HARVARD T.H. CHAN | SCHOOL OF PUBLIC HEALTH

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The Baby-Friendly Hospital Initiative: Truly Baby-Friendly?

Overview

The staff of Pinevale's hospital, the only hospital serving a mid-sized city in the Southeastern United States, is conflicted. Three years ago, the four lactation consultants and several Ob/Gyns at Pinevale, championed an effort to designate the hospital as "Baby-Friendly" by Baby-Friendly USA. While the hospital progressed to the stage of implementing all Ten Steps to Successful Breastfeeding, several issues with implementation, as well as pushback from both local community-based lactation advocates and a small group of hospital staff clinicians, is causing Pinevale's administration to consider foregoing the Baby-Friendly Hospital designation and re-writing their lactation policies.

You are the Director of Women's Health Services at Pinevale, and have been tasked by its CEO to evaluate the evidence and the local situation and make the decision whether to continue the process to become a Baby-Friendly Hospital or to revise the lactation policies recently written to comply with this process. What will you choose? If you choose to continue pushing for the hospital to become Baby-Friendly what arguments will you use to convince skeptics? If you decide to re-write policies, how will you amend them to best support breastfeeding women in the hospital and in the community?

The rise of infant formula-use in the United States

Infant formula was developed in the 19th century and has grown into a $3 billion industry since it was first marketed by Nestle in 1867. Breast milk had long been understood to be the optimal infant food, however, the ease of infant formula feeding, its relative safety compared to using animal milk, and heavy marketing from the formula industry (first directly to clinicians, and then in the late 1980s directly to consumers), led to a precipitous decline in U.S. breastfeeding rates from near 100% in 1900 to 70%

in 1915, down to 25% in the 1950s. By the 1970s, a vast majority—78%—of American babies were formula-fed from birth[1].

The public health consequences of widespread formula use are huge, especially in developing countries. The risk of diarrheal illness and respiratory infections in formula fed infants is high, due to a combination of lack of clean water to mix with powdered formula, and the fact that formula-fed infants are deprived the immunological benefits of breastmilk. The World Health Organization (WHO) estimates that if all infants were fed breastmilk exclusively for six months according to recommendations, 800,000 infant deaths would be prevented.[2]Even in developed countries, the use of infant formula instead of breastmilk increases the risk of later obesity, types 1 and 2 diabetes, leukemia, and Sudden Infant Death Syndrome[3] in infants and premenopausal breast cancer, ovarian cancer, retained gestational weight gain, and type 2 diabetes in mothers.

In the 1970s at the nadir of breastfeeding rates across the globe, public health education and advocacy efforts accelerated to encourage breastfeeding and curtail the marketing of breastmilk substitutes. The WHO, the U.S. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics all recommend that infants receive only breastmilk until 6 months of age and are then fed a combination of solid food and breastmilk until at least one year of age (the WHO recommends breastfeeding until age 2 or longer). Through nationwide public health campaigns, the training and education of clinicians, and lobbying efforts in governments around the world, breastfeeding rates began to rise in the 1980s and 1990s[1] and continue to do so today[4].

Pinevale gets a Lactation Consultant

The national rise in breastfeeding rates was paralleled at Pinevale General Hospital, where clinicians and administrators noticed an increase in the number of women planning on breastfeeding and asking hospital staff for assistance doing so beginning in the 1990s, but rapidly accelerating in the early 2000s. In response to this, in 2005, the hospital decided to hire their first International Board Certified Lactation Consultant (IBCLC). Luckily, Amy Bryn, a nurse working on the labor and delivery floor, had decided to pursue certification and enthusiastically agreed to become the hospital's first staff lactation consultant.

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[1]Institute of Medicine (US) Committee on Nutritional Status During Pregnancy and Lactation. Nutrition During Lactation. Washington (DC): National Academies Press (US); 1991. 3, Who Breastfeeds in the United States?Available from: https://www.ncbi.nlm.nih.gov/books/NBK235588/

[2]https://www.who.int/maternal_child_adolescent/news_events/news/2016/exclusive-breastfeeding/en/

[3] Stuebe A. (2009). The risks of not breastfeeding for mothers and infants. *Reviews in obstetrics & gynecology*, *2*(4), 222–231.

