

Central Lancashire Online Knowledge (CLoK)

Title	Global implications of the new WHO and UNICEF implementation guidance on the revised Baby-Friendly Hospital Initiative
Type	Article
URL	https://clock.uclan.ac.uk/23463/
DOI	##doi##
Date	2018
Citation	Aryeetey, Richmond and Dykes, Fiona Clare orcid iconORCID: 0000-0002-2728-7967 (2018) Global implications of the new WHO and UNICEF implementation guidance on the revised Baby-Friendly Hospital Initiative. <i>Maternal & Child Nutrition</i> , 14 (3). e12637. ISSN 1740-8695
Creators	Aryeetey, Richmond and Dykes, Fiona Clare

It is advisable to refer to the publisher's version if you intend to cite from the work. ##doi##

For information about Research at UCLan please go to <http://www.uclan.ac.uk/research/>

All outputs in CLoK are protected by Intellectual Property Rights law, including Copyright law. Copyright, IPR and Moral Rights for the works on this site are retained by the individual authors and/or other copyright owners. Terms and conditions for use of this material are defined in the <http://clock.uclan.ac.uk/policies/>

Global implications of the new WHO and UNICEF Implementation Guidance on the revised BABY-FRIENDLY HOSPITAL INITIATIVE

- Richmond Aryeetey, University of Ghana School of Public Health, Legon, Accra, Ghana
- Fiona Dykes, Maternal and Infant Nutrition and Nurture Unit (MAINN), University of Central Lancashire.

ABSTRACT

Although breastfeeding confers both short- and long-term benefits for children and their mothers, breastfeeding practice remains sub-optimal, globally. In addition to barriers including misperceptions and inappropriate marketing of breast milk substitutes, inadequate support for breastfeeding remains a challenge in many settings. To improve access to appropriate health system support, the WHO has reviewed the Baby Friendly Hospital Initiative (BFHI), which ensures provision of optimal clinical care and support to mothers and their infants. This review has resulted in revision of the Ten Steps to Successful Breastfeeding, which form the core standards of BFHI. These now consist of critical management procedures to support breastfeeding (steps 1 and 2) and key clinical practices to support breastfeeding (steps 3-10). In step 1, there is now specific emphasis on compliance with the World Health Organization Code of Marketing of Breast -milk substitutes (WHO 1981) and relevant World Health Assembly resolutions as well as on internal monitoring. There are also significant position shifts like the recommendation to ‘Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers’, which is a departure from the earlier position of avoiding reference to these technologies. These revisions require countries and states to revise activities and tools for their local situation but without compromising the standards.

INTRODUCTION

Breastfeeding is a biological norm for feeding young children. When practiced appropriately, it confers a myriad of health and other human development benefits on the child, the mother, and the society as a whole. Recent evidence has demonstrated that increasing rates of breastfeeding could generate about 300 billion dollars each year for the global economy. Further, scaling up optimal breastfeeding practices could prevent more than 800,000 deaths in children per year. Breastfeeding also has benefits for the breastfeeding mother. A key outcome of appropriate breastfeeding is reduced risk of future-onset non-communicable diseases. For example, increasing and improving breastfeeding practices can reduce about 20,000 deaths per year from breast cancer (Rollins et al., 2016; Victora et al., 2016).

The World Health Organization (WHO) recommends exclusive breastfeeding for the first 6 months of an infant's life, with continued breastfeeding up to 2 years of age or beyond, along with nutritionally adequate, safe, and appropriate complementary foods (WHO, 2003). However, breastfeeding practice is increasingly under threat of being rolled back due to cultural change, aggressive marketing of breast-milk substitutes and inadequate support from the health system, families, communities, and the workplace (Rollins et al., 2016). Mothers and their families, therefore, need guidance and support that will enable them to successfully initiate and sustain appropriate breastfeeding. This support should be underpinned by appropriate evidence-based standards and capacity.

HEALTH SYSTEM SUPPORT FOR BREASTFEEDING

In 1989, in an effort to reverse the global trend towards increased use of breastmilk substitutes and hospital practices that were detrimental to breastfeeding, the WHO and United Nations Children's Fund (UNICEF) published a joint statement: *Protecting, Promoting and Supporting Breastfeeding* (WHO/UNICEF, 1989). This statement included Ten Steps to Successful Breastfeeding (Ten Steps) (see figure 1).

