastmilk), scheduled feeds or other inappropriate practices are displayed or given to pregnant women or mothers.

Observations in the postnatal wards/rooms and discussion with staff show that at least 80% of the babies are being fed only breastmilk or there are acceptable sound clinical reasons for receiving a breastmilk substitute.

At the time of audit at least 80% of the randomly selected breastfeeding mothers report that their babies had received only breastmilk or, if they had received anything else, it was for sound clinical reasons, described by the staff, or as a result of mothers' informed decision making. Documented clinical reasons and/or evidence of mothers informed decision is required.

The person(s) responsible for midwifery or nursing services or another clinical staff member should be able to give sound clinical reasons for these cases (see *Appendix – Acceptable Sound Clinical Reasons for Supplementation*). Evidence of the information, given to a breastfeeding mother who requests a breastmilk substitute for her infant, must be available for review. This information must include the health implications associated with the supplementation

Step Seven Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.**Step Seven:**Rooming-in of Mothers
& Infants

All of the randomly selected mothers, with babies who are not in special care, report that since birth their babies have stayed with them day and night, unless their babies are away for a short time (up to an hour) for clinical indications which the staff are able to justify.

The facility has information for mothers on safe and unsafe sleep practices.

At least 80% of the randomly selected clinical staff can give three reasons why rooming-in 24 hours a day, while in hospital, is important for mothers and their babies.

At the time of assessment 100% of the mothers:

- in the postnatal ward(s), whose babies are not in special care, should be observed, to have their babies with them, unless their babies are away for a short time (up to an hour) for clinical indications, which the staff are able to justify
- interviewed, whose babies were not in special care, report that their babies were with them 24 hours a day, unless their babies were away for a short time (up to an hour) for clinical indications.

Where a baby is removed from the mother's room:

- for a clinical indication the baby should be held during the time of separation or closely supervised at all times
- at the mother's request, staff must discuss the safety implications, e.g. the inability to ensure supervision during time of separation and the increased risk of infection
- the reason for separation and evidence of discussion should be documented in the mother's and baby's clinical notes.

There is no hospital nursery (or similar room) available for the purpose of mother-baby separation.

Step Eight **Encourage breastfeeding on demand.**

Step Eight:
Encouragement

The person(s) responsible for midwifery or nursing services confirms that mothers are advised to feed their babies on demand for as long as they want (so long as babies are breastfeeding effectively).

At least 80% of the randomly selected mothers of babies who are breastfeeding (whose babies are feeding effectively) report that they have been told how to recognise when their babies are ready to breastfeed and can describe at least two early feeding cues. They are advised to feed their babies when recognising these early feeding cues. No restrictions have been placed on the frequency or the length of breastfeeds (as long as babies are breastfeeding effectively).

At least 80% of the randomly selected mothers with babies in special care, report that they have given information and an explanation so they can identify feeding cues.

Step Nine **Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.**

Step Nine:
Appropriate Use of Feeding Devices

The person(s) responsible for midwifery or nursing services reports that breastfeeding babies are not fed using bottles or teats, or given pacifiers (dummies) by staff.

Observations in the postnatal wards/rooms indicate that at least 80% of the breastfeeding babies observed are not fed using bottles or teats, or using pacifiers. Where these are in use, staff can provide documented evidence that information was provided on the implications of their use and evidence of the mothers' informed decision.

Of the randomly selected breastfeeding mothers whose babies are not in special care, at least 80% report that their babies have not been fed using bottles or teats, or provided with pacifiers⁶ by staff. Where these have been used, there is evidence that mothers have been informed of the implications and that consent was given for use. Mothers report that they were informed of the implications.

The facility has policies or guidelines covering the appropriate use of nipple shields/bottles or teats and pacifiers.

⁶ Effect of restricted pacifier use on duration of breastfeeding in full-term infants, Jaafar S, Ho JJ, Jahanfar S, Angolkar M, 30 August 2016

Step Ten Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Step Ten:
Support Groups &
Referral

The person(s) responsible for midwifery or nursing services reports that:

- mothers are given information on where they can get support if they need help with breastfeeding their babies after returning home, and the staff member(s) can name sources of support
- staff encourage mothers to call their LMC or postnatal midwife (in accordance with *Section 88*) soon after discharge for skilled assessment of feeding and breastfeeding support, and referral to specialist lactation services if required.

