Beyond Maternity Nursing: The Baby-Friendly Hospital Initiative

Nurses can support public health through promotion of long-term breastfeeding.

ABSTRACT: The Baby-Friendly Hospital Initiative (BFHI) is a program developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to promote breastfeeding in hospitals and birthing facilities worldwide. Since the program was launched in 1991, breastfeeding initiation, duration, and exclusivity have increased globally, a trend largely attributed to changes in hospital policies and practices brought about by the BFHI. This article provides an overview of these practices and policies, the institutional benefits of achieving BFHI certification, and the process through which health care facilities can do so. All nurses—whether they work in maternity care or another nursing specialty in a hospital, ambulatory, or community setting—can play a role in promoting societal health through their support of long-term breastfeeding as recommended by the WHO and UNICEF.

Keywords: Baby-Friendly certification, Baby-Friendly Hospital Initiative, breastfeeding, breastfeeding policy

It is well documented that breast milk is the best choice for newborns and infants, providing protection against many common causes of infant morbidity. Exclusively breastfed newborns and infants have lower rates of otitis media, respiratory infection, gastroenteritis, urinary tract infection, conjunctivitis, and thrush than those who receive only partial or no breastfeeding.[1,2] Breastfeeding has also been found to reduce the risk of type 1 and type 2 diabetes, childhood leukemia, overweight and obesity, and necrotizing enterocolitis.[3-5] There is also evidence that breastfeeding is positively and significantly associated with a child's intelligence (as measured by IQ score) at all ages, even when birth weight and such parental factors as intelligence, educational level, social class, and age are statistically controlled for.[6]

Although obstacles to long-term follow-up have hindered efforts to document the maternal benefits of breastfeeding, there is evidence that breastfeeding for one year or more reduces the mother's risks of breast and ovarian cancers, cardiovascular disease, and type 2 diabetes.[4] An analysis of data from the National Institute of Child Health and Human Development

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on more than 1,300 families found an association between breastfeeding and positive changes over time in "maternal sensitivity," or heightened responsiveness to infant cues.[7] Likewise, exclusive breastfeeding is inversely associated with postpartum depression.[4, 8, 9] While depression during the third trimester (as measured by the Edinburgh Postpartum Depression Scale) is associated with lower rates of breastfeeding, exclusive breastfeeding at three months postpartum is associated with significantly decreased depression scores.[8] Such findings, which suggest that breastfeeding may reduce depressive symptoms, underscore the importance of recognizing prenatal depression as a risk factor for early breastfeeding cessation and of offering extensive breastfeeding support to new mothers who show signs of depression. Achieving breastfeeding self-efficacy within the first week postpartum is positively correlated with both breastfeeding exclusivity and duration through six months postpartum.[10, 11]

Taken together, the benefits of breastfeeding are enormous. A 2010 cost analysis used pediatric disease data collected by the Agency for Healthcare Research and Quality, 2005 breastfeeding rates (the most recent available at that time) calculated by the Centers for Disease Control and Prevention (CDC), and 2007 dollars to estimate the potential health and financial benefits of breastfeeding. The analysts concluded that if the proportion of U.S. mothers who followed the medical recommendation of exclusively breastfeeding their infants for at least six months after birth were to rise from 12.3% to 90%, it would prevent more than 900 deaths per year and save the United States approximately $13 billion in annual health care expenditures.[12] Despite evidence of the pediatric and maternal benefits of breastfeeding, however, many countries, including the United States, have low levels of breastfeeding, with the CDC reporting that only 22.3% of U.S. mothers were exclusively breastfeeding through six months in 2016.[13] This article describes the Baby-Friendly Hospital Initiative (BFHI) developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to promote breastfeeding throughout the world. It discusses the hospital policies the BFHI advocates and factors that contribute to breastfeeding success. It explains the BFHI certification process (in which hospitals that complete the process are designated as "Baby-Friendly"), institutional benefits associated with certification, and the practices through

which all nurses can support long-term breastfeeding and associated societal health.