[4] https://www.cdc.gov/breastfeeding/data/reportcard.htm

Lactation consultants are clinicians specially trained in the clinical management of breastfeeding[1]. The IBCLC credential arose in the 1970s as part of the push to re-normalize and promote breastfeeding in the United States. Originally funded by La Leche League, the International Board of Lactation Consultant Examiners legitimized, standardized, and regulated the burgeoning profession. Now, there are over 32,000 Lactation Consultants certified in 122 countries[2]. Lactation consultants work as part of the health care team with new families to promote optimal breastfeeding techniques, and clinically manage issues with lactation that may arise. IBCLCs, unlike "Lactation Educators" or "Lactation Counselors," must follow a specified curriculum of coursework and clinical hours and must sit for and pass a written exam before becoming certified. Many IBCLCs are already clinicians such as nurses or dieticians when they pursue the IBCLC credential, but not all.

From day one on the job, Amy was an enthusiastic and dogged advocate for breastfeeding at Pinevale. She was drawn to becoming an IBCLC after struggling to breastfeed her own son. During the first six weeks of her son's life, she worked with a friend who is a lactation consultant at a private practice to overcome issues with low milk supply and a poor latch. After returning to work, Amy used her experience to support several postpartum patients that were having difficulty with their baby's first feed. She realized that she loved supporting breastfeeding mothers.

By the time Pinevale decided to hire a lactation consultant, she was only 6 months away from sitting for the certifying exam. Amy was ecstatic to be re-hired by her own hospital. She was happy to be supporting postpartum mothers in breastfeeding, and enthusiastic about teaching the hospital's patient breastfeeding class, and wanted to positively influence Pinevale's policies so that all patients would be empowered to choose breastfeeding. Early in her time on the job, she began cataloguing hospital policies and practices she felt were not conducive to breastfeeding and communicating them with the Director of Women's Health Services and other hospital administrators.

One of the policies most concerning to Amy was the routine practice of including formula samples in the "baby basket" women receive on the postpartum floor. This basket, including basic infant care supplies like a nasal aspirator, receiving blankets, a onesie, and written materials on safe sleep and baby care practices, also contained several small samples of formula, formula coupons, and a pacifier. Amy had read several peer-reviewed articles suggesting that provision of formula samples to postpartum women in the hospital decreased the length that they practiced exclusive breastfeeding. Furthermore, the practice violates the WHO's *International Code of Marketing of Breastmilk Substitutes*, which states that "health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families." Amy also shared concerns voiced by many lactation advocates, that

the introduction of a pacifier before breastfeeding could lead to a shorter duration of breastfeeding.

While a labor and delivery nurse, Amy had also noticed that very few Ob/Gyns encouraged the practice of uninterrupted skin to skin contact between mother and baby directly following delivery for at least an hour. Skin to skin contact has been shown to have several benefits. Not only does skin to skin contact help to regulate newborn temperature and promote early bonding, it also helps to ensure that breastfeeding is initiated in the first hour after birth. This is important as studies have shown that early initiation of breastfeeding is associated with higher likelihood and a longer duration of exclusive breastfeeding[5]. Unfortunately, prioritizing this uninterrupted time was not part of Pinevale's clinical culture. Instead, nurses often took babies to the newborn nursery or to another part of the delivery room to run routine tests, procedures, and give the infant its first bath.

Furthermore, although nurses and doctors at Pinevale never actively *discouraged* mothers from breastfeeding, many didn't actively encourage it either. Many nurses were quick to suggest formula when a mother complained of breastfeeding issues, and Amy had heard of nurses on the postpartum floor giving formula to babies in the newborn nursery without consulting the infant's mother beforehand, especially if the mother was asleep or seemed especially worn out. Many of the pediatricians in the hospital were encouraging supplementation with formula if a newborn lost more than 5% of their weight post-birth. Amy knew that this was counter to evidence-based information and could harm the early breastfeeding relationship.