In 1991, WHO and UNICEF launched the global Baby Friendly Hospital Initiative (BFHI) as a facility-based action to provide optimal clinical care and support to mothers and their infants (WHO and UNICEF 1992). The BFHI achieves this purpose by ensuring maternity facilities adopt and implement the Ten Steps. Current evidence, collated in a narrative systematic review, has demonstrated that adherence to the Ten Steps impacts rates of breastfeeding (early initiation immediately after birth, exclusive breastfeeding, and total duration of any breastfeeding). Further, there is a dose–response relationship between the number of BFHI steps women are exposed to, and the likelihood of improved breastfeeding outcomes (Pérez-Escamilla et al, 2016). To become 'Baby friendly', a facility that provides maternity services must adopt and demonstrate capacity to implement the Ten Steps (UNICEF, 2009). Thereafter, an initial self-assessment followed by an assessment by an external team of assessors is needed to designate a facility as 'Baby friendly', if it meets the standards. These standards are implemented based on a set of guidance and assessment tools used at facility level to ensure infants and mothers receive appropriate support to successfully breastfeed their infants. However, after nearly three decades, it is evident that implementation of the BFHI is far from optimal (WHO 2017a). Currently, only an estimated 10% of children are delivered in facilities that are certified as 'Baby friendly'. This is due to multiple factors including country inertia to own and invest in the implementation of the ten steps, irregular monitoring of facility services, and non-enforcement of quality standards at facility level (UNICEF and WHO 2017). As a result, in many countries BFHI remains unsustainable without external support.

The BFHI has undergone several reviews. It was first updated in 2006 following extensive user surveys that allowed incorporation of new evidence, including 'breastfeeding in the context of HIV', and 'mother-friendly care' (WHO and UNICEF 2013). This allowed the BFHI to be relaunched in 2009. More recently, the WHO and UNICEF have evaluated the BFHI by assessing the current state of implementation. A wide variety of approaches have been utilized in this evaluation process to include case-studies, key informant interviews and a global policy survey (UNICEF and WHO 2018). In addition, and crucially, the WHO developed a Guideline on protecting, promoting, and supporting breastfeeding in facilities providing newborn services. This was based on twenty-two systematic reviews following procedures of the Cochrane Handbook for Systematic reviews, plus qualitative syntheses using the GRADE-CERQual approach (WHO 2017b). From this evaluation, what is clear is that implementation of the BFHI and its accompanying steps has ensured improved attitudes and skills of care providers, dramatic reductions in use of formula, reduced separation of infants from their mothers, and made nurseries an uncommon practice. Beyond these, BFHI has also led to facility-wide changes to protect, promote, and support breastfeeding in a baby-friendly environment (UNICEF and WHO, 2018). It has also unearthed important implementation challenges that must be surmounted to ensure improved scale-up of appropriate quality standards that are sustainable. Out of these challenges, lessons must be learned that will stimulate and re-energize BFHI in all countries. A key lesson is to prioritize state funding for BFHI at national and sub-national levels. There is a need to sustain standards of implementation by investing in a well-trained facility staff to deliver services through in-service as well as pre-service training programs. These staff should be supported by higher level specialist coaches who will motivate them to keep their status beyond the initial passion of designation. It is also important to cultivate and sustain champions at facility level who will not only advocate for breastfeeding standards but also to pass on the passion. The evaluation has given opportunity for revising again the Ten Steps underlying the BFHI (see figure 1). While the basic themes have been maintained, the Ten Steps have been reworded, and in some cases, updated with new components to better reflect the current evidence and practice realities. The Ten Steps have now been divided into critical management procedures to support breastfeeding (steps 1 and 2) and key clinical practices to support breastfeeding (steps 3-10). Important changes include incorporation of compliance with the International Code of Marketing of Breast-milk substitutes (WHO 1981) and internal monitoring into Step 1; a focus on staff knowledge and competence has been embedded in step 2. Step 5 now has a broader scope that includes positioning, suckling and competence of the lactating mother. The emphasis in step 8 is now towards the relational aspects of breastfeeding with emphasis on responsiveness to infant cues. The changes in step 9 are perhaps the most controversial with the new guidance taking a significant position shift in its recommendation to, 'counsel mothers on the use and risks of