Staff can describe the help available to mothers with feeding their babies after they return home. At least 80% of the randomly selected staff can state what help is available from:

- the facility
- community support groups, peer counsellors or other community health services including breastfeeding support groups/services.

At least 80% out of the randomly selected mothers can confirm that:

- their follow-up support, after discharge by the health care facility staff, has been discussed
- they have been given written information on how to get help from the facility and/or how to contact support groups, peer counsellors, or other community health services, if they have questions about feeding their babies after they return home

A review of documentation indicates that printed information is discussed and distributed to mothers by staff, prior to discharge. The information covers how and where mothers can find help on breastfeeding their infants after returning home, including information on at least two types of help available.

7 Compliance with The Code

Compliance with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions.

The person(s) responsible for midwifery or nursing services reports that:

- no infant formula company employees, or distributors of breastmilk substitutes, bottles, teats or pacifiers have any direct or indirect contact with pregnant women or mothers.
- the hospital does not receive free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from manufacturers or distributors of breastmilk substitutes, bottles, teats or pacifiers
- no pregnant women, mothers or their families are given marketing materials or samples or gift packs by the facility that include breastmilk substitutes, bottles/teats, pacifiers, other infant feeding equipment or coupons.

A review of records and receipts indicates that any breastmilk substitutes, including special formulas and other supplies, are purchased by the health care facility for the wholesale price or more. A policy for brand rotation and evidence of compliance is available.

There is a written policy which identifies who the manufacturers or distributors of breastmilk substitutes, bottles, teats and dummies can contact, in the facility.

A review of the breastfeeding and artificial feeding policies indicates that they uphold The Code and relevant subsequent WHA resolutions by prohibiting:

- the display of posters or other materials provided by manufacturers or distributors of breastmilk substitutes, bottles, teats and dummies or any other materials that promote the use of these products
- any direct or indirect contact between employees of these manufacturers or distributors and pregnant women or mothers in the facility
- distribution of samples or gift packs with breastmilk substitutes, bottles or teats or of marketing materials for these products to pregnant women or mothers or members of their families
- acceptance of free gifts (including food), literature, materials or equipment, money or support for in-service education or events from these manufacturers or distributors by the hospital
- demonstrations of preparation of infant formula for anyone who does not need them
- acceptance of free or low-cost breastmilk substitutes or supplies.

Observations in the antenatal and maternity services and other areas where facility staff work, (e.g. special care baby units)

7 (cont.)**Compliance with
The Code**

indicate that no materials that promote breastmilk substitutes, bottles, teats or dummies, or other designated products, are displayed or distributed to pregnant women, mothers or staff.

Infant formula cans, 'ready-to-feed' and prepared bottles are kept out of view, and inaccessible to mothers.

At least 80% of the randomly selected clinical staff members can give two reasons why it is important not to give samples from formula companies to mothers.

At least 80% of the pregnant women interviewed can report they have received neither group instruction nor any written promotional material on the use of infant formula.

Products that fall under the scope of The Code

The following products come under the scope of The Code and health workers should be on the alert for their promotion:

- **infant formula:** Any preparation intended to satisfy the nutritional requirements of infants from birth until six months or older. Infant formula includes soy formula, lactose-free formula, low-birth-weight/premature formula, and any other 'special' formula.
- **other milk products that are represented as suitable for use as a partial or total replacement for breastmilk:** In practical terms, this includes follow-on milks and toddler milks marketed for babies between six months to two years. These products always replace the breastmilk part of the baby's diet which is recommended for two years and beyond. Therefore, follow-on milks and toddler milks may not be promoted for babies below two years of age.
- **any other food or beverage that is represented as suitable to be fed to infants less than six months old.** Products to watch for are complementary foods and drinks labelled as suitable for use for infants below six months of age. This includes products such as cereals, infant dinners, pureed vegetables, fruits or meats in ready-to-feed jars, infant teas, herbal drinks, baby biscuits, mineral water and juices. Since infants need complementary foods in addition to breastmilk after six months, complementary foods marketed for babies above six months do not come under the scope of The Code.
- **feeding bottles and teats.**

❖ **100% compliance for the above components of The Code is required.**

Refer to *International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions, August, 2006*.
Available from <http://www.ibfan-icdc.org/index.php/publications/publications-for-sale>

For all 'Key Points from the Code' refer to Part 1:Background& BFHI in NZ, page 10.