Weight loss in the first couple of days post-birth is normal as newborns transition from receiving all nutrients from the umbilical cord to taking in nutrients orally. Formula-fed babies receive on average a much higher volume of nutrition post-birth as they immediately receive formula. In contrast, a normal, breastfeeding mother will first produce colostrum, a nutrient-dense, thick substance that contains a large number of antibodies. This first milk helps to regulate infant blood sugar, coats the lining of the stomach, killing microorganisms and preventing inflammation. It also has laxative properties that clear out the meconium, the thick black stool that has accumulated in the baby's body while in the womb. Because only a small quantity of colostrum is produced, and likely as well due to colostrum's laxative properties, some breastfed babies lose more weight, from 7 to 10% of birthweight, in the first couple of days[6].

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[5] Moore ER, Bergman N, Anderson GC, Medley N. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD003519. DOI: 10.1002/14651858.CD003519.pub4.

[6] https://www.newbornweight.org/wp-content/uploads/2017/05/ABM-Clinical-Protocol-3.pdf

When Pinevale's pediatricians recommended to supplement breastfed babies losing more than 5% of their birthweight with formula, not only were they doing so unnecessarily, Amy had been trained that early supplementation with formula could undermine the breastfeeding relationship. Breastfeeding works through a supply and demand feedback loop. The more a baby nurses, the more milk the breasts are stimulated to make. Thus, it's important, especially in the early weeks of breastfeeding, for the newborn to nurse on demand and only eat from his or her mother's breast unless there are established problems with milk supply or latch. Even then, Amy was taught to help mothers hand express or pump milk in these circumstances to feed newborns. If a baby receives unnecessary formula, his or her mother would produce less milk, potentially leading to the vicious cycle of supply issues, followed by more supplementing, leading to further supply issues[7].

Amy was certain that Pinevale needed a cultural change and that clinical staff needed more training and education if they were going to adequately support mothers choosing to breastfeed. At the same time, one lactation consultant was nowhere near adequate for the workload at Pinevale. Amy spent the first three years in her position successfully advocating for the hospital to hire more staff lactation consultants. By the end of her third year in her position, she was one of four lactation consultants employed by Pinevale. She had also worked to build a coalition of other clinical staff members to support cultural and clinical policy changes at Pinevale in order to empower patients to choose exclusive breastfeeding. Together, they were ready to petition Pinevale's leadership to start the process to become a Baby-Friendly Hospital.

The Baby-Friendly Hospital Initiative

The Baby-Friendly Hospital Initiative (BFHI), introduced in 1991 by UNICEF and the World Health Organization, is a global program to encourage the broad implementation of the Ten Steps to Successful Breastfeeding and *the International Code of Marketing of Breast-milk Substitutes*. The Ten Steps to Successful Breastfeeding, included below, are meant to be the basic steps hospitals can take to ensure their patient population is supported and empowered to exclusively breastfeed:

Critical management procedures:

1a. Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions.

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[7]Sriraman, N. (2017). The Nuts and Bolts of Breastfeeding: Anatomy and Physiology of Lactation. *Current Problems in Pediatric and Adolescent Health Care, 47*(12), 305-310.

1b. Have a written infant feeding policy that is routinely communicated to staff and parents.
1c. Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
Key clinical practices:
3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

In its own words,

> The BFHI assists hospitals in giving mothers the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies and gives special recognition to hospitals that have done so. In cases where patients have a medical indication or have made an informed decision to use formula, the safe preparation and feeding of formula is provided to mothers.[8]

Emphasizing that feeding babies breastmilk, rather than formula is the biological norm, the BFHI is meant to put in place policies and practices in hospitals to encourage and empower new parents to choose breastmilk. Many of the policies outlined in the Ten Steps to Successful Breastfeeding addressed particular pain points in Pinevale's clinical policies that affected breastfeeding. The Ten Steps calls for staff training to ensure all staff "have sufficient knowledge, competence and skill to support breastfeeding," uninterrupted skin to skin contact after birth, the encouragement of rooming in, and for clinicians not to supplement infants with formula unless medically necessary. It also calls for adherence to the *WHO's International Code of Marketing of Breast-milk*

[8] https://www.babyfriendlyusa.org/about/

Substitutes (prohibiting hospitals to accept free formula and to give formula to all patients).

