Making BC Baby-Friendly

Report of the British Columbia Baby-Friendly Network Survey of Hospitals & Community Health Agencies

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Table of Contents

Making BC Baby-Friendly - Executive Summary

The British Columbia Baby-Friendly Network (BCBFN) disseminated a survey to 63 hospitals with maternity units and 57 community health agencies in BC in the fall of 2004. The main purpose was to identify their progress with the Baby-Friendly Initiative (BFI). This report summarizes progress with the BFI in 14 hospitals and 18 community health agencies in BC.

Although over 19,000 organizations internationally have been designated Baby-Friendly, none is in BC. At present, one BC hospital is awaiting an external assessment and five respondents indicated that their organizations intend to become Baby-Friendly in the next two years. Almost all respondents were familiar with the outcome indicators used in the BFI assessments. Challenges and successes in accomplishing the 10 Steps for hospitals and the 7 Points for community health agencies were identified. Ways BCBFN could assist organizations to become Baby-Friendly included completing or interpreting a self-assessment, developing an action plan and recommending educational resources.

Major conclusions arising from the survey are:

- BC is lagging considerably behind many other developed countries in becoming Baby-Friendly
- Although some individuals are very committed to BFI, the interest and effort across the health authorities in working towards Baby-Friendly designation is limited
- Many forces conspire against successful breastfeeding including a lack of administrative commitment and resources; a lack of knowledge and interest by health professionals; a lack of the appropriate committees; staff shortages; problems communicating with physicians; the negative influence of the formula companies; the reorganization of the health authorities; and the emphasis on short-term cost-containment
- Breastfeeding policies are often out-of-date or not known to staff
- There is a desire to share existing local programs and practices that support breastfeeding
- There is a need for accessible, low cost, and up-to-date breastfeeding education and information for health professionals and for childbearing families

There is a close relationship between breastfeeding and health promotion/disease prevention. If BC is to become Baby Friendly, changes are needed within government, the health authorities, hospitals, community health agencies and the individual health professional. Recommendations include:

- The BC Ministry of Health Services should add BFI as a key strategy to support healthy lifestyle choices and add breastfeeding rates as a performance measure
- The health authority decision-makers should understand how current staffing shortages and funding priorities negatively impact breastfeeding and the health of their communities, and provide resources and support for their hospitals and communities to become Baby-Friendly
- BCRCP should incorporate breastfeeding education into all perinatal programs, and provide quality, timely, affordable, and accessible education for health professionals
- BCBFN should provide the strategic support and assistance as requested by organizations

Making BC Baby-Friendly: Report of the British Columbia Baby-Friendly Network Survey of Hospitals & Community Health Agencies

Introduction

The Baby-Friendly Hospital Initiative (BFHI) was started in 1991 by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). The aim was "to give every baby the best start in life by creating a health care environment where breastfeeding is the norm, thus helping to reduce the levels of infant morbidity and mortality in each country."[1] Interestingly, it is the only UNICEF program that is for both developing and developed countries. There is extensive evidence showing the relevance and scientific basis of the practices contained in the 10 Steps of the BFHI program.[2,3,4,5,6,7,8,9] These criteria are internationally acknowledged and designation as a WHO/UNICEF Baby-Friendly hospital shows that a hospital has met the international standard for protecting, promoting and supporting breastfeeding. There are now over 19,000 hospitals worldwide that are designated as Baby-Friendly.

In Canada, this initiative was launched in November 1998 with the appointment of the Breastfeeding Committee for Canada (BCC) as the national authority to promote and support implementation of the Baby-Friendly Initiative.[10] A grant from the Health Canada Population Health Fund was awarded to the BCC to build the implementation infrastructure.[11] Based on the Canadian health care structure, the implementation within provinces and territories is allocated to baby-friendly implementation committees within each jurisdiction.

The British Columbia Baby-Friendly Network (BCBFN) is a multidisciplinary committee of health care providers, ministry representatives, and consumers interested in protecting, promoting, and supporting breastfeeding. It was designated by the Minister of Health and the Minister for Children and Families in 1999 as BC's baby friendly implementation committee (Terms of Reference, Appendix A). In October 2003, Dr. Penny Ballem, Deputy Minister, Ministry of Health Planning and Health Services, wrote to the chief executive officers of the six health authorities encouraging them to work with the BCBFN "to create an environment conducive to breastfeeding in BC." She encouraged them to work with the BCBFN to pursue Baby-Friendly designation and she described it as an "important opportunity for BC to become a leader in this international child health initiative." (Appendix B). The significance of the Baby-Friendly Initiative (BFI) is further supported in the 6th edition of *Baby's Best Chance*.[12] This book, provided to all childbearing families throughout the province, has been updated to meet the BFI criteria.

Critical to healthy child development are the prenatal, infancy and early childhood experiences of individuals. This early developmental period is the optimum time for infants to be breastfed, to start healthy lifestyle behaviors, and to develop and enhance attachment behaviors between mothers and their infants. Exclusive breastfeeding for six months

following birth is recommended by Health Canada,[13] the Canadian Pediatric Society,[14] the College of Family Physicians of Canada,[15] and the Registered Nurses Association of British Columbia.[16] Data from Statistics Canada indicate 85 per cent of Canadian mothers start off breastfeeding, however only 19 per cent continue to breastfeed exclusively at the six-month stage.[17] To reflect the continuum of care for breastfeeding mothers and babies outside of the hospital environment and to focus on helping mothers to sustain exclusive breastfeeding for six months, the 10 Steps of the BFHI (Appendix C) have been adapted to community settings. A 7 point plan, which sets out the standard for a Baby-Friendly community health agency, was published and distributed throughout Canada in 2002[18] (Appendix D). In this extended context, BFHI is often referred to as BFI in Canada.