8 BFHI and the Treaty of Waitangi / te Tiriti o Waitangi

The Treaty of Waitangi / te Tiriti o Waitangi is an integral part of BFHI in Aotearoa New Zealand.

In recognition of their commitment to the Treaty, maternity facilities can demonstrate or provide evidence to indicate that:

- The breastfeeding policy aligns with other DHB cultural policies and plans e.g. Māori Health Plan, Māori Health Policy, tikanga best practice guidelines / models of care for Māori patients.
- Consultation processes include Māori representatives from other groups inclusive of local iwi, Māori health providers and community organisations.
- Staff records indicate that 80% of midwifery / nursing staff have met the education requirement for breastfeeding for Māori women, which incorporates the Treaty.
- Relationships exist within the District Health Board with the Māori health services, for example, Māori Health Unit, Cultural Advisor and/or relevant Māori health services.
- Relationships exist with relevant community based Māori Health Providers and community organisations e.g. local iwi, Tamariki Ora providers, Māori Women's Welfare League.
- Whānau are recognised as an integral part of the care of the pregnant and breastfeeding mother.
- Access to kaumatua support or Māori Health Worker or culturally appropriate support is available if required.
- Processes are in place for Māori to participate in the review, development and evaluation of the service.
- If applicable, Māori workforce development pathways are identified and appropriate to the facility demographics.
- Observations within the facility indicate an environment that is culturally appropriate and supportive.

9 Standards of Care for Non-Breastfeeding Mother and Her Baby

1. Artificial Feeding Policy:

The health facility has a written Artificial Feeding policy for the feeding of a breastmilk substitute. This policy must be routinely communicated to **Level Three Specialist** staff who have contact with pregnant women and/or mothers and babies.

The policy requires that mothers who have clinical indications for which breastfeeding is not recommended, or mothers of babies with such clinical indications, receive counselling on infant feeding and guidance on selecting options likely to be suitable for their situations.

This policy must include the importance of:

- the availability of information for mothers regarding the implications associated with the use of formula
- the safe preparation and handling of infant formula
- skin-to-skin contact for the mother and her infant
- rooming-in 24 hours a day, safe and unsafe sleep practices
- responsive (cue-based or baby-led) feeding with guidelines for appropriate intake
- parenting and well child services.

This policy is not for public consultation or public display and must be reviewed at least three yearly.

For Audit:

The artificial feeding policy is available for review by the audit team.

2. Level Three Specialist

Level 3 staff must ensure that their knowledge about artificial feeding is current.

Standards for education

The education programme needs to be available and include information on:

- the implications of formula feeding
- how to provide support for non-breastfeeding mothers
- the safe preparation, handling & feeding of formula
- the care of formula feeding equipment
- the importance of skin-to-skin contact and rooming-in 24 hours a day, irrespective of method of feeding
- parenting and well child services available following discharge.

9 (cont.)**Standards of
Care for Non-
Breastfeeding
Mother and Her
Baby**

The curriculum should ensure that Level 3 Specialist staff, have completed the standards, as described above, and will receive further updates, as required, to ensure competency is maintained.

Requirements for Level 3 Specialist

At least 80% of the randomly selected **Level 3 Specialist** staff providing clinical care for pregnant women, mothers and their babies can:

- confirm that they have received orientation on the artificial feeding policy and their role in implementing this policy
- describe two issues that should be discussed with a pregnant woman/mother if she indicates that she is considering feeding her baby food or fluid other than breastmilk
- describe how non-breastfeeding mothers can be assisted to safely prepare their feeds, or can describe to whom they refer mothers on their shifts for this advice
- identify two support services available in the community for the non-breastfeeding mother and her baby.

One or more designated staff member(s) may be assigned to the role of educating the non-breastfeeding mother with the practical aspects of artificial feeding. This should be done in private, on a one-to-one basis. If a woman makes an informed decision to artificially feed her baby this decision is to be documented in her clinical notes and thereafter is she is well supported to do so.

She should be shown the safe preparation and feeding of infant formula. Accurate and appropriate information must be given and staff must ensure that the mother has understood the instructions. Mothers should have received this information prior to discharge.