THE INTERNATIONAL BFHI

Launched in 1991 by UNICEF and the WHO to increase support for breastfeeding in facilities that provide maternity care, the BFHI is the global standard for hospital support of breastfeeding. Mothers who deliver at institutions that follow BFHI practices are more likely to initiate breastfeeding and continue breastfeeding their infants for at least six weeks postpartum than mothers who deliver at institutions that do not.[14-17] The BFHI was founded on 10 evidence-based practices for promoting breastfeeding (see *The Ten Steps to Successful Breastfeeding*).

Institutional factors can promote or impede breastfeeding. Perrine and colleagues analyzed data from the Infant Feeding Practices Study II, which surveyed 1,457 women who had given birth to a single healthy child in a U.S. hospital between 2005 and 2007 and intended to exclusively breastfeed for periods ranging from less than one month to more than seven months.[18] The women answered survey questions during their third trimester and approximately every month after giving birth for about 10 months. Initially, more than 85% of the women surveyed planned to breastfeed exclusively for three months or longer, but only 32.4% of the women met their intended breastfeeding goal, and 15% had stopped exclusively breastfeeding before hospital discharge. When the researchers investigated hospital practices, they found that the percentage of women who breastfed for as long as they intended rose with the number of BFHI practices the hospital followed. When hospitals followed none or only one of the Ten Steps to Successful Breastfeeding (Ten Steps), only 23.4% of the women met their intended breastfeeding goal, compared with 46.9% of the women whose hospital followed six of the Ten Steps. Successful breastfeeding was nonsignificantly associated with breastfeeding within one hour of giving birth, not giving the infant a pacifier, and rooming-in (mothers and infants remaining together throughout the hospital stay), and cessation or disruption of breastfeeding was significantly associated with administering formula to healthy breastfeeding infants.[18] Similarly, a Hong Kong study found that policies prohibiting hospitals from accepting free formula from manufacturers reduced in-hospital formula supplementation and increased both in-hospital exclusive breastfeeding and breastfeeding duration.[19]

Unfortunately, institutional adherence to BFHI guidelines is not optimal even among hospitals that have achieved BFHI certification. In a study of 915 mothers who gave birth at four BFHI-accredited birthing facilities in Maine, only 34.6% of the mothers reported that their hospital followed all seven of the BFHI practices the researchers investigated, and 28.4% reported receiving a gift pack containing formula—a practice prohibited by the BFHI because of its association with breastfeeding cessation.[15] In a study from the United Kingdom that included 1,130 mothers, fewer than 18% were happy with the breastfeeding information they received during pregnancy from health care professionals, fewer than 50% reported receiving adequate information on how to find breastfeeding support after birth, and more than 92% of those who stopped breastfeeding by six weeks postpartum said they would have liked to have continued beyond that point.[20]

THE BREASTFEEDING REPORT CARD

National breastfeeding data are collected by the CDC and documented in the Breastfeeding Report Card, which provides information on breastfeeding practices in all states, the District of Columbia, and Puerto Rico. This report card is published every two years, most recently in 2016 (www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf).[13] The report card indicators are based on the breastfeeding goals outlined in the U.S. Department of Health and Human Services (DHHS) Healthy People 2020 initiative. For health care facilities, the aims are to reduce the proportion of newborns who receive formula in the first two days of life and to increase the proportion of live births that occur in facilities that provide

The 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 the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-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. Practice rooming-in—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.