Amy and the other Lactation Consultants, as well as a group of Ob/Gyns and pediatricians that wanted to promote breastfeeding agreed that the best way to push for a large scale cultural and policy change at Pinevale was to advocate for the hospital to become Baby-Friendly. The group set about collecting information on the process of becoming a Baby-Friendly Hospital, its associated cost, and any benefits that the hospital could expect to receive. They quickly realized it would be a challenge to successfully complete the process, but were committed to what they felt was the most comprehensive and complete way to support breastfeeding mothers at Pinevale.

Becoming Baby-Friendly

Becoming a Baby-Friendly hospital is a long, laborious, multi-step process. Baby-Friendly USA dubs the pathway to successfully obtain the designation as Baby-Friendly the "4-D Pathway." The 4-D Pathway consists of four phases, the Discovery Phase, the Development Phase, the Dissemination Phase, and the Designation Phase.

During the Discovery Phase, interested hospitals register themselves in the Baby-Friendly USA database. More importantly, the hospital must submit a letter of support and intent to go through the designation process from its CEO and complete a self-appraisal form, meant to identify areas of needed improvement. Once these tasks are completed, and a fee is paid, hospitals enter the Development Phase.

Self-appraisal was the easy part of the procedure. Amy had started the work of appraising barriers to supporting breastfeeding years ago, and as she continued supporting women and working with other lactation consultants and providers, she had an even better understanding of how the hospital would have to change to comply with the Ten Steps. The hard part was getting CEO buy-in.

Amy and her small group of supporters had a plan to secure the needed letter of intent. They had compiled a thorough report on the Baby-Friendly Hospital Initiative including its history, objectives, and the process to becoming a Baby-Friendly Hospital. To win support from hospital administration, however, they were banking on three factors. First, the Surgeon General, in 2011, released a Call to Action to Support Breastfeeding, which encouraged hospitals to complete the process to become Baby-Friendly. Since then, the State's Department of Health had implemented a publicly available "All-Star List" of hospitals that were designated as Baby-Friendly. Amy and her team were banking on the hospital wanting to be a part of this list.

The other factor was the careful cost-benefit analysis the group had done. The major costs of becoming Baby-Friendly are the fees leveraged by Baby-Friendly USA (about $12,000 over the course of being awarded designation, depending on the size of the hospital), the cost of paying out of pocket for previously free formula, and the cost of training staff. Pinevale's lactation consultants were confident that they could work together to adequately train staff for a limited number of extra paid hours, and other Baby-Friendly hospitals had reported spending much less on formula than anticipated given a higher number of women planning to breastfeed, and an anticipated reduction in use when formula wasn't taken home as part of the baby basket. The group estimated a cost of about $15 extra per birthing patient[9], at the low end of more formal analyses of the cost of implementing Baby Friendly practices. This would be minimal, they thought, especially since starting the process to become Baby-Friendly would enable them to apply for grants from the Department of Health.

Most importantly, the group planned to share recent studies published by the Baby Friendly Hospital Initiative showing that the designation increased exclusive breastfeeding rates as well as duration of breastfeeding among hospital patients. The strongest study they planned to share with administration was the Promotion of Breastfeeding Intervention Trial (PROBIT). A randomized control trial conducted in Belarus which included 31 hospitals and 16, 492 mother/infant pairs. The study found a large increase in exclusive breastfeeding at 3 months (43.3% vs. 6.4%) as well as a higher prevalence of breastfeeding at any age up to and including 12 months[10]. This evidence, the group thought, would convince the administration that becoming Baby-Friendly is a low-cost way to greatly improve the health and wellbeing of Pinevale's children.

Armed with this information, the group met with the hospital's CEO and with you, Claudia, Pinevale's Director of Women's Services. Both administrators felt that the time had come to implement more formal policies to promote breastfeeding and given the relatively low cost of obtaining the certification, the most straightforward way to do so would be through Baby-Friendly USA. Amy's group left the meeting with the promise of a letter of support in the next week.