The LMC has a responsibility to ensure that the mother continues safe preparation, handling and feeding practice.

For Audit:

Evidence must be provided to demonstrate that Level 3 Specialist staff (who have contact with mothers and/or infants and have been on the staff six months or more) have received the required orientation to the policy and education, either at the facility or prior to arrival.

This documentation will also identify the date of the instructional orientation to the facility's policy on artificial feeding and any infant feeding education undertaken.

The hospital has an adequate facility/space and the necessary equipment for giving demonstrations on how to prepare formula and other feeding options away from breastfeeding mothers.

9 (cont.)**Standards of
Care for Non-
Breastfeeding
Mother and Her
Baby****3. Antenatal Care:**

Facilities should ensure that pregnant women, who have medical indications for which breastfeeding is not recommended and are receiving antenatal care from facility staff have the opportunity to individually discuss feeding with a midwife or nurse.

The education will include:

- the implications associated with feeding a baby a breastmilk substitute
- the importance of skin-to-skin contact
- the importance of rooming-in 24 hours a day
- responsive (cue-based or baby-led)) feeding with guidelines for appropriate intake
- safe and unsafe sleep practices
- parenting and well child services.

Artificial feeding handout materials for use in the antenatal period must include the importance of breastfeeding, the implications and costs of using infant formula, be free from advertising and comply with The Code.

For Audit:

All information offered to these women, including antenatal handouts, will be available to the audit team.

9 (cont.)

Standards of
Care for Non-
Breastfeeding
Mother and Her
Baby

4. Postnatal Care:

- skin-to-skin contact, as described in *Part 2-Step Four*, applies to the non-breastfeeding mother and her baby
- rooming-in, as described in *Part 2-Step Seven*, applies to the non-breastfeeding mother and her baby
- information on the care of full and uncomfortable breasts should be available and discussed with women who are not breastfeeding
- all teaching of the preparation and feeding of infant formula should be provided on an individual basis only for those mothers who need it or wish it.

For Audit:

Documentation of the care for the non-breastfeeding mother and her baby will be available for review, by the auditors, at the time of audit. All information offered to these women will be available.

A review of documentation indicates that printed information is discussed and distributed to mothers by staff before discharge.

Where possible assessors will interview non-breastfeeding mothers. However in New Zealand, non-breastfeeding mothers may not be available for interview due to low numbers. Therefore, these interviews will not impact on facility compliance with this standard.

The selected non breastfeeding mothers report:

- that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situation
- that they have been offered help in preparing and giving their babies feeds, can describe the advice they were given, and have been asked to prepare feeds themselves, after being shown how
- that, if their babies are in Special Care and NICU, staff have talked with them about the implications and importance of various feeding options.

Mother interviews will identify the information discussed with them by facility staff. This information will include:

- the importance of skin-to-skin contact
- practical information in safely preparing and giving their babies feeds, with this discussed on an individual basis
- care for their breasts if they become full and uncomfortable
- the importance of rooming-in 24 hours a day, safe and unsafe sleep practices
- how to recognise when their babies are ready to feed
- responsive (cue-based or baby-led) feeding with guidelines for appropriate intake
- written information on how to get help from the facility and / or how to contact well child providers and parenting support groups.

❖ **To pass the BFHI standards of care for the non-breastfeeding mother and her baby the facility must show compliance to all of the above standards (1 – 4).**

10 Acceptable Sound Clinical Reasons for Supplementation

Exclusive breastfeeding is the norm.

In a small number of situations there may be a sound clinical indication for supplementing with breastmilk or for not using breastmilk at all. It is important to distinguish between:

1. infants who cannot be fed at the breast but for whom breastmilk is available
2. infants who may need other nutrition in addition to breastmilk
3. infants who should not receive breastmilk, or any other milk, including the usual breastmilk substitutes and need a specialised formula
4. infants for whom breastmilk is not available
5. maternal conditions that affect breastfeeding recommendations.