From the World Health Organization, Division of Child Health and Development. *Evidence for the Ten Steps to Successful Breastfeeding*. Geneva, Switzerland; 1998.

recommended care for lactating mothers and their infants. The results of the last report card are positive, showing that U.S. breastfeeding levels continue to rise incrementally, with 2013 rates exceeding those of 2011 for the proportion of newborn infants who started to breastfeed (more than 81% versus 79%), were breastfeeding at six months (nearly 52% versus 49%), and were breastfeeding at one year (nearly 31% versus 27%).[13,21] But despite these improvements, Healthy People 2020 targets for breastfeeding duration and exclusivity are not yet being met (see Table 1). In 2013, the Healthy People 2020 targets of at least 60.6% of infants still breastfeeding and at least 25.5% of infants still exclusively breastfeeding at six months were met in only 12 and 16 states, respectively.[13] In addition to breastfeeding rates, the report card includes data on such "breastfeeding support indicators" as the percentage of live births that occur in institutions receiving Baby-Friendly designation, the number of international board-certified lactation consultants per 1,000 live births, and the number of La Leche League leaders per 1,000 live births.

In 2015, the CDC reported that policies and practices of maternity units had improved nationally since 2007, but that more work was needed to ensure that all women receive breastfeeding support and education during their hospitalization.[22] According to this report, the percentage of U.S. hospitals that incorporate the majority of practices recommended in the Ten Steps increased from 29% in 2007 to 54% in 2013, but of the 3,300 maternity hospitals in the United States, only 289 had been certified as Baby-Friendly.[22]

Table 1. Healthy People 2020 Breastfeeding Targets and Current Rates

Objective	2020 Target, %	Current Rate, %[a]
Increase the proportion of infants who are breastfed		
• Ever	81.9	81.1
• At six months	60.6	51.8
• At one year	34.1	30.7
• Exclusively through three months	46.2	44.4
• Exclusively through six months	25.5	22.3
Increase the proportion of employers that have worksite lactation support programs	38	Not available
Reduce the proportion of breastfed newborns who receive formula supplementation within the first two days of life	14.2	17.1
Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies	8.1	18.3[b]

[a] Current rates represent infants born in 2013, per the National Immunization Survey 2014–15, except where noted.
[b] Current rate represents infants born in hospitals designated as of June 2016 as Baby-Friendly. As of June 9, 2017, the Baby-Friendly USA website had updated the rate of annual births that occur in facilities designated as Baby-Friendly to 21.5.
Adapted from the Centers for Disease Control and Prevention. *Breastfeeding report card, progressing toward national breastfeeding goals: United States, 2016.* Atlanta; 2016.

BABY-FRIENDLY CERTIFICATION

When institutions achieve Baby-Friendly status, not only does it help them meet Healthy People 2020 targets and improve national health outcomes, but the certification process can strengthen the organizations' leadership and increase staff competence. When a hospital commits to the work involved in achieving this designation, it can stimulate new ways of thinking among all nursing staff, the maternity team, and the facility's administration. In addition, with Baby-Friendly certification, a facility meets the Joint Commission's maternity care standards for exclusive breastfeeding.[23]

Baby-Friendly certification is awarded when a facility has successfully implemented the Ten Steps and the International Code of Marketing of Breast-Milk Substitutes.[17] The 13-page BFHI Self-Appraisal Tool, which a facility uses to appraise its current practices as part of the certification process, breaks down each of the Ten Steps into several substeps in the form of yes–no questions. For example, step 1—"Have a written breastfeeding policy that is routinely communicated to all health care staff"—is followed by 11 substeps, such as, "1.1 Does the facility have a written breastfeeding/infant feeding policy that establishes breastfeeding as the standard for infant feeding and addresses all *Ten Steps to Successful Breastfeeding* in maternity services?" (The BFHI Self-Appraisal Tool is available online at www.breastfeedingor.org/wp-content/uploads/2012/10/using-bfhi-self-appraisal-tool-2011.pdf.) It is important to note that these policies should take effect on pediatric units, EDs, medical–surgical units, ambulatory surgical units, outpatient units, and any others in which a mother or infant may be admitted for care.[17]