feeding bottles, teats, and pacifiers’, which is a departure from the earlier position of avoiding reference to these technologies. This, in no way suggests a relaxation in the emphasis upon protection, promotion and support of breastfeeding but rather a recognition that parents who decide not to exclusively breast feed, need support in optimizing their alternative approaches to feeding. Step 10 shifts responsibility to facilities providing maternity and newborn services to plan and facilitate provision of ongoing community support for mothers rather than relying of mother-to-mother support groups.

Beyond the Ten Steps, the new guidance on BFHI proposes actions to enable states to improve coverage and standards in BFHI implementation. These include scaling up BFHI coverage in both public and private facilities, integrating the BFHI into existing initiatives in the health system and even beyond, ensuring adequate capacity of health system staff, and regular monitoring and taking corrective action to ensure standards are maintained. External monitoring is also emphasized to ensure appropriate service delivery. These programmatic changes should be implemented in a way that is consistent with the Ten Steps.

Figure 1: WHO/UNICEF Ten Steps to Successful Breastfeeding (original version-1989 and revised version 2018)

STEP	Original version (1989) ‘Every facility providing maternity services and care for newborn infants should’:	Revised version (2018)
1	Have a written breastfeeding policy that is routinely communicated to all healthcare staff.	<ul style="list-style-type: none"> a) Comply fully with the International Code of Marketing of Breast-milk substitutes and relevant World Health Assembly resolutions. b) Have a written infant feeding policy that is routinely communicated to staff and parents. c) Establish ongoing monitoring and data-management systems.
2	Train all healthcare staff in the skills necessary to implement the breastfeeding policy.	Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding
3	Inform all pregnant women about the benefits and management of breastfeeding.	Discuss the importance and management of breastfeeding with pregnant women and their families
4	Help mothers to initiate breastfeeding within half an hour of birth.	Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5	Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants	Support mothers to initiate and maintain breastfeeding and manage common difficulties.

6	Give newborn infants no food or drink other than breastmilk, unless medically indicated.	Do not provide breastfed newborn infants any food or fluids other than breastmilk, unless medically indicated
7	Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.	Enable mothers and infants to remain together and to practice rooming-in 24 hours a day.
8	Encourage breastfeeding on demand	Support mothers to recognize and respond to their infant's cues for feeding.
9	Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.	Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

MONITORING AND LEARNING FROM IMPLEMENTATION

It is important to consider further research questions related to actual implementation of the revised BFHI to update existing knowledge (Pérez-Escamilla et al 2016; Schmied et al., 2014). Recognizing that scaling up breastfeeding takes place in a complex adaptive world (Pérez-Escamilla and Hall Moran 2016), we could use ecological perspectives to further explore the ways in which change in relation to the revised BHI is managed at a macro (society-level), meso (community-level) and micro (individual-level) (McLaren and Hawe, 2005). This perspective may be adapted to health care systems with macro relating to the social, economic, and health policy contexts; meso relating to the maternity and newborn care environments, organization of care, staffing structures and leadership; and micro relating to individual experiences and perspectives (Dykes et al., 2016). Research is increasingly showing the importance of person-centered approaches for women (Schmied et al., 2011), and prioritizing relationships to better facilitate mothers' capacities to respond to their babies' cues (Dykes and Flacking 2010, Thomson et al., 2012). Thus we need studies that include in-depth ethnographic exploration of implementation of the BFHI, to explore and observe implementation of the revised Ten Steps and the acceptability for parents using the maternity and newborn services. These studies need to be conducted in a range of country and cultural contexts with cross-cultural comparative processes embedded.