INFANT CONDITIONS

Infants who should not receive breastmilk or any other milk except specialised formula include:

- infants with classic galactosemia: *a special galactose-free formula is needed*
- infants with maple syrup urine disease: *a special formula free of leucine, isoleucine and valine is needed*
- infants with phenylketonuria: *a special phenylalanine-free formula is needed. Some breastfeeding is possible, under careful monitoring.*

Infants for whom breastmilk remains the best feeding option but who may need other food in addition to breastmilk for a limited period include:

- infants born weighing less than 1500g (very low birth weight)
- infants born at less than 32 weeks of gestation (very preterm)
- newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic⁷ if their blood sugar fails to respond to optimal breastfeeding or breastmilk feeding
- Infants who show symptoms of clinical dehydration, and for whom breastfeeding and maternal lactation has been fully assessed, confirming a delay in lactogenesis II.

Breastfeeding Answers Made Simple, pp. 203, 414, 619, N Mohrbacher, 2010.

MATERNAL CONDITIONS

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

⁷ Oral dextrose gel for treatment of newborn infants with low blood glucose levels
Weston PJ, Harris DL, Battin M, Brown J, Hegarty JE, Harding JE;4 May 2016

Maternal conditions that may justify permanent avoidance of breastfeeding:

- HIV infection (New Zealand Ministry of Health Guidelines)⁸

Maternal conditions that may justify temporary avoidance of breastfeeding:

- severe illness that prevents a mother from caring for her infant, e.g. sepsis
- herpes simplex virus type 1 (HSV-1). Direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved
- maternal medication:
 - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available⁹
 - radioactive iodine-131 is better avoided given that safer alternatives are available – a mother can resume breastfeeding about two months after receiving this substance
 - excessive use of topical iodine or iodophor (e.g. povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided
 - cytotoxic chemotherapy may require that a mother stops breastfeeding during therapy.

Hypoglycaemia of the newborn: review of the literature. Geneva, World Health Organization, 1997

(WHO/CHD/97.1; http://whqlibdoc.who.int/hq/1997/WHO_CHD_97.1.pdf,

⁸ **HIV and Breastfeeding in New Zealand**; <http://www.health.govt.nz/our-work/diseases-and-conditions/hiv-and-aids/breastfeeding-women-hiv-infection>
<http://www.moh.govt.nz/moh.nsf/indexmh/breastfeeding-questions-hiv>

⁹

Medications: <http://www.medsafe.govt.nz/Profs/PUarticles/June2015/June2015Lactation.htm>

'Medications and Mothers' Milk', Thomas W. Hale, 17th edition, 2017.

Maternal conditions during which breastfeeding can still continue, although health problems may be of concern:

- breast abscess. *Breastfeeding should continue on the unaffected breast. Feeding from the affected breast can continue if the situation of the abscess/drainage area permits.*¹⁰
- hepatitis B. *Infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter.*¹¹
- hepatitis C
- mastitis. *If breastfeeding is very painful, milk must be removed by expressing to prevent progression of the condition.*¹⁰
- tuberculosis. *Mother and baby should be managed according to national tuberculosis guidelines.*¹²
- substance use¹³
 - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies
 - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

Further information on substance abuse and breastfeeding is available from:

- the United States National Library of Medicine (NLM)
website: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

¹⁰ **Mastitis: causes and management. Geneva**, World Health Organization, 2000 (WHO/FCH/CAH/00.13;
http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf).

¹¹ **Hepatitis B and breastfeeding**. Geneva, World Health Organization, 1996. (Update No. 22).

¹² **Breastfeeding and Maternal tuberculosis**. Geneva, World Health Organization, 1998 (Update No. 23).

¹³ Guidelines for Tuberculosis Control in New Zealand (2010) Management of the Neonate exposed to Maternal Tuberculosis (page 95)
[http://www.moh.govt.nz/moh.nsf/Files/guidelines-tuberculosis-2010/\\$file/guidelines-tuberculosis-control-new-zealand.pdf](http://www.moh.govt.nz/moh.nsf/Files/guidelines-tuberculosis-2010/$file/guidelines-tuberculosis-control-new-zealand.pdf)

**Appendix:
Education
Examples for
Staff Levels**

At the time of the BFHI external audit at least 80% of each level (Levels One, Two, Three) of staff must have **completed** their required education hours.

A selection of fictional scenarios is described below to show how education can be collated for all levels of staff in maternity facilities.