Training of maternity nursing staff is formal, consisting of 20 hours of instruction, including 15 sessions required by UNICEF and the WHO and five hours of supervised clinical experience to ensure clinical competence.[24] Other health care providers (physicians, midwives, physician assistants, and advanced practice RNs) involved in labor, delivery, maternity, or newborn care require at least three hours of breastfeeding management education and should thoroughly understand the benefits of exclusive breastfeeding, the physiology of lactation, and which medications are safe

to use while breastfeeding. Health care providers who are unable to describe or demonstrate breastfeeding skills are expected to provide mothers with appropriate referrals to others who can.[24] To practice in accordance with the International Code of Marketing of Breast-Milk Substitutes, institutions must not accept free or reduced-cost supplies of breast milk substitutes and feeding supplies. In addition, any educational material given to mothers must be free of commercial identifiers, such as logos. Staff members are forbidden to receive gifts in the form of nonscientific material, equipment, money, or meals from producers of breast milk substitutes or artificial nipples and bottles.[24]

A prospective cohort study of 2,560 mother–infant pairs in public hospitals in Hong Kong investigated the effects of the BFHI guidelines on breastfeeding rates for 12 months following birth or until the cessation of breastfeeding.[19] A total of 1,320 mothers delivered before and 1,240 delivered after the hospitals had implemented the guidelines. Investigators found that the proportion of mothers exclusively breastfeeding during hospitalization rose from 17.7% before guideline implementation to 41.3% afterward, and median duration of breastfeeding increased from eight to 12.5 weeks. Increased formula supplementation was associated with higher rates of breastfeeding cessation.

THE ROAD TO BABY-FRIENDLY STATUS

In the United States, implementation of the BFHI occurs in four phases, called the "4-D Process." The four phases are as follows[25]:

- **The Discovery Phase** is the first phase, in which staff learn what BFHI practices include and all that they entail. In this phase, the facility or institution must register with Baby-Friendly USA (BFUSA) and submit a completed BFHI Self-Appraisal Tool, a letter of support from its chief executive officer, and a completed facility data sheet (a sample of which is included in the online BFHI Self-Appraisal Tool). It should be noted that all forms must be completed online by one of two facility personnel authorized to use the BFUSA portal.
- **The Development Phase** is the planning phase, in which the facility plans how to implement and sustain the Ten Steps. In this phase a committee is formed to oversee the process, including policy development and staff training. There are specific time frames associated with each task in this phase and, starting at this point, phase fees are required. (A fee schedule is available at www.babyfriendlyusa.org/get-started/fee-schedule.)
- **The Dissemination Phase** is when all facility staff members who may be affected by this policy receive an orientation. Facilities must establish a breastfeeding education program for pregnant women and new mothers and begin collecting breastfeeding data from patient medical records and audits of maternity care practices.
- **The Designation Phase** occurs after the facility submits a "Request to Move Letter" to BFUSA. This must include data demonstrating that the facility has met the specific guidelines.

According to the BFUSA website, as of June 9, 2017, 440 U.S. hospitals and birthing centers had been designated as Baby-Friendly (for a regularly updated list, see www.babyfriendlyusa.org/find-facilities). In 2007, only 2.9% of U.S. births occurred in facilities with the Baby-Friendly designation, and this figure has grown to about 21.5%, exceeding the Healthy People 2020 target of 8.1%.

Bumps in the road. The process for achieving Baby-Friendly status may seem simple, but implementation can be difficult. A qualitative study that included 31 participants, representing midwifery, medical, nursing, and ancillary staff from six Australian maternity hospitals, found that the understanding and personal views of staff, as well as a "bottle-feeding culture," were often at odds with BFHI objectives.[26] Unpaid education time further impeded the goals and stressed staffing levels. A San Francisco hospital found it took eight years to achieve Baby-Friendly status, with challenges including health care providers with limited breastfeeding knowledge, hospital practices that did not support rooming-in or skin-to-skin contact between mother and infant, and little breastfeeding education overall.[27]