Evidence that breastfeeding protects and promotes the health of infants, children and their mothers continues to grow.[19] Breastmilk has been shown to decrease the incidence and the severity of viral and bacterial conditions, including otitis media, lower respiratory disease,[20,21] diarrhea, gastroenteritis, bacteremia, bacterial meningitis, botulism, urinary tract infection, necrotizing enterocolitis, and to reduce the risk of Sudden Infant Death Syndrome in the first year of life.[21] Beyond infancy, the effects of breastfeeding are associated with contributing to protection against childhood cancers, type 1 diabetes, atopic disease, cardiovascular disease, childhood and adolescent obesity,[21,22] Crohn's disease, and improved cognitive development, particularly in preterm and low birth weight infants.[21,23,24,25]

For the mother, breastfeeding during the postpartum period enhances uterine contractions and involution and a more rapid return to her pre-pregnant weight. Continued breastfeeding for seven or more months is associated with offering women protection against ovarian and premenopausal breast cancers, improved bone remineralization postpartum, and a reduction in postmenopausal hip fractures.[21]

Weimer, in a review and analysis of the economic benefits of breastfeeding in 2001, concluded that a minimum of $US 3.6 billion would be saved if breastfeeding rates were increased to 50% at six months. These cost savings represent only three childhood diseases (otitis media, gastrointestinal and necrotizing enterocolitis).[26] The cost of **not** breastfeeding is also substantial in terms of the burden of illness to families, the expense of artificial milk, and the cost of other maternal/infant diseases to the health care system in the short and long term.

Educating healthcare professionals about the BFI standards is an effective primary care intervention to promote breastfeeding.[27] The UNICEF/WHO 18-hour course, Breastfeeding Management and Promotion in a Baby-Friendly Hospital,[28] or a course that is equivalent in content and practice, has been shown to be effective in changing practices and increasing breastfeeding rates. [3,29,30]

A hospital maternity facility can be designated as Baby-Friendly when it has implemented the WHO/UNICEF 10 Steps to support successful breastfeeding and the same designation is

awarded to community health agencies that implement the 7 Point Plan. To facilitate these achievements, documents that more fully describe the requirements to meet each of the steps and points were published and distributed throughout Canada in 2003.[31] As of March 2005, there are three hospitals, one birthing centre, and one community health service designated as Baby-Friendly in Canada. All but one hospital are in Quebec.

In the fall of 2004, the BCBFN partnered with the British Columbia Reproductive Care Program (BCRCP) to develop a survey that was sent to the 63 hospitals with maternity units (Appendix E) and to 57 community health agencies (Appendix F) in BC. The purpose of the survey was to:

1. identify progress with the BFI in the hospitals and community health agencies in BC
2. provide direction to the BCBFN to assist organizations in working towards BFI designation
3. report to the BC government the status and needs for BFI support in the province.

The survey was also posted on the BCRCP website and sent to a variety of individuals upon request, so the total number of agencies that received the questionnaire is not known. There were 16 responses from hospitals and 19 from community health agencies. Some of the community responses represented several community health agencies within a region, but they were reported as one agency. Therefore, although 19 responses were received, they actually represented 44 health units. In addition, two responses from one community health agency were received so these responses were amalgamated to form one response, bringing to 18 the total number of community health agency respondents. Finally, the quantitative data from two hospitals were excluded as they no longer provided maternity services; however, the comments about how they reached out to their small communities are included in this report.

This report identifies progress with the Baby-Friendly Initiative in 32 agencies that provide maternity care in BC. The responses from 14 hospitals and 18 community health agencies are summarized as: baby-friendly planning and awareness; the progress made towards Baby-Friendly designation; organizations' requests for assistance from BCBFN; additional comments; conclusions; and recommendations.

Baby-Friendly Planning and Awareness

No hospital or community health agency was designated as Baby-Friendly in BC at the time of this survey; however, staff in one hospital are awaiting an external Baby- Friendly assessment in 2005. Respondents' intentions that their organization become Baby-Friendly and their knowledge of the BCC outcome indicators are shown in Table 1 and their general comments follow. While only five respondents intend that their organization become Baby-Friendly in the next two years, almost all had seen the BCC BFI outcome indicators.

Table 1: Baby-Friendly Planning and Awareness

Questions asked	Total Response N = 32	Hospital Response n = 14	Community Response n = 18
Intention to become BFI in the next 2 years?			
Yes	5	4	1
No	23	7	16
Don't know/not sure/no response	4	3	1
Committee in place to lead the BFI?			
Yes	13	8	5
No	18	6	12
On hold	1	0	1
Committee resources to carry out its mandate?			
Yes	8	4	4
No	8	5	3
Not Applicable	12	3	9
Not Known	3	2	1
No Response	1	0	1
Awareness of BCC BFI Outcome Indicators?			
Yes	29	13	16
No	2	0	2
No response	1	1	1
Seen BCC BFI Outcome Indicators?			
Yes	29	13	16
No	2	1	1
No response	1	0	1

Hospital Comments

When asked if their hospital had been designated Baby-Friendly the comments ranged from we are "not even close – still accepting free formula for our nursery" to we "have been working diligently." When asked about plans to become Baby-Friendly within the next two years, some noted two years was a short time frame. Other respondents had no information about their hospital's plans, had no mandate from their health authority or "very little support to become BF from nurses, physicians, management, etc." Some had good intentions, but vague plans, "…it is the goal of the Perinatal Committee to become baby-friendly at some time." One respondent considered her hospital to be taking "baby-friendly baby steps."

Community Comments

Comments from community respondents were mixed. Positive responses included "we would like to be designated within two years but realistically it is a slow process," "a small amount of nursing time has been approved to work on guidelines to support the Breastfeeding Plan (policy to be) and funding for doctors' education lunch," and "BFI has not been part of the strategic plan but it will be taken to the Leadership team as it ties in with other initiatives from the Early Childhood Child Health Report that are being pursued."

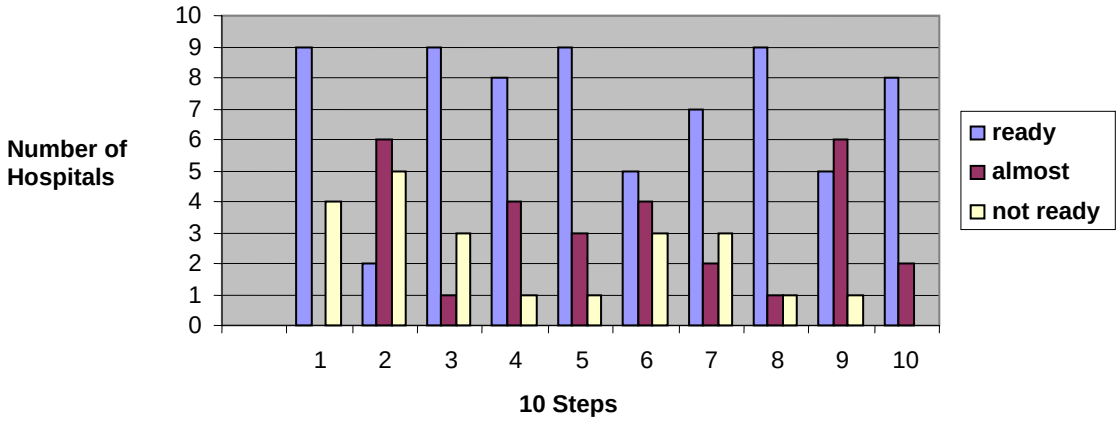
Several respondents indicated there were currently no plans in place to promote the initiative and one response suggested that they had no intention to become Baby-Friendly because "client-centred care and client-directed informed choice" is the belief within the agency and the BFI is not viewed within this agency as congruent with supporting women who choose not to breastfeed.