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[9]DelliFraine, Jami, Langabeer, Jim, II, Williams, Janet F., Gong, Alice K., Delgado, Rigoberto I., & Gill, Sara L. (2011). Cost comparison of baby friendly and non-baby friendly hospitals in the United States. *Pediatrics, 127*(4), E989-94.
[10]Kramer MS, Chalmers B, Hodnett ED, et al. Promotion of Breastfeeding Intervention Trial (PROBIT): A Randomized Trial in the Republic of Belarus. *JAMA*. 2001;285(4):413–420. doi:10.1001/jama.285.4.413

“It’s not the will women are lacking, it’s the way!”

Once Pinevale Hospital had registered their intention of seeking Baby-Friendly designation and had paid their initial fee, the next step was to form a Multidisciplinary Committee to spearhead the process of revising (or writing) policies, planning for staff training, and devising how new policies and procedures would be rolled out. Baby-Friendly USA emphasizes relationships with community providers in order to have a “warm hand off” between the hospital and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or other organizations in Pinevale promoting breastfeeding, so it was important to include members from the community. Amy and Claudia worked together to brainstorm with community members and to invite them to join. Several months after registering, the Multidisciplinary Committee was formed and included Amy (as the most senior lactation consultant at Pinevale Hospital); Claudia; two Ob/Gyns; a pediatrician; the Postpartum Nurse Manager, Theresa; two community lactation consultants; and Jameela, Pinevale’s WIC Clinic Director.

Much of the Multidisciplinary Committees work was straightforward. Baby-Friendly USA provides detailed guidelines on policies and procedures that comply with designation and what metrics to use to track success. However, over the course of the planning year, two points of contention arose within the committee. The first was whether or not to shutter Pinevale Hospital’s well-baby nursery. The Ten Steps to Successful Breastfeeding states that hospitals should “enable mothers to remain together and to practice rooming in 24 hours a day.” While Baby-Friendly USA does not require hospitals to remove the well-baby nursery, any time longer than 1 hour in which mothers are separated from their baby has to be documented and reported.

Amy felt that there was no better way to encourage rooming in than to remove the option of a newborn nursery. Claudia agreed with Amy, adding “if the majority of mothers are going to be rooming in with their babies, staffing and maintaining a well-baby nursery just doesn’t make financial sense. We have a NICU just in case, anyway.” Theresa disagreed. She was concerned that many mothers might need a longer break from their newborns, especially after difficult labors. In the end, Theresa was overruled by the financial argument. The well-baby nursery would go.

A much more contentious, and recurring argument was whether Pinevale Hospital’s efforts to become Baby-Friendly were really going to make a difference in the number of women who follow recommendations regarding breastfeeding. Jameela, Pinevale’s WIC Clinic Director, voiced her concern early in the Committee’s meetings that Pinevale Hospital’s efforts were misdirected. “I get why the hospital wants to do this,” she said, “but I don’t think you all becoming Baby-Friendly will address the real reasons women aren’t able to breastfeed.” Given the short period of time women are in the hospital after

delivery (typically between 24 and 48 hours), Jameela was skeptical that the hospital had enough time to change any patient behavior, or even that they were the right place. "Right now, we already have more than three quarters of women choosing to initiate breastfeeding, it's not the will that women are lacking, it's the way!" She continued, "The real issue isn't getting women to start breastfeeding, it's helping them figure out how to keep going 6 weeks in when they feel like they have no supply, or when they go back to work and can't get time off to pump."

The community lactation consultants on the Committee echoed Jameela's statements with stories of clients who came to them gung-ho about breastfeeding, but hit snags after the first three months trying to fit breastfeeding in to their already busy lives. "The hospital can be as supportive as they want" one lactation consultant said, "but they're still discharging moms and babies, 24 hours after birth, into a desert of lactation support, before babies have learned to eat-and before many women's milk supply has even come in." While these committee members were willing to help Pinevale Hospital become Baby-Friendly, they were frustrated that more public health attention (and dollars) weren't being paid to community efforts to support breastfeeding, particularly by the State Department of Health.

Amy and the hospital staff on the committee largely agreed with Jameela and the community lactation consultants, but felt that the hospital could make some positive difference in breastfeeding rates. Amy pointed to the evaluation studies showing that evidence-based maternity care practices increased breastfeeding exclusivity and duration. "And", she argued, "any amount of breast milk is a good thing."