Hospital policies and lack of breastfeeding education on the part of staff are not the only impediments to achieving Baby-Friendly status and improving breastfeeding rates. Population characteristics such as language barriers, homelessness, substance abuse, and poverty can present challenges as well.[27]

ACHIEVING SUCCESS

The Guided Infant Feeding Technique (GIFT), an educational program based on the Ten Steps, was introduced to 1,086 participants from 35 Louisiana hospitals between November 2008 and February 2012.[28] Within 30 months, the number of hospitals that had achieved GIFT certification rose from nine to 24. Subsequently, Louisiana's breastfeeding rates, as documented in the CDC's Breastfeeding Report Card, increased from 50.7% ever breastfed in 2007 (the year before the program was introduced) to 60.9% ever breastfed in 2016, though this rate is still well below the Healthy People 2020 target of 81.9%.[13,29] Similarly, among mothers giving birth in a large multicenter medical institution in Chicago, rates of exclusive breastfeeding throughout the hospital stay rose from 38.6% to 53.5% over a four-month period after nurses completed a 20-hour BFHI education program.[30]

Other facilities that achieved Baby-Friendly designation noted that the following factors contributed to their success[31]:

- involvement of all staff, not only nurses

- financial assistance in the way of grants, which help offset educational fees
- ongoing technical assistance with data collection

Maintaining momentum. Once an institution has been designated as Baby-Friendly, it is important to maintain the momentum that was involved in attaining that status and to continue practicing in accordance with the BFHI. A study that included 915 women who gave birth in one of four Maine hospitals that were BFHI accredited either before or during the study period found that adherence to the Ten Steps was not optimal. Only 34.6% of the women reported that the hospital followed at least seven of the steps, with 35% of the women who gave birth at hospitals working toward Baby-Friendly status and 28% of the women who gave birth at hospitals that had already achieved Baby-Friendly status reporting that they had received gift packs containing formula upon discharge.[15] As the number of BFHI-accredited hospitals grows, follow-up on practices will be an important area of continued nursing research.

Implications for Nursing Practice

- Educate all nursing staff, not only those on obstetric units, on the importance of providing breastfeeding support to mothers in their care.
- Do not provide formula to breastfeeding mothers in the immediate postpartum period unless indicated in accordance with the nursing assessment of the mother or infant.
- Cease providing new mothers with gift packs that include formula or any materials that have the logo of formula companies.
- Develop breastfeeding clinics for follow-up and support of breastfeeding mothers.
- Consider RN home visits (to evaluate the infant for weight loss, dehydration, or other signs of danger) for breastfeeding mothers who did not establish breastfeeding prior to discharge.
- Provide information about community resources for breastfeeding upon discharge.
- Provide a comfortable, clean area for breastfeeding and pumping to visitors as well as staff.
- Include breastfeeding education in undergraduate nursing curricula.

SUPPORT FOR BREASTFEEDING

Health care facility programs. The DHHS has included the promotion of breastfeeding in its Healthy People 2020 objectives since 1990. Professional organizations, including the Association of Women's Health, Obstetric and Neonatal Nurses, the American College of Obstetricians and Gynecologists,[32] and the American Public Health Association,[33] encourage health care facilities that serve childbearing families to maintain programs that support the successful initiation and continuation of breastfeeding.