Progress towards Baby-Friendly Designation in Hospitals

Respondents estimated their hospital's progress in implementing each of the Baby-Friendly Steps as summarized in Table 2. The least progress was made on the three steps related to training staff (step 2), supplementing newborns (step 6) and giving pacifiers (step 9). The most progress was made on the four steps related to having a policy (step 1), informing women about breastfeeding (step 3), showing women how to breastfeed (step 5) and breastfeeding on demand (step 8).

Table 2: Hospital Progress in Meeting the 10 Steps

n=14



Challenges and Successes in Accomplishing Each of the 10 Steps (Hospitals)

The respondents in hospitals described the challenges and successes they encountered in implementing each step. Their responses are summarized below.

Step 1

Have a written policy that is routinely communicated to all health care staff.

While nine respondents reported their hospital had a breastfeeding policy, others described outdated policies, policies that were not followed or policies that were not inclusive of the community. One respondent expressed frustration that their policy was "shelved" during the regionalization process although there had been "thousands of dollars spent on getting a 'Baby-Friendly Initiative Ad Hoc Committee' together and working on a new regional breastfeeding policy." Another reported the "WHO Code 10 steps are posted on the Maternity Ward."

Step 2

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

Formal breastfeeding education was a requirement in some hospitals. "The [on-line breastfeeding] course is mandatory for all Mat-Child staff at our hospital." In one hospital, the lactation consultant provided education "constantly on an informal basis." It was difficult to provide the 18-hour course as well as three hours of supervised clinical experience in some hospitals and, at times, only nurses were trained. Respondents said it was challenging to involve or get "buy-in" from doctors, other health professionals and older nurses.

Step 3

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

Prenatal classes were the main approach to informing women about breastfeeding. One respondent described special classes for Indo-Canadian women. *Baby's Best Chance* and other materials were also made available in a variety of ways. The Breastfeeding Challenge was also noted as a successful strategy. However, there was still a need to "get the word out" and develop a "consistent plan on how to reach all moms."

Step 4

Help mothers initiate breastfeeding within a half-hour of birth.

While eleven hospitals were ready or almost ready to help mothers initiate breastfeeding within a half-hour of birth, breastfeeding was delayed in many hospitals following a Cesarean birth. However, one respondent reported "even CS moms have babies stay with them in PAR and then come up together unless general anesthetic (is used)." Staffing shortages were another reason the initial breastfeeding was delayed.

Step 5

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

Respondents from twelve hospitals reported they were ready or almost ready with this step. One respondent said "SCN supports pumping and storing EBM." Another said "care plans are discussed and given to moms who have PHN contact." Another reported "we are working on improving the knowledge base of the nurses working on the units so they become more aware of how to effectively assist moms having problems breastfeeding." There were concerns that not all health care providers taught the same thing and "we could improve

working on teaching more hand expression." Consistent coverage by a lactation consultant was desired but "contingent on available funding."

Step 6

Give newborns no food or drink other than breastmilk unless medically indicated.
Respondents reported supplementation with water and formula was an ongoing concern despite hospital policy. In some facilities "pediatricians readily suggest supplement" and "formula is in clear view of parents." One respondent reported that "staff are beginning to realize that the majority of babies do not require supplementation" and "nursing staff are comfortable with cup feeding, finger feeding, manual expression."

Step 7

Practice 24-hour rooming-in.
Eight respondents said their hospitals were ready or almost ready to meet this step. One noted that their normal nursery will close soon, implying that would resolve the rooming-in problem. They reported "all mothers room-in unless babe ill or in SCN" and "mom's partners are encouraged to stay 24 hours with mom and babe and sleep in chairs provided." Another said that rooming-in often starts with a family member cuddling (but not feeding) the baby if the mother has gone to the Recovery Room. Reasons for not rooming-in were related to staff simply not complying with the policy. Poor lighting was also a problem "so nursing staff routinely separate infants from their mothers to do routine checks on the babies." Another commented "we are struggling with whether or not moms can co-sleep with their babies."

Step 8

Encourage breastfeeding on demand.
Nine respondents reported they were ready or almost ready to meet the demand feeding criterion. There were few comments on this step. One noted it "happens most of the time but needs to be done all of the time." Another said although it was their policy it is "not encouraged enough by staff."

Step 9

Give no artificial nipples or pacifiers to breastfeeding infants.
The challenges associated with meeting this step related to mothers requesting soothers, parents bringing them in and nurses supporting their use. "We get bottles and teats free from the formula company." Another reported pacifiers were only available in SCN where they are used for nonnutritive sucking of babies who are gavage fed. "Premies require sucking opportunities." One hospital gift shop had discontinued sale of soothers and nipple shields. Another hospital provided handouts on the "danger of soothers."