"It's still a patient's right not to breastfeed"

After a year of planning, Pinevale Hospital submitted their policies, staff training plan, and patient education plan to Baby-Friendly USA who approved them with very few caveats. Pinevale Hospital was ready to enter the 3rd phase of the process to become a Baby-Friendly Hospital, the Dissemination Phase, during which all of the planned policies and procedures would be implemented. The Multidisciplinary Committee had decided to spend several months training staff before implementing any policies regarding skin to skin contact, rooming in, supplemental feeding, or provision of formula.

Amy had mobilized herself and her small team of lactation consultants to both plan and deliver the required training to hospital staff. The training went smoothly, although there were a few grumbles from some of the clinical staff-Amy heard a few murmured comments like "I didn't breastfeed my children, and they were fine." However, most of the clinical staff were enthusiastic and engaged in the process. After most of the staff

had received training, the committee decided to move forward with implementing the rest of the Baby-Friendly Hospital Initiative policies they had developed over the past year.

It wasn't until about halfway through the year-long Dissemination Phase when problems began to arise. First, it seemed like early projections of the cost of purchasing formula after implementation were significantly lower than reality. Amy and her colleagues had assumed that only 30% of newborns would be fed formula while at the hospital, but at least during implementation, this was an underestimate. The Baby-Friendly Hospital Initiative also prohibited accepting formula at below market value, and the cost of formula on top of the cost of becoming a Baby-Friendly hospital, while not insurmountable, was hard to stomach for Pinevale Hospital's administration. Amy and her fellow lactation consultants anticipated that the cost of formula would decrease as the Baby-Friendly policies increased rates of exclusive breastfeeding at Pinevale, and did their best to allay the fears of the administration.

At the same time, Theresa, the Postpartum Nurse Manager, was hearing several complaints from postpartum nurses regarding new policies. One source of patient frustration was the Baby-Friendly requirement to obtain informed consent and document patient choice not to breastfeed or to breastfeed with formula supplementation. Specifically, the Baby-Friendly Guidelines state:

"When a mother specifically states that she has no plans to breastfeed or requests that her breastfeeding infant be given a breast milk substitute, the health care staff should first explore the reasons for this request, address the concerns raised, and educate her about the possible consequences to the health of her infant and the success of breastfeeding. If the mother still requests a breast milk substitute, her request should be granted and the process and the informed decision should be documented."

Operationally, the process of informed consent consisted of a conversation with the patient, outlining the potential health consequences of not breastfeeding, and if the patient decided to supplement or to exclusively formula feed, the patient was asked to sign a document stating that they had been counseled on the risks, and chose to formula feed. This requirement, meant to ensure that patients were informed of the risks of formula feeding, was being interpreted by some patients as a shaming mechanism by hospital staff. Furthermore, while some of the postpartum nurses reported feeling comfortable with counseling on the risks of formula-feeding, others felt deep discomfort with these conversations, feeling like they were indeed pressuring patients to make a choice they didn't want. "Breast may be best," a postpartum nurse told Theresa, "but it's still the patient's right to choose not to breastfeed."

In some cases, it was difficult not to agree with the patient's choice to formula-feed. Several mothers communicated that while they would love to breastfeed their babies, and knew that breastmilk is the best source of nutrition, the option just wasn't open to them. Some mothers didn't work jobs that offered paid maternity leave, meaning they would have to return to work quickly to make ends meet. Others had access to some maternity leave, but no ability to maintain milk supply at work. These jobs, typically either lower-wage positions at fast food restaurants or higher-wage fast-paced positions such as police officer or E.R. clinician, didn't have the policies or culture in place to allow pumping or breastfeeding breaks. As one mother put it "It's either breastfeed, or keep my job. Formula is the best choice available to me."

