Challenges the hospitals faced in meeting and sustaining the standards of the Baby Friendly Initiative

Report prepared January 21, 2014 by Dr Genevieve Becker,
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at the request of Biddy O'Neill, HSE Health Promotion

The hospitals are asked each year what were the challenges they faced in meeting and sustaining the standards of the Baby Friendly Initiative, however it is not in a format that is easy to access and review thus this is my impression, in order of frequency, from reading the hospital reports and discussing with the hospital contact people:

Low managerial support / action at individual hospital level and national. The standards expected in a Baby Friendly hospital are similar to the practices contained in the HSE National Maternity and Neonatal Infant Feeding Policy. In some hospitals the policy is viewed by some staff members as optional, and if they regularly do not follow the policy/practice in accordance with the standards there is no response from their manager and no disciplinary action taken. This is most noticeable in relation to: staff members (midwives, nurses, doctors, dietitans) recommending formula use (top-ups) when there is no medical need to disrupt exclusive breastfeeding; early skin to skin contact being viewed as a lower priority than processing the mother and baby out of the delivery suite as rapidly as possible; and allowing/encouraging links between formula companies and staff as regards speaking at events / receiving awards (that use the hospital name in the publicity), and posting of event publicity from formula companies.

Other examples, the room used for holding on-ward education and support sessions for new mothers was taken away in at least three hospitals for reasons including the medical trainees needed a study space convenient to the wards, the newborn audiology service needed an office, beds were put into the room; the lactation consultant office moved way across a car park a long outdoor walk from the maternity services, and a lactation consultant directed to spend more time assisting a commercial company who wanted to provide materials to mothers because the company "was supportive of the maternity services and the service needed their funding". Low support at hospital level can relate to the allocation of time also.

National management support is also a factor. Inclusion of specific practices/outcomes related to Baby Friendly practices in Key Performance Indicators for maternity services at a national level would be a great help. Without a national focus and specific targets for maternity services it will always be pushed to the background.

Frequently breastfeeding and the supportive practices of the BFHI are compartmentalised into health promotion activities focused on telling the mother of the benefits of breastfeeding and that she should have support, and measuring if the mother did breastfeed. Cross-programme and cross-department awareness and action related to the needs of infants and their mothers is often limited. The dairy processing industry is subsidised and encouraged by one (or more) government departments to increase the sales of infant formula (therefore aiming to decrease breastfeeding) while some parts of the health service battle to protect breastfeeding and reduce marketing. Legislation and agreements designed to protect infants, their parents and health workers from marketing practices are diluted or not enforced. Reducing unemployment (by increasing employment in the dairy processing industry) is seen as a higher priority than the impact on the lifelong health and wellbeing of children and their mothers. Token mention is made of the link between infant and young child feeding and obesity; however the increased risk of later obesity from formula use is not highlighted to health professionals, parents and the wider public, as is done in some other countries. Workplace supports such as paid lactation breaks cease at 26 weeks after birth which conflicts with the health recommendations to continue breastfeeding into the second year and beyond.

No allocated time to coordinate the participation in the initiative at the hospital level such as prepare the documentation, keep the records, do the audits, send the reports etc. All of the eight currently designated Baby Friendly hospitals have a full or part time post for a CMS in Breastfeeding or similar. For the one hospital that was designated originally the main reason they did not seek re-designation was because there was no longer anyone in a position with allocated time to work on the initiative. Out of the 12 non-designated hospitals, only 3 have an allocated post that involves coordination and two of these hospitals are actively working towards implementing the standards and being ready for external assessment.

Other hospitals have interested individuals but generally the time they spend on coordinating BFHI activities is volunteer time after working hours or at home in their personal time. Additionally, without a post the activities of these individuals may be viewed by colleagues and managers as the person's pet project and not part of overall hospital policy and practice. During 2013 there were three hospitals that for a large part of the year did not have anyone assigned to receive communication about BFHI (i.e. a name for the envelope or email) let alone respond to the communication.