Step 10

Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.
Some respondents described communities with breastfeeding clinics and an active La Leche League. One respondent reported "community health has a robust support structure" for

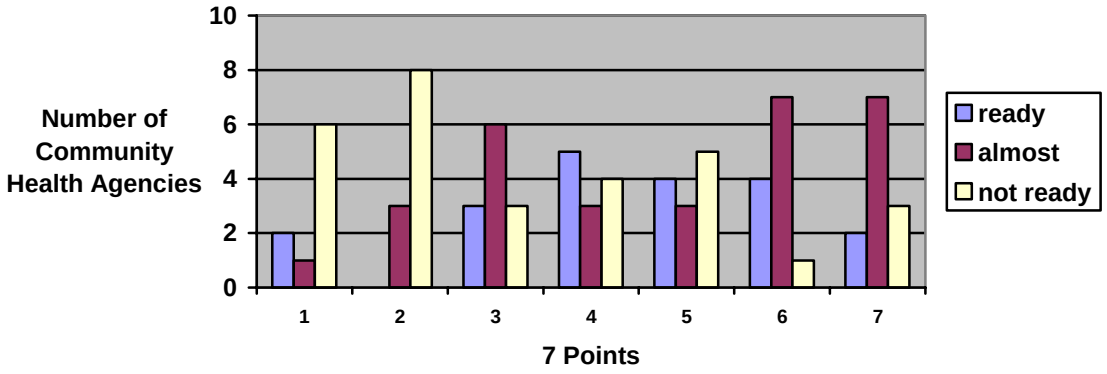
breastfeeding women. In one community, some special needs women had "support and transport to groups." Some hospital nurses provided outpatient consultation as time permitted. Written information was given to "all our patients regarding community breastfeeding support." Breastfeeding support was problematic in some communities for example, when public health nurses did not visit on weekends, early postnatal visits were delayed. One respondent said "even our prenatal classes dropped their breastfeeding class" and attributed it to a lack of funding.

Progress towards Baby-Friendly Designation in Community Health Agencies

Respondents estimated their community health agency's progress in implementing each of the 7 baby-friendly points as summarized in Table 3. The least progress was made on the points related to having a policy (point 1) and training staff (point 2). The most progress was made on the three points related to informing women about breastfeeding (point 3), providing a welcoming atmosphere (point 6) and cooperation between staff and the broader community (point 7).

Table 3: Community Health Agencies' Progress in Meeting the 7 Points

n = 18



Challenges and Successes in Accomplishing each of the 7 Points (Communities)

Thirteen of the 18 respondents described the challenges and successes they had had in implementing each point. Their responses are summarized below.

Point 1

Have a written policy that is routinely communicated to all staff and volunteers.

Three respondents indicated that a policy is currently being discussed; two others said that their policy should be revised; another reported that a policy draft had been written by a student, and two others felt that the policy should be provided by the health authority. The greatest challenges were time and resources for both developing policy and communicating the policy to all staff.

Point 2

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

Successes reported from eight agencies primarily relate to staff opportunities to attend courses, for example at Grant McEwen and Douglas College, the on-line course from BC Women's and Children's, or support for individuals to be certified as an International Board Certified Lactation Consultant (IBCLC). An ongoing 18-hour breastfeeding course was provided in two areas and in other areas staff are financially supported to attend conferences. An innovation that has been implemented in one area is the collaboration between hospital and community agency to utilize breastfeeding expertise from each area. Ten respondents described the challenges. These include lack of time and resources, cutbacks in funding for education, the BFI requirement that all staff who are in contact with mothers and children are educated, and variability in types of education. Added to these is the longstanding problem of inconsistency in breastfeeding advice and use of techniques provided to mothers.

Point 3

Inform pregnant women and their families about the benefits and management of breastfeeding.

Although respondents reported prenatal breastfeeding classes were held within nine of the jurisdictions, either through the health agency or a pregnancy outreach program, it was a challenge to provide information to all women. In one area it was estimated that only 20% of the pregnant population was reached. Consistency of information, translation of materials to languages other than English, and verbal communication with mothers were other challenges. In one region, updated information provided to all nurses, such as prenatal class instructors and community health nurses, and education for hospital nurses has been useful in providing more consistent care to mothers. The use of the INFACT "Cost of Formula Wheel" was also described as helpful in promoting breastfeeding.

Point 4

Support mothers to establish and maintain exclusive breastfeeding to six months.

Established support services for postpartum families were reported by four respondents. These included seven days a week programs and ongoing support for families as needed. Follow-up telephone calls to mothers at three and six weeks postpartum were described by another respondent as supporting mothers. The primary challenge for five respondents was helping mothers to maintain exclusive breastfeeding to six months. The problems included a lack of current information for professionals; written material for mothers which only addresses the first few weeks of breastfeeding; and mothers not continuing breastfeeding for six months in spite of efforts by nurses. However, support for this recommendation by Health Canada and some professional organizations is viewed as helpful in promoting exclusive breastfeeding. One agency suggested that a breastfeeding survey for mothers to complete at immunization clinics and drop-in groups would be helpful to determine breastfeeding status.

Point 5

Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

The greatest challenge to infant feeding beyond six months is that the care of women in a community is provided by a number and variety of health professionals who may lack current breastfeeding information. One respondent reported that trying to provide resources in the workplace for women was an ongoing challenge. Others indicated that because mothers are often not seen between six and 12 months after delivery breastfeeding information is difficult to provide. Several respondents indicated that breastfeeding information is given in early postpartum visits and at child health clinics. Ongoing surveillance of breastfeeding rates was reported as a challenge to determine actual breastfeeding rates although one agency is using the recent breastfeeding definitions, developed by the BCC, to try and gather this information. In one agency a breastfeeding survey was undertaken in 1998.

Point 6

Provide a welcoming atmosphere for breastfeeding families.

Private areas for breastfeeding and lack of commercial advertising within agencies were common successes that were reported. Amalgamation of health units into hospital sites, however, has created difficulties in providing a welcoming atmosphere, for example, parking for families has become a major challenge in some urbanareas.

Point 7

Promote collaboration between health care providers, breastfeeding support groups and the local community.

Eight respondents described positive collaborative relationships as the following: links established between service providers, support groups, and in some cases, community members; active perinatal or mother/infant committees; liaisons with educational institutions and having multidisciplinary health students in the area; provision of grand rounds for physicians; and in one area, a hospital-staffed breastfeeding clinic is held at the health unit. The greatest collaboration challenge was communication with family physicians and pediatricians. Other respondents reported a need for peer support groups, such as La Leche League, in their community. Lack of funding and not having a local Baby-Friendly hospital were other issues reported. One agency said that the stigma attached to poverty and addiction issues makes it difficult for some mothers to attend groups.

Requests for Assistance from Respondents in Hospitals and Communities

The survey listed five ways the BCBFN could assist hospitals and communities become Baby-Friendly and asked respondents to identify what would be helpful to them. There was also an opportunity to make additional requests for assistance from BCBFN. Table 4 shows that half the respondents requested help with completing or interpreting a self-assessment, developing an action plan, and recommending educational resources.