Anaesthetist Education

While anaesthetists have not been included in any of the defined level of education classifications, it is important to ensure those who work clinically in the birthing area have been orientated to the Breastfeeding Policy. Particular attention must be given to *Step Four*, highlighting the importance of skin-to-skin contact between mother and baby immediately after birth, and the potential effect on the newborn and the initiation of breastfeeding of medications, administered during labour and birth.

Anaesthetists must be included in any updates and reviews of the Breastfeeding Policy.

Example:

While there are 11 anaesthetists who work in the facility only two regularly work in the birthing area; one assigned full-time to cover this area with another on-call during the weekend hours. The other nine cover the night hours on a rotational basis.

Both of the anaesthetists who work regularly in this area had received a one hour (one-on-one) education session during the past three years. This included a review of the Breastfeeding Policy but focussed particularly on *Step Four*. For one of these health professionals it was the second review of the policy as he had worked in the unit for years.

Level One - Awareness

On audit, these staff have completed the equivalent of **one hour** of education, which encompasses the mandatory subjects, **every year** since employment. For example, if employed for three years this must equate to three hours in the previous three years. Examples of *Level One* staff are receptionists, cleaners, telephonists and hearing screeners.

Example:

At the time of audit five out of six (83%) of the Level One staff had completed the base education requirements. The documentation showed that this was achieved through the delivery of one hour of education annually as follows:

Of these six staff, three commenced employment with the facility prior to the last audit. At the time of their three-yearly audit they had completed the required three hours of education (including orientation to the Breastfeeding Policy) attending annual hourly updates, therefore meeting the educational requirement for a Level One staff member.

Out of the three remaining staff, two commenced employment with the facility in the past two years and received orientation to the Breastfeeding Policy, and two hours of breastfeeding education, meeting the educational requirements for a Level One staff member of one hour annually from the date of employment.

The remaining staff member commenced employment three years ago and has attended a one-hour education session only. This staff member also completed three hours of breastfeeding education four years ago at another facility. The staff member incorrectly thought that the three hour of previous education was still valid. This is not the case as she requires an hour of education annually, which equates to three hours completed within the previous three yearly cycle or four hours in a four yearly cycle.

Level Two - Generalist:

At audit a **Generalist** staff member should have completed **two hours** of infant feeding education, which encompasses the mandatory subjects, **every year** since employment. If employed for over three years this must equate to **six hours** in the previous **three years**.

Once the initial six hours of breastfeeding education has been achieved within three years, which covers the mandatory subjects, then ongoing breastfeeding education for a **Level Two Generalist** staff member must show a **minimum of one hour three yearly which includes** a review of the Breastfeeding Policy and any relevant policies relating to infant feeding. Examples of *Level Two* staff include doctors, obstetricians and paediatricians.

Example:

Four out of the four (100%) of Level Two staff completed the required six hours of mandatory and ongoing education since employment. There was evidence that this was achieved through the delivery of regular annual education sessions, however each staff member completed their education in different ways.

The first staff member (a doctor) has always had an interest in breastfeeding/lactation management, attending sessions on a regular basis since commencing employment 18 months ago, completing in excess of eight hours of education during this time. He was involved in the Breastfeeding Policy review.

The second staff member (an obstetrician) has been employed with the facility for ten years. He completed six hours of education to comply with the previous assessment of the facility and has recently attended a Policy review led by the BFHI Co-ordinator, lasting 75 minutes.

The third staff member (a registrar) has only been at the hospital three months and has received orientation to the Breastfeeding Policy on commencement of employment and attended a short 30-minute education session. The staff member was put on the roster to attend an additional education session for a Level Two staff member in three months' time. While not meeting the six-hour educational requirement as yet the staff member received orientation to the policy and is rostered to attend the next available education session therefore meeting the criteria for a new staff member who has commenced employment with the facility within the last six months.

The fourth staff member (a doctor) was employed by the facility nine months ago receiving orientation to the Breastfeeding Policy on commencement of employment. As she is now outside the 'new employee criteria' she is required to have had two hours of infant feeding education. The person responsible for education delivery had scheduled two hours of breastfeeding education just prior to the audit with the programme including reading research, reviewing case studies and one-on-one discussion on the Ten Steps to Successful Breastfeeding and The Code. The staff member completed the two hours of base education within seven months of employment, two months prior to the audit. She meets the required standard.