One of the difficulties women and families face in continuing to breastfeed after hospital discharge is lack of support, and it has been shown that support after discharge can increase continued breastfeeding rates. For example, in one study, 27 first-time mothers received weekly telephone calls from a lactation consultant for three months after discharge, and then once monthly for the next three months or until the infant was weaned. At six months postpartum, 73% of the women were still breastfeeding exclusively, compared with the hospital's baseline breastfeeding rate of 38%.[34] In a larger study conducted in Italy, 114 first-time mothers were randomized into two groups: an intervention group receiving weekly structured telephone counseling by a midwife for the first six weeks postpartum, and a control group having routine postnatal visits with a physician at one, three, and five months postpartum. Overall breastfeeding rates in the intervention group were significantly higher than those in the control group, and postpartum rates of exclusive breastfeeding were consistently higher at one month (76.4% versus 42.4%), three months (54.5% versus 28.8%), and five months (25.5% versus 11.9%).[35]

Peer counseling is also effective in promoting breastfeeding, as demonstrated in a study of 990 women who were receiving services from Michigan's Special Supplemental Nutrition Program for Women, Infants, and Children. Women who participated in a peer-counseling breastfeeding support program in addition to receiving prenatal services were significantly more likely to initiate breastfeeding and to continue it for six months than were those in a control group who received prenatal counseling but no peer counseling.[36] A systematic review of 31 qualitative studies found that the mere presence of a supportive person who is available to assist with breastfeeding and with whom the mother has a trusting, sincere rapport can increase rates of continued and exclusive breastfeeding.[37]

To be effective, breastfeeding support must be culturally appropriate, thorough, specific, consistent, and delivered both prenatally and postpartum. In a qualitative study in Maryland, women reported that, though they were encouraged to breastfeed because of the benefits it offered, they were not given specific oral or written information.[38] Only one of the 75 women interviewed reported having received consistent information and support both at the hospital and from the pediatrician after discharge. She was also the only one interviewed who, at 10 months postpartum, reported never having given her child formula.

Workplace support is also essential in promoting continued breastfeeding. Although many women stop breastfeeding when they return to work, participation in a workplace lactation program is associated with exclusive breastfeeding at six months.[39] Furthermore,

Section 4207 of the Affordable Care Act amended the Fair Labor Standards Act to require employers to provide time and space for new mothers to express breast milk for their infants for up to one year after birth.[40] Informing patients of this protection may substantially increase the likelihood that they will continue breastfeeding after returning to work.

Public perception. Others' negative attitudes about breastfeeding in public spaces can discourage exclusive breastfeeding. In a survey conducted by the New York City Department of Health and Mental Hygiene, more than half of the 1,979 respondents believed women should breastfeed in private only.[41] Patients should be informed that breastfeeding in public is sanctioned by laws in 49 states (all except Idaho), as well as the District of Columbia and the U.S. Virgin Islands.[42] For more information on state breastfeeding laws, visit the website of the National Conference of State Legislatures at www.ncsl.org/research/health/breastfeeding-state-laws.aspx.

CONCERNS ABOUT BFHI ENFORCEMENT

While most health care providers would agree that the BFHI can help improve outcomes for mothers and infants, the initiative has faced criticism that it is, in some cases, too rigidly enforced and may even interfere with nursing judgment. Some have expressed concerns that, with strict enforcement, mothers who have had an operative delivery may not be provided adequate time to recover before being encouraged to initiate skin-to-skin contact with their infant and begin breastfeeding.[43] Some nurses have expressed the belief that hospitals need to reduce rates of cesarean section before embarking on this initiative. The BFHI prohibition against pacifier use has also been questioned, because pacifiers have been associated with a reduced risk of sudden infant death syndrome.[43] Finally, some articles in the popular press have suggested that new mothers are being made to feel guilty if they cannot or choose not to breastfeed, and some nurses, midwives, and physicians echo this sentiment, voicing discomfort with hospital policies that prohibit infant formula from being provided without a medical order.

Whether following an operative delivery or a long labor and vaginal birth, it's clearly important for exhausted mothers to be carefully observed during the postpartum period when engaged in skin-to-skin contact, breastfeeding, or bottle feeding.[44] The BFHI does not prevail on mothers to breastfeed when it is unsafe for them to do so, and with appropriate observation, infants will be moved to a separate sleep surface if the mother is drowsy. Regarding pacifier use, since it is associated with shortened duration of both exclusive breastfeeding and any breastfeeding