Table 4: Requests for BCBFN Assistance

Requests	Total N = 32	Hospital n = 14	Community n =1 8
Strategies for establishing an effective committee			
Yes	13	7	6
No	10	4	6
No response	9	3	6
Completing/interpreting a self-assessment			
Yes	16	6	10
No	8	4	4
No response	8	4	4
Developing an action plan			
Yes	16	6	10
No	7	4	3
No response	9	4	5
Recommending educational resources			
Yes	16	9	7
No	6	1	5
No response	10	4	6

Additional Requests for Assistance

There was also an opportunity to make additional requests for assistance from the BCBFN. Respondents from the hospitals and the community health agencies had some additional requests as described below.

Additional Requests from Hospitals

Generally there were few additional requests for help for hospitals. One respondent pointed out that they had a BCBFN member on their steering committee, implying their needs were met. Others were looking for suggestions to obtain more funding for breastfeeding support and for contacts with resource people in other Canadian Baby-Friendly hospitals. One respondent had multiple requests for additional assistance, including to evaluate the effectiveness of their policy, to increase funding for staff to attend breastfeeding courses, to discontinue delivery of *Parenting* magazine, to provide a baby-friendly parenting manual and to keep Cesarean mums and babies together.

Additional Requests from Community Health Agencies

Although requests were few from respondents in community health agencies, it was evident that sharing information and strategies between community agencies that were working towards BFI would be of greatest benefit. Specific materials that would be helpful are those on

"Getting Started", co-sleeping, lactational amenorrhea method of birth control and multilingual literature that can be distributed to families. Education was also identified as a need, including education for rural communities, the 18-hour breastfeeding course for hospital nurses and new staff, and strategies to encourage regular educational updates for nurses and physicians. Other requests included help with concerns about formula contracts.

Additional Comments

The final part of the survey asked respondents for any additional comments. Respondents from the two hospitals that returned surveys, but no longer provided maternity services, indicated that their community supported breastfeeding women particularly through the public health nurse visits. Other hospital respondents identified the need for more lactation consultants and hoped that with more money being directed toward health care, breastfeeding might benefit. One respondent commented that "while [Baby-Friendly] certification is a laudable achievement, the cost of pre-assessment, assessment and ongoing recertification is very high" and with reduced operating dollars, not a priority, however, "breastfeeding education for staff and new parents is the priority."

Additional comments received from respondents in community health agencies identified that the BFI is a positive strategy but currently there is limited knowledge about the initiative among staff and inadequate support from management. One respondent indicated there had been limited success in BFI implementation because it has not been identified as a priority within the health region. Another respondent recommended that BFI should be considered an organizational priority similar to achieving accreditation from the Canadian Council on Health Services Accreditation. Foresight was evident in the following statement made by one respondent, "we are being inclusive and proactive in establishing and maintaining a Regional Approach to this [BFI] and we are asking for more support to conclude this unique action plan."

Limitations of the Survey

The survey was distributed to managers in more than 120 maternity hospitals and community health agencies in BC The survey was also posted on the BCRCP website, therefore it is not possible to determine an accurate response rate. Respondents from 14 hospitals and 18 community health agencies from all six BC health authorities provided the data that were analyzed for this report. Three of the community responses represented more than one agency in a region. The findings provide information about the status of BFI in the reporting agencies and cannot be generalized to all health care organizations. It is also acknowledged that the data are based on the respondents' perceptions at one point in time. Nonetheless, we can draw conclusions from this survey about implications for future policy development and we know which organizations would like assistance from the BC Baby-Friendly Network.

Conclusions

While we can draw no conclusions about the organizations that did not respond to the survey, there are seven major conclusions that can be drawn from the aggregate responses of those individuals who did answer the survey questions.

1. BC is lagging behind Ontario and Quebec and many other developed countries, including the United Kingdom, Sweden, Norway, Switzerland, Australia and the United States, in meeting the provincial government's commitment to become a leader in this international Baby-Friendly Initiative.
2. There are varying degrees of interest and effort across BC in working towards a Baby-Friendly designation. While some organizations are ready or almost ready to be assessed, many more are not at all ready. Some individuals are working very hard to assist breastfeeding women and to establish support for breastfeeding in their organizations.
3. Many forces within and outside health care organizations conspire against successful breastfeeding including a lack of top administrative commitment; a lack of resources; a lack of interest, consistency and knowledge by health professionals; a lack of designated committees; staff shortages (including lactation consultants); problems communicating with physicians; and the influence and marketing practices of the multinational formula companies.
4. With the reorganization of the health authorities and the emphasis on cost-containment in the short-term, breastfeeding is perceived to be a low priority within health authorities in BC.
5. Many organizations have breastfeeding policies that are outdated, not known or not followed. There is recognition that up-to-date policies that are consistently applied within organizations are essential.
6. Some organizations have developed creative programs or practices to support breastfeeding and indicated an interest in sharing initiatives across BC.
7. There is a clear need for accessible, low cost, and up-to-date breastfeeding education and information for health professionals and for childbearing families in BC.

Recommendations

There is a close relationship between breastfeeding and health promotion/disease prevention. Changes have to occur at all levels: government, the health authorities, hospitals, community health agencies and the individual health professional. A significant change in the priorities of the health authorities is necessary before health care organizations in BC can be designated Baby-Friendly. Change of this magnitude is time-consuming and complex. To successfully implement the BFI in BC there needs to be careful and thoughtful planning. Kotter describes an eight-stage process to create successful social change.[32] Health care leaders within government and the health authorities can apply Kotter's change process to implement the BFI as outlined in Appendix G.

Specific recommendations to assist in making BC Baby-Friendly follow:

1. The BC Ministry of Health Services should add the BFI as a key strategy under its objective "individuals are supported in their efforts to stay healthy and make healthy lifestyle choices"[33] and add breastfeeding rates as a performance measure.
2. The health authorities should adhere strictly to the WHO International Code of Marketing of Breast-milk Substitutes[34] and the Ministry of Health Services should monitor compliance.
3. The health authority decision-makers need to understand how current staffing shortages and funding priorities negatively impact breastfeeding and the related health effects on the population. They should include BFI and the WHO Global Strategy for Infant and Young Child Feeding[35] as a priority and provide resources and support for committee work, policy development and staff education.
4. The health authorities should encourage breastfeeding collaboration among hospitals and community agencies and facilitate communication and sharing of BFI implementation strategies throughout the province.
5. BCRCP should incorporate breastfeeding education into all their perinatal programs.
6. BCRCP should take a leadership role in providing BFI education and training for health professionals that is equivalent to the UNICEF/WHO course and seek the appropriate continuing education credits. Education should be high quality, timely, affordable, accessible and customized for different groups of health professionals, i.e., administrators, physicians, nurses. It should use a variety of strategies including telehealth, on-line learning modules, and face-to-face workshops.
7. BCBFN should partner with other organizations such as BCRCP to provide follow-up support to the survey respondents who identified particular needs within their organizations.
8. BCBFN should partner with other organizations such as BCRCP to support organizations to establish BFI committees, conduct organizational assessments, and develop strategies to move ahead towards Baby-Friendly designation.
9. BCBFN should help health care leaders understand the small cost of becoming Baby-Friendly is greatly outweighed by the benefits.
10. BCBFN should advocate with the Ministry of Health Services and the Provincial Health Authority for funding for a provincial breastfeeding coordinator.
11. BCBFN should advocate for breastfeeding research to be included as part of the transdisciplinary research agenda of the Women's Health Research Initiative at BC Women's Hospital & Health Centre.
12. BCBFN should distribute this report widely within BC including to the survey respondents, all hospitals and community health agencies, the chief executive officers and the chief nursing officers of the health authorities, the Deputy Minister of Health Services, the Provincial Health Officer, the Program Director of BCRCP, Canada's Chief Public Health Officer, and other key stakeholders.

13. BCBFN should develop strategies to recognize and celebrate achievements of those individuals and organizations within BC that are making progress towards Baby-Friendly designation.
14. BCBFN should publicly recognize any organization in BC that achieves Baby-Friendly designation.
15. BCBFN should promote awareness among health professionals and childbearing families of *Baby's Best Chance* (6th edition) which has been revised to meet baby-friendly criteria.
16. BCBFN should collaborate with BCRCP to conduct another survey in 2006 and to distribute a follow-up report to key stakeholders on the progress towards making BC Baby-Friendly.

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Appendix A
British Columbia Baby-Friendly Network Terms of Reference

The British Columbia Baby-Friendly Network is a multidisciplinary committee of health care providers, ministry representatives, and consumers interested in protecting, promoting, and supporting breastfeeding. The Minister of Health Services and the Minister for Children and Families have designated the British Columbia Baby-Friendly Network as the implementation committee for the Baby-Friendly Initiative in British Columbia.

Members of the committee determine the chair of the British Columbia Baby-Friendly Network.

Membership is open to relevant organizations or groups interested in working toward a baby-friendly province.

Meetings are held quarterly. Additional meetings may be called when the need arises.

The British Columbia Baby-Friendly Network will:

1. Act as the designated implementation committee for the Baby-Friendly Initiative in British Columbia.
2. Promote breastmilk as superior to breastmilk substitutes and promote breastfeeding as the norm for feeding infants.
3. Share information about strategies to support initiation and maintenance of breastfeeding and decrease barriers to breastfeeding.
4. Promote societal awareness and support for women initiating and continuing breastfeeding, anytime, anywhere.
5. Work toward implementing and maintaining strategies that support breastfeeding women in the communities in which they live and work.
6. Encourage education of health care workers and support other relevant activities to promote the Baby-Friendly Initiative.
7. Encourage governments at all levels to work towards effective monitoring and implementation of the International Code of Marketing Breastmilk Substitutes and the WHO/UNICEF Ten Steps to the Baby-Friendly Hospital Initiative.
8. Foster dialogue between the 'Network' and the British Columbia public in providing up-to-date information to promote, protect and support breastfeeding across the province.
9. Membership on breastfeeding subcommittees and as committee chairs will be for a two-year term at which time it will be reviewed.

BRITISH COLUMBIA

Appendix B
Dr. P. Ballem's Letter to Chief Executive Officers, Health Authorities

October 10, 2003 443028

Chief Executive Officers
Health Authorities

Dear Chief Executive Officers:

Re: BC *Baby Friendly* Network

This letter is to introduce the BC *Baby Friendly* Network (Network) and to encourage health authorities to work with the Network to create an environment conducive to breastfeeding in BC.

The Network's mandate is to promote, protect and support breastfeeding throughout BC. In 1998, the Minister of Health and Minister for Children and Families designated the Network to be the implementation committee for the *WHO International Baby Friendly Initiative* in BC. In this role, the Network identifies health care organizations and communities interested in becoming *Baby Friendly*, and assists them in meeting the requirements for the *Baby Friendly* designation.

The Ministry of Health Planning recognizes that breastfeeding provides considerable health benefits to mothers and babies.

> Breastfeeding contributes to the healthy growth and psychosocial development of babies.
> Breast milk provides optimal nourishment for babies and boosts their immune systems, protecting them from gastrointestinal, respiratory and ear infections and lowering their risk for allergies.
> Breastfeeding reduces a women's risk of ovarian and breast cancers and osteoporosis.

However, the Ministry also realizes that women need the support of families, friends, health professionals and communities to initiate and sustain breastfeeding.

I encourage health authorities to work with the Network to pursue *Baby Friendly* designation for your health care organizations. This is an important opportunity for BC to become a leader in this international child health initiative

….2

Ministry of Health Planning
Ministry of Health Services
Office of the Deputy Minister
5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

For more information, contact Barbara Selwood, Chairperson, BC *Baby Friendly* Network by telephone at: (604) 507-5420, or Lisa Forster-Coull, Consultant, Child and Youth Health, Prevention and Wellness Planning Division, Ministry of Health Planning, by telephone at: (250) 952-1124.

Sincerely,

ORIGINAL SIGNED BY

Penny Ballem, MD
Deputy Minister

pc: Barbara Selwood, Manager, Health Services
Fraser Health Authority

Lisa Forster-Coull, Consultant
Child & Youth Health
Prevention and Wellness Planning, Ministry of Health Planning

Appendix C
UNICEF/WHO Baby-Friendly Hospital Initiative: Ten Steps to Successful Breastfeeding

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

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in - that is, allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services,* a joint WHO/UNICEF statement published by the World Health Organization.

Appendix D
Breastfeeding Committee of Canada's Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings

All providers of community health care will:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote co-operation between health care staff, breastfeeding support groups and the local community.

Appendix E

British Columbia Baby-Friendly Network Survey for Hospitals

The British Columbia Baby-Friendly Network (BCBFN) is a multidisciplinary committee of health care providers, ministry representatives and consumers interested in protecting, promoting, and supporting breastfeeding. The Minster of Health Services and the Minister for Children & Family Development have designated the British Columbia Baby-Friendly Network as the implementation committee for the Baby-Friendly™ Initiative in British Columbia.