CONCLUSION

Over 25 years since initial implementation, the BFHI is yet again at the starting line of a new phase. Will it keep the same low scale-up pattern evident over the last few years or will it see renewed state-led action aimed at making all maternity facilities 'Baby friendly'? The pathway will depend very much on the current context in each country or state. To be successful, it is important to situate the country context within the broader

program framework with consideration for adequate advocacy, and buy in from champions and decision makers who will provide the needed resources for action (Perez-Escamilla et al., 2018). In countries where positive change will occur in response to the revised guidance on BFHI, there will be appropriate investment in capacity at national and sub-national levels. In addition, a strengthened monitoring system at facility level as well as at higher levels will be useful to determine an appropriate course of action.

REFERENCES

- Dykes, F., Flacking, R. (2010). Encouraging breastfeeding: a relational perspective. *Early Human Development*. 86, 733-736.
- Dykes, F., Thomson, G., Gardner, C., Hall Moran, V., Flacking, R. (2016). Perceptions of European medical staff on the facilitators and barriers to physical closeness between parents and infants in neonatal units. *Acta Paediatrica*. 105: 1039-1046.
- McLaren, L., and Hawe P, (2005). Ecological perspectives in health research. *Epidemiology & Community Health*. 59., 6-14.
- Pérez-Escamilla, R., and Hall Moran, V. (2016). Scaling up breastfeeding programmes in a complex adaptive world. *Maternal and Child Nutrition* 12(3): 375-380.
- Pérez-Escamilla, R., Martinez, J.L., Segura-Pérez, S. (2016). Impact of the Baby-friendly Hospital Initiative on breastfeeding and child health outcomes: a systematic review. *Maternal and Child Nutrition* 12(3): 402-17.
- Pérez-Escamilla, R., Hromi-Fiedler, A. J., Gubert, M. B., Doucet, K., Meyers, S. & Dos Santos Buccini, G. (2018). Becoming Breastfeeding Friendly Index: Development and application for scaling-up breastfeeding programmes globally. *Maternal and Child Nutrition* doi: 10.1111/mcn.12596. [Epub ahead of print].
- Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M. & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet*, 387, 491-504.

Schmied, V., Beake, S., Sheehan, A., McCourt, C., Dykes, F. (2011). Meta-synthesis of women's perceptions and experiences of breastfeeding support. *Birth: Issues in Perinatal Care* 38, 49-60.

Schmied, V., Thomson, G., Sheehan, A., Burns, E., Byrom, A., Dykes, F. (2014). Meta-ethnographic study of health care staff perceptions of the WHO/UNICEF Baby Friendly Health Initiative. *Women and Birth* 27, 242-249.

Thomson, G., Bilson, A., Dykes F. (2012). 'Changing Hearts and Minds': An evaluation of implementation of Unicef UK Baby Friendly Initiative in the community. *Midwifery* 28: 258–264

United Nations Children's Fund, 2009. *Baby Friendly Hospitals Initiative: Guidelines and Tool for External Re-assessment*. Geneva: United Nations.

United Nations Children's Fund & World Health Organization (WHO) (2017). *Country experiences with the Baby-friendly Hospital Initiative: Compendium of case studies of the Baby-friendly Hospital Initiative*. Geneva: UNICEF and WHO.

United Nations Children's Fund & World Health Organization (2018). *Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE*. Geneva: UNICEF and WHO.

Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., Murch, S., Sankar, M. J., Walker, N. & Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet*, 387, 475-490.

World Health Organization (1981). *International Code of Marketing of Breast Milk Substitutes*. Geneva: WHO.

World Health Organization & United Nations Children's Fund. (1989), *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*. Geneva: WHO & UNICEF.

World Health Organization & United Nations Children's Fund. (1992). *Baby Friendly Hospital Initiative Part II. Hospital Level implementation*. Geneva: WHO/UNICEF.

World Health Organization. (2003). *Global Strategy on Infant and Young Child Feeding*. Geneva: WHO.

World Health Organization & United Nations Children's Fund. (2013). *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care*. [Online]. Geneva: WHO.

World Health Organization (2017a) *National implementation of the Baby-friendly Hospital Initiative*. Geneva: WHO.

World Health Organization (2017b) *Guideline: Protecting, Promoting and supporting breastfeeding in facilities providing newborn services*. Geneva: WHO