Another source of frustration for patients was the increased pressure to room in with their newborns. The loss of the well-baby nursery was acutely felt by some patients, especially those recovering from C-sections or long labors. Patients delivering their second or third child at Pinevale Hospital were irritated when the postpartum nurses told them that they would no longer take newborns overnight to allow new mothers to sleep. A few times, mothers were so sleep deprived or weak that the night shift nurses kept their newborns at the nurse's station for several hours just to give them a little break. While Pinevale communicated with patients that it was best to have a support person present during their time in the hospital, some women didn't have the family or partner support to rely on and were left alone to care for their new babies. Theresa shared with the committee that she was concerned about patients dropping their infants or falling asleep with their babies in the hospital bed. In fact, her staff had walked in on a patient sleeping with their baby in a hospital bed on several occasions.

In March, 8 months into the Dissemination Phase, the Multidisciplinary Committee was informed of a newborn re-admitted to the hospital with dehydration. The newborn's mother was distraught, and claimed that hospital staff pressured her to breastfeed exclusively and "talked her out of" giving her newborn supplementation with formula. Once discharged, she had continued to try to exclusively breastfeed, convinced by hospital staff that this was the best option for her baby. While she had been counseled on the signs of newborn dehydration, she told the E.R. physician that she was taking prescribed opioids after her C-section and didn't retain much of the counseling session. The committee agreed to reconsider policies on when lactation counseling was done, but the consensus was that while this was an unfortunate occurrence worthy of action, it was not a reason to stop pursuing the BFHI designation. Formula feeding also carries innate risks of miscommunication. Pinevale had experienced several cases of failure to thrive due to patient error in mixing formula reported by Pinevale Hospital's community pediatricians each year, and not a failure of the Baby-Friendly Hospital Initiative as a whole.

A small group of Pinevale's staff physicians disagreed, including Pinevale's Director of Neonatology, Ronald Jones. Dr. Jones, a veteran neonatologist who has practiced at Pinevale for the last 15 years, took the case as an early warning sign that Pinevale's new Baby-Friendly policies could do unintentional harm to newborns. He had met Dr. Christie Del Castillo-Hegyi, the co-founder of the Fed is Best Foundation, a nonprofit advocating for safe breastfeeding and bottle-feeding support, at a recent conference, and decided to enlist her as an ally in convincing Pinevale administration to forego the Baby-Friendly Hospital designation. Dr. Del Castillo-Hegyi and Fed Is Best are vocally critical of the Baby-Friendly Hospital Initiative, claiming that Baby-Friendly policies have increased complications due to insufficient feeding such as "excessive jaundice, dehydration, and hypoglycemia" and publicly calling on hospitals to suspend their Baby-Friendly designation and re-write their lactation policies. Dr. Jones decided to invite Dr. Del Castillo-Hegyi to speak on the complications of the Baby-Friendly Hospital Initiative at Pinevale's grand rounds in June.

The Multidisciplinary Committee was aware of the upcoming grand rounds, as well as the forming staff coalition against continuing to designation, and were anxious to plan a rebuttal to some of Fed is Best's claims. The committee members who were staff at Pinevale decided to attend the grand rounds as well as research Fed is Best information online in order to be able to respond to any arguments against continuing the process to become Baby-Friendly.

As the committee members researched the arguments of Fed is Best, they understood that their argument against the Baby-Friendly Hospital Initiative boiled down to the perception that negative outcomes such as newborn jaundice, hypoglycemia, dehydration, and accidents were increased due to the below policies they perceived as Baby-Friendly (taken directly from Fed is Best):

1. the >80% exclusive breastfeeding at discharge metric
2. requiring physician prescriptions for supplementation, particularly in infants showing persistent hunger signs
3. unsupervised, prolonged skin-to-skin care
4. the ban on pacifiers (which has been abandoned by the 2017 WHO guidelines due to its effects on SIDS rates)
5. the forced 24-hour rooming in policy along with nursery closure, and
6. misleading patient education on the size of the newborn stomach, cluster-feeding, rarity of insufficient breast milk and risks of formula without education on the risk of starvation-related complications while exclusively breastfeeding with insufficient milk intake.