The purpose of this survey is to identify progress with the Baby-Friendly™ Initiative in the health authorities in BC, and to identify ways the British Columbia Baby-Friendly Network can support facilities/agencies to become baby-friendly™. The survey takes about 10 minutes to complete. Participation is voluntary and you have the right to refuse to participate without jeopardizing any current or future involvement with the British Columbia Baby-Friendly Network. Your responses will be treated in a confidential manner. All data will be aggregated and reported at the health authority and provincial levels. By responding to this survey, it is assumed your consent was given. If you choose to provide your name and phone number, a member of the British Columbia Baby-Friendly Network will be able to contact you to discuss ways we can provide follow-up support.

If you have any questions about this process or the survey, please contact Barbara Selwood, Chair, British Columbia Baby-Friendly Network, Box 39007, West 10th Avenue, Vancouver, BC, V6R 1G0, or by phone at 604-875-3762 or by e-mail at bselwood@interchange.ubc.ca.

British Columbia Baby-Friendly Network (BCBFN) SURVEY

Contact information for person completing the survey

Name:_____

Position:_____ _____

Health Authority/Agency:_____

Address:_____

Phone: _____

Fax:_____

E-mail:_____

Health Care Setting:

- Hospital _____
- Community/public health – Specify _____
- Other: Specify _____

Our facility/agency has been designated as Baby-Friendly™

- Yes
- No

Comments:

_____

_____

_____

_____

Our facility/agency intends to become Baby-Friendly™ within the next two years:

- Yes
- No

Comments:

_____

_____

_____

_____

_____

Our facility/agency has a committee designated to lead the Baby-Friendly™ Initiative:

- Yes
- No

Comments:

_____

_____

_____

_____

Our facility/agency has provided this committee with resources to carry out its mandate.

oYes
oNo
oNA

Name resources:

_____

_____

_____

_____

_____

_____

The person in charge of our Baby-Friendly™ implementation process is:

oSame as person completing this questionnaire
oNA

Name:_____

Position:_____

Phone:_____

E-mail:_____

Are you aware of the BFI Practice Outcome Indicators published by the Breastfeeding Committee for Hospital and Community Health Services for Canada?

oYes
oNo

Have you seen the BFI Practice Outcome Indicators for Hospitals and Community Health Services? (Available on the BCC website: www.breastfeedingcanada.ca)

oYes
oNo

Our progress in implementing the 10 steps is:

oNA

	Level	Challenge	Success
Step 1: Have a written policy that is routinely communicated to all health care staff: 10 steps, WHO Code.	○ Ready ○ Almost/close ○ Not ready Unknown		
Step 2: Train all health care staff in skills necessary to implement policy.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 3: Inform all pregnant women about the benefits and management of breastfeeding.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 4: Help mothers initiate breastfeeding within a half-hour of birth.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 6: Give newborn infants no food or drink other than breastmilk unless medically indicated.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 7: Practice 24-hour rooming-in.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		

	Level	Challenge	Success
Step 8: Encourage breastfeeding on demand.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 9: Give no artificial nipples or pacifiers to breast-feeding infants.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		
Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.	○ Ready ○ Almost/close ○ Not ready ○ Unknown		

Requests:
Our facility/agency requests help from the Baby-Friendly Network (BCBFN) in the following areas:

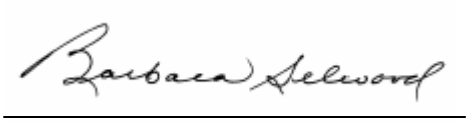
	Yes	No
Strategies for establishing an effective committee	○	○
Completing/interpreting a self-assessment	○	○
Developing an action plan	○	○
Recommending educational resources	○	○
Other requests for help from the BCBFN	○	

Please identify other requests for assistance from the British Columbia Baby-Friendly Network:

Additional Comments:

Please complete this survey and return it by fax to Barbara Selwood at 604-875-3747, by January 14th, 2005. Additional copies of the survey may be downloaded from the BCRCP website at www.rcp.gov.bc.ca.

Thank you.



Barbara Selwood, Chair

The BC Baby-Friendly Network

Supported by The BC Reproductive Care Program

Appendix F

British Columbia Baby-Friendly Network Survey for Community Agencies

The British Columbia Baby-Friendly Network (BCBFN) is a multidisciplinary committee of health care providers, ministry representatives and consumers interested in protecting, promoting, and supporting breastfeeding. The Minster of Health Services and the Minister for Children & Family Development have designated the British Columbia Baby-Friendly Network as the implementation committee for the Baby-Friendly™ Initiative in British Columbia.

The purpose of this survey is to identify progress with the Baby-Friendly™ Initiative in the health authorities in BC, and to identify ways the British Columbia Baby-Friendly Network can support facilities/agencies to become Baby-Friendly™. The survey takes about 10 minutes to complete. Participation is voluntary and you have the right to refuse to participate without jeopardizing any current or future involvement with the British Columbia Baby-Friendly Network. Your responses will be treated in a confidential manner. All data will be aggregated and reported at the health authority and provincial levels. By responding to this survey, it is assumed your consent was given. If you choose to provide your name and phone number, a member of the British Columbia Baby-Friendly Network will be able to contact you to discuss ways we can provide follow-up support.

If you have any questions about this process or the survey, please contact Barbara Selwood, Chair, British Columbia Baby-Friendly Network, Box 39007, West 10th Avenue, Vancouver, BC, V6R 1G0, or by phone at 604-875-3762, or by e-mail at bselwood@interchange.ubc.ca.