Level Three – Specialist

Level Three Specialist staff have completed the **mandatory requirement of 21 hours** (as stipulated in *Part 2: Step Two*, page 12), and following this, the ongoing education should equate to **four hours** annually of infant feeding education. The ongoing education includes a minimum of **one hour** supervised clinical education and a **30-minute** Breastfeeding for Māori Women education programme in the previous **three or four years**. These staff are midwives, nurses or hospital aides depending on their clinical role.

Example:

Twenty-two out of 30 (73%) Level Three staff had completed their mandatory education prior to the last audit and there is evidence that

over the past four-year period they have maintained their education by receiving over sixteen hours of continuing education.

Those meeting the Level Three requirements were:

Fifteen of the 22 Level Three staff had been employed prior to the last audit (four years ago) and had completed their 21 hours of mandatory infant feeding education. Over the past four years they had attended two full-day workshops, (with additional clinical education) and equated to over 16 hours of infant feeding education.

Two of the 22 Level Three staff had been appointed in the past twelve months and received orientation to the Breastfeeding Policy on employment, and completed the 21-hour educational requirement within the year.

One of the 22 Level Three staff was a newly-appointed graduated midwife who received orientation to the Breastfeeding Policy and worked alongside the BFHI Coordinator to complete her clinical education (which was documented). The combination of these three factors means that she met the required standard, as the midwifery school tuition covers all of the breastfeeding education hours required, giving greater than the 21-hour breastfeeding education component. This also includes the Breastfeeding for Māori Women education programme. The clinical hours and orientation to the Breastfeeding Policy are the only necessary education needing to be completed to meet the full requirement.

Four of the 22 Level Three staff, who met the requirements, had breastfeeding education hours from their previous employment which complied with the requirements of *Step Two*. Evidence, in the form of certificates and programmes with confirmed attendance, was submitted to verify that the education had taken place.

*Those **not** meeting the Level Three requirements were:*

Three of the 22 Level Three staff mistakenly believed that they had met the requirement. They had attended 16 hours of infant feeding lectures over the past four years, but had no documentation of any education prior to the last audit. While they had attended sufficient documented ongoing education hours they had failed to meet the initial mandatory standards of 21 hours. Four of the 22 Level Three staff had completed twenty hours of infant feeding education in the past but they had never completed the Breastfeeding for Māori Women education component.

One of the 22 Level Three staff had completed her mandatory education hours prior to the previous assessment but had only attended one seven-hour workshop since that time – as a result she has not met the ongoing education requirement.

Summary:

Eight of the Level Three staff did not meet the requirements:

To meet the 80% educational requirement, the facility could have scheduled three of the four midwives to attend the Breastfeeding for Māori Women self-learning package which would have given them an 83.3% pass rate which would have complied with the requirements of *Step Two*.

Level Four - Expert

There must be documented evidence demonstrating that the facility has arranged or supported appropriate ongoing annual education for this staff member to ensure 75 Continuing Education Recognition Points (CERPs) can be earned over a five-year period enabling recertification. Examples of *Expert* level staff are International Board Certified Lactation Consultant employed to clinically assist/educate pregnant women and breastfeeding mothers and to educate staff to meet the BFHI education requirements.

- Programs with instruction specific to lactation are awarded [L-CERPs](#) (a minimum of fifty are required).
- Education on topics about the ethics of practice for IBCLCs is awarded [E-CERPs](#) (a minimum of five are required).
- [R-CERPs](#) can be earned from professional education that is related to the work of an IBCLC, but is not specifically about breastfeeding (twenty can be R CERPs).

Continuing Education Recognition Points (CERPs) can be earned not only by attending conferences or seminars but also by preparing, researching and presenting education sessions at a level appropriate for IBCLC education. One (1) CERP is equivalent to sixty (60) minutes of instructional or preparation time.

Example:

An IBCLC, employed as the facility Lactation Consultant/BFHI Co-ordinator four years previously, has organised three different study days for the midwifery staff over the past three years. While she has delivered the same sessions several times, to cover all staff, the CERP allocation is only given to the first presentation – not repeat days. Therefore, this IBCLC has earned twenty-one hours (Each day equates to seven hours of teaching.) for her presentations and an equal number of CERPs for her preparation of those sessions.