Breastfeeding seen as an optional extra. HSE and individual hospital materials and policies that refer to mother needing to ask for (or choose to do) practices that are in the national policy as routine practices. Breastfeeding phrased as a benefit above the norm of formula feeding, and withholding of information on established risks of formula use. There is still "education" on infant feeding being provided to staff by formula companies and the language used to market formula is reflected in the language used by the health service staff.

There are examples of staff refusing to facilitate infants in the neonatal unit to receive human milk from their own mother or from the milk bank, despite the vast amount of research evidence and guidelines that human milk is vitally important to fragile infants, and encouraging / insisting on using formula instead. The mother wanting to breastfeed and requesting baby friendly practices referred to by a group of student midwives as a "whims of the mother that only causes difficulties for staff". A focus on tasks rather than holistic wellness of the service user, i.e. filling in the infant feeding chart is seen as more important that talking to the mother about her confidence in feeding her baby.

Breastfeeding may be seen as the responsibility of the mother and she is blamed if breastfeeding doesn't go well. For example, acceptance by health workers (and decision makers at all levels) that it is not a problem that about 5000 mothers per year commence breastfeeding and have totally ceased before hospital discharge, and comments that the mother wasn't motivated enough to continue.

Breastfeeding supportive practices not included in routine audits and quality activities – left to a small group to do their own audits with no support from more skilled people, and no action on the results.

Another aspect is where people in specialist lactation posts are finding their time to carry out their role is reduced as they are taken from their specialist role to work in general midwifery or other duties. Sometimes this is planned and on-going, such as reassignment to spend 20-100% of their time in another area; in other hospitals this may be sudden and unexpected short-term reassignment when there is staff shortage in another area. This reduces supports for mothers, staff training, audits, development of policies and other activities and thus hampers the hospital's process towards being a Baby Friendly hospital, as well as the specialist feeling she is not valued in her role. In recent years, when the specialist post holder is on leave no-one is allocated into that post. This can mean the phone line for breastfeeding support is not answered or messages responded to for a week or more, breastfeeding support groups are cancelled, staff education does not occur, specialist input is not sought for policy development, etc.

Lack of staff, tired and burnt out staff. The staff may have knowledge and willingness but not time/facilities to carry out best practice. On-going overwork with no opportunity to discuss a situation with a more knowledgeable colleague, look up a reference or further information, participate in continuing education, or get back to a mother later to see how she is getting on.

Babies are born at all hours of the day and night and over weekends also. Mothers have questions and need help at all hours. When staffing at night and weekends is intentionally reduced, or agency staff and general nurses less familiar with breastfeeding supportive practices are used instead, this results in some mothers and infants receiving a poor service solely because of the time or the day of birth.

Other examples include: mother told to ring the bell for the midwife at the next feed for assistance, she does but no-one comes; midwives taken from the postnatal ward when the labour ward is busy; lack of PHNs results in some hospital staff saying that it is better that the mother having difficulties stop breastfeeding before discharge because she will get no help after discharge and become distressed and baby is at risk of getting fed inadequately.

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What hospitals need in order to meet and sustain the practices of a Baby Friendly Hospital

1. Managerial awareness and commitment to ensuring that policy and practices are implemented and monitored to a similar level of other HSE policies and expected practices
2. Skilled staff allocated to provide assistance to mothers and infants with additional needs, serve as a resource to other staff, and coordinate the BFHI activities in the hospital. When a post holder is on leave, another skilled person is, at a minimum, available for the advertised support services.
3. Quality teams are aware of BFHI activities, recognise their value, and encouraging and supportive to BFHI teams.
4. Breastfeeding and supportive practices are taken as the norm, materials reflect these practices as the expected/routine practice, and practices that deviate from policy are recorded and investigated.
5. Adequate staffing levels so that staff are not frequently too tired to care.
6. Protection from marketing of infant formula and other breastmilk substitutes.
7. Widespread government level support for the importance of breastfeeding and the practices which support breastfeeding to happen.