British Columbia Baby-Friendly Network (BCBFN) SURVEY

Contact information for person completing the survey

Name: _____

Position: _____

Health Authority & Agency: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Health Care Setting:

oCommunity / public health - Specify_____
oHospital_____
oOther: Specify_____

Our facility/agency has been designated as Baby-Friendly™:

oYes
oNo

Comments:

_____

_____

_____

_____

Our facility/agency intends to become Baby-Friendly™ within the next two years:

oYes
oNo

Comments:

_____

_____

_____

_____

_____

Our facility/agency has a committee designated to lead the Baby-Friendly™ Initiative:

oYes
oNo

Comments:

_____

_____

_____

_____

Our facility/agency has provided this committee with resources to carry out its mandate:

oYes
oNo
oNA

Name resources:

_____

_____

_____

_____

_____

_____

The person in charge of our Baby-Friendly™ implementation process is:

oSame as person completing this questionnaire
oNA

Name:_____

Position: _____

Phone: _____

E-mail: _____

Are you aware of the BFI Practice Outcome Indicators published by the Breastfeeding Committee for Hospital and Community Health Services for Canada?

oYes
oNo

Have you seen the BFI Practice Outcome Indicators for Hospitals and Community Health Services? (Available on the BCC website: www.breastfeedingcanada.ca)

oYes
oNo

Our progress in implementing the 7 points is:

oNA

Point description	Level	Challenge	Success
Point 1: Have a written policy that is routinely communicated to all staff and volunteers: WHO Code.	o Ready o Almost/close o Not ready o Unknown		
Point 2: Train all health care staff in skills necessary to implement policy.	o Ready o Almost/close o Not ready o Unknown		
Point 3: Inform pregnant women and their families about the benefits and management of breastfeeding.	o Ready o Almost/close o Not ready o Unknown		
Point 4: Support mothers to establish and maintain exclusive breastfeeding to six months.	o Ready o Almost/close o Not ready o Unknown		
Point 5: Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.	o Ready o Almost/close o Not ready o Unknown		
Point 6: Provide a welcoming atmosphere for breastfeeding families.	o Ready o Almost/close o Not ready o Unknown		
Point 7: Promote collaboration between health care providers, breastfeeding support groups and the local community.	o Ready o Almost/close o Not ready o Unknown		

Requests:
Our facility/agency requests help from the Baby-Friendly Network (BCBFN) in the following areas:

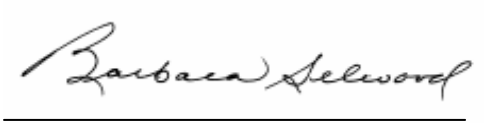
	Yes	No
Strategies for establishing an effective committee	o	o
Completing/interpreting a self-assessment	o	o
Developing an action plan	o	o
Recommending educational resources	o	o
Other requests for help from the BCBFN	o	o

Please identify other requests for assistance from the BC Baby-Friendly Network:

Additional Comments:

Please complete this survey and return it by fax to Barbara Selwood at 604-875-3747, by January 14th, 2005. Additional copies of the survey may be downloaded from the BCRCP website at www.rcp.gov.bc.ca.

Thank you.



Barbara Selwood, Chair

The BC Baby-Friendly Network

Supported by The BC Reproductive Care Program

Appendix G

Using Kotter's Change Process to Implement BFI

John Kotter describes am eight-stage process to create successful social change. Breastfeeding advocates can apply Kotter's model to implement the Baby-Friendly initiative as outlined below.

Stage	Strategy
1. Establishing a sense of urgency	Recognizing and communicating the reality of the current situation creates the necessary urgency. BC has no designated BFI organizations. It lags behind Ontario and Quebec and many other developed countries including the United Kingdom, Sweden, Norway, Switzerland, Australia and the United States. At present only 19% of Canadian women are breastfeeding at six months. Many forces within and without health care organizations subvert successful breastfeeding. The evidence clearly demonstrates that the importance of breastfeeding can no longer be discounted.
2. Creating the guiding coalition	Guiding coalitions should be established by employers and include key stakeholders who are knowledgeable and committed to supporting BFI. Appoint breastfeeding committee members who are powerful, knowledgeable, capable, respected, trusted and team players and who have the skills to weather the forces opposing change. Recognize this is an opportunity to demonstrate client-centred care and nurture support for BFI at all levels in the organization. Provide the committee with the necessary financial and human resources and support.
3. Developing a vision and a strategy	Each health authority needs to put maternal/child well-being on the agenda if they are committed to health promotion and disease prevention.. Develop a picture of a baby-friendly environment in the future that is clear, appealing and easy to communicate to staff and families alike.
4. Communicating the vision	A focus on the health and well being of mothers, infants and their families needs to underlie all communication strategies and the actions of management and staff. Use multiple strategies to articulate the need for BFI and emphasize the correlation with better health outcomes for patients and society. Recognize people require time to adapt to change and seek to understand the personal impact of change. Acknowledge emotions openly and sympathetically. Personalize the vision to help individuals cope. Use both formal and informal communication channels. Avoid jargon. Ensure leaders are visibly in support of the change and helpful to others in seeing its tangible benefits. Continually communicate the planning process and changes as they occur so staff know what to expect.

Stage	Strategy
5. Empowering broad-based action	Create an organizational structure that supports a collaborative approach to BFI, particularly between hospitals and community health agencies. Identify, confront and overcome major obstacles including general anxiety and resistance to change, existing system limitations, a lack of executive commitment, unrealistic expectations and a lack of cross functional teams. Identify and designate champions and provide time, authority and resources to implement unit-based initiatives. Provide continuing assistance, support and guidance to the BFI committee. Provide early adaptors with recognition and the necessary support to further their BFI initiatives. Recognize some organizations may chose to implement all the Steps/Points simultaneously while others may initially have a narrower focus.
6. Generating short-term wins	Treat the history of the organization with respect. Recognize individuals need to let go of the past and deal with perceived losses. Establish small pilot projects with a high likelihood of success within a year and develop short-term formative evaluations. Develop measurement and feedback systems to monitor the achievement of BFI and its associated benefits for staff and clients. Mark endings and celebrate achievements. Recognize early successes and celebrate the people involved to reinforce the success and build momentum.
7. Consolidating gains and producing more change	Collaborate and build bridges within and across organizations to ensure the change continues. Demonstrate flexibility to try new things and encourage creative thinking and action. Support leaders at lower levels in the organization who demonstrate interest and initiative related to BFI. Use the success of pilot projects at the unit level to tackle larger projects across the organization that need to come in line with the vision for BFI Ensure people are hired, promoted and developed in line with the vision.
8. Anchoring change in the culture	Sustaining BFI gains over the long-term requires continuing commitment by all levels in the organizations and an ongoing recognition and celebration of the benefits of the change to staff and patients. Recruit new generations of perinatal leaders who actively support BFI. BFI designation resulting in enhanced morale, recruitment, retention and productivity and correlating with improved maternal/child outcomes, has the potential to develop self-sustaining momentum and become rooted in organizational culture.