She organised a one-hour session for the staff entitled Breastfeeding for Māori Women which she also attended. In her role she has organised a review of both the Breastfeeding Policy and the Artificial Feeding Policy.

There have been two unusual clinical situations on the postnatal ward for which she sought confirmation of appropriate management from an independent lactation consultant.

She has attended two Lactation Conferences over the past three years each gaining 19.5 CERPs of varying categories.

The combination of both the prepared and attended education sessions gives a minimum of 21 + 21 + 19.5 + 19.5 CERPs which potentially meets the requirements for recertification providing the L, R and E CERP categories meet the necessary levels. The requirement has possibly been

achieved within three years. The IBCLC herself should ensure the CERP categories are met by selecting the appropriate sessions – this is not the facility’s responsibility.

The facility has supported her financially to attend the seminars and allowed time for the preparation and teaching of her education sessions.

Overview educational attainment used in the examples above		
Anaesthetists	2 out of 2	(100%)
Awareness Level One	5 out of 6	(83%)
Generalist Level Two	4 out of 4	(100%)
Specialist Level Three	22 out of 30	(73%)
Expert Level Four	1 out of 1	(100%)
Total	34 out of 43	(79%)

Comment:

Every staff designation (Anaesthetists, Level One, Level Two, Level Three and Level Four) must meet the **80% threshold** to meet the educational requirements of *Step Two*.

In these scenarios Level Three staff did not meet the 80% requirement and therefore did not meet the requirements of *Step Two*. This could have been achieved if the facility had scheduled three of the four midwives to attend the Breastfeeding for Māori Women self-learning package which would have given them an 83.3% pass rate.

Defining Clinical Education

At least 80% of all clinical staff (Level Three – Specialist) need to have completed a minimum of **three hours of one-on-one supervised clinical tuition** at the time of the BFHI audit. Ongoing supervised clinical education equates to **one hour annually** and is included as part of the annual four-hour ongoing education programme.

The initial mandatory tuition is on a one-to-one basis and must include all practical aspects of positioning, aligning and latching of baby for breastfeeding, hand expressing of breastmilk and cup feeding techniques. This may be assessed in a classroom situation with a small group working in pairs overseen by the educator or in a clinical situation in the facility. Once these aspects have been completed and 'signed-off' the ongoing clinical education can include any other clinical components related to practical infant feeding situations.

'Supervision' means 'under the guidance of'. All clinical education should be supervised by an appropriately skilled educator.

Example:

A midwife, employed for eight years, has been reluctant to be assessed in her clinical practice. She was having a busy shift and called the IBCLC to the postnatal ward to assist a mother with her breastfeeding. Appropriately the Lactation Consultant (IBCLC) asked the midwife to discuss the issues and to show her how she had managed the situation thus far, indirectly assessing her clinical ability.

Comment:

This may only have been a brief encounter but it means that this midwife had commenced the clinical requirement of the education programme. She showed clinical competence during this session, both in the teaching of hand expressing and positioning, along with aligning and attempting to latch the baby at the breast. Discussion after the event, when she was less pressured, allowed the IBCLC to give praise and extend her knowledge by giving practical tips.

The full amount of time, including both observation and discussion, was approximately thirty minutes. Because, in this clinical setting, the IBCLC was able to observe a high level of competency, the first two aspects of the clinical education had been completed, with only cup feeding to be discussed and observed to cover the basic requirements.

For the midwife, this equated to sixty minutes of clinical education - thirty minutes for the practical demonstration and thirty minutes for the discussion. She still requires two hours to meet the minimum standard.

The extra practical/clinical hours can be achieved in many ways:

- discussion regarding a clinical situation where breastfeeding is not progressing well, including the implementation of a plan to assist the mother. If the plan is inaccurate the lactation consultant can make suggestions to ensure a positive learning environment
- the preparation and feeding of formula
- assembling and using a breastpump
- self-directed learning, with feed-forward on a clinical aspect of breastfeeding e.g. ankyloglossia, rusty-pipe syndrome or Raynauds Phenomenon
- discussion and demonstration on safe sleep practices / cues to feed.

In a classroom situation the topic of mastitis, what is it and how does it affect the breast, is not classified as a clinical component but when addressed in practice it becomes applicable.