Immediately, the committee recognized that many of these policies were not actually espoused by the Baby-Friendly Hospital Initiative. Specifically, there was no

requirement for physician prescriptions for supplementation, no ban on pacifiers (patients requesting a pacifier were given one), and no forced 24-hour rooming in and no requirement that hospitals close nurseries. While patients or clinicians may interpret Baby-Friendly guidelines as pressure, there was no requirement to breastfeed or not to supplement in Baby-Friendly policies. The committee was confident that many of Fed is Best's concerns could be addressed by better training or supplementing policies, such as requiring that a nurse be present during skin-to-skin care, or better communication about access to pacifiers.

In their 6th point, Fed is Best argues that for many women, the amount of milk that they produce in the first week or two of their newborn's life is insufficient. Dr. Del Castillo-Hegyi even claims that colostrum does not contain the sufficient number of calories to sustain the majority of newborns. This claim is contested by the WHO and breastfeeding experts, who maintain that colostrum is the ideal first food and that for the vast majority of newborns it is sufficient until a mother's milk comes in. The committee agreed that the claims that a large number of women had insufficient early supply were most certainly invalid. However, they could not dismiss the fact that some unknown number of women will have real physiological reasons for lactation failure that aren't readily apparent in the short time a woman is in the hospital postpartum.

Again, the committee felt that this was not a failing of the Baby-Friendly Hospital Initiative or a reason not to promote breastfeeding, but a failing of the U.S. healthcare system and a lack of cultural support and knowledge of breastfeeding. Many other countries either had hospitals that kept women postpartum for a longer period of time, robust home-visiting programs by health professionals that could more easily identify breastfeeding failures, or a more close-knit social circle familiar with breastfeeding that could support new mothers.

The consensus on the committee was that many of Fed is Best's claims could be refuted, but that the role of the hospital in encouraging breastfeeding was complicated and fraught with ethical and logistical issues outside of the scope of the hospital's action. While they felt that the Baby-Friendly Hospital Initiative was still a worthwhile choice, they worried that Pinevale's administration would not share their view.

The committee's worries were not unfounded. Dr. Del Castillo-Hegyi's presentation struck a balance of reporting on the few deaths from lactation failure (a tragedy difficult to ignore) and the possibility of lawsuits against the hospital, with scientific evidence (albeit skewed) of the consequences of lactation failure. Concurrent with the June grand rounds presentation, the group of pediatricians against Baby-Friendly policies wrote and submitted a letter to Pinevale's administration echoing Fed is Best's arguments and

calling into question the Baby-Friendly Hospital Initiative's success at improving exclusive breastfeeding in the United States.

This argument was not anticipated by the committee, and is not baseless. Reputable scientists and physicians argue, most prominently in a recent article published in the Journal of Perinatology[11], that previous evaluations of the Baby-Friendly Hospital Initiative, including the PROBIT study, were conducted in healthcare systems very different than the U.S.'s and cannot be used to support the efficacy of BFHI in the U.S. The Journal of Perinatology article also includes discomfort over certain BFHI positions on the use of pacifiers, 24-hour rooming in, and prolonged skin-to-skin care. The conclusion of the authors is that wide-scale adoption of BFHI is premature without further evaluation.

Pinevale's administration feels compelled to act, but is torn. While they had invested time and energy into the Baby-Friendly Hospital Initiative and are committed to encouraging initiation of breastfeeding, there have been early problems with the implementation of BFHI policies, and Fed is Best's arguments, while not wholly founded, brought up fears of adverse outcomes and potential lawsuits difficult to ignore. The CEO and Vice President have an emergency meeting and decide to task Claudia, the Director of Women's Health Services, with reviewing the current evidence and coming up with recommendations to either forego Baby-Friendly designation and re-write lactation policies, or move forward with the designation, with an eye towards making sure policies and procedures minimize potential for patient dissatisfaction and adverse outcomes.

Putting yourself in Claudia's place, do you choose to defend BFHI? If so, how do you defend it and convince hospital administrators and concerned doctors? If not, what policies or procedures would you recommend to ensure breastfeeding is supported in the hospital?

[11] Gomez-Pomar, E., & Blubaugh, R. (2018). The Baby Friendly Hospital Initiative and the ten steps for successful breastfeeding. a critical review of the literature. *Journal of Perinatology, 38*(6), 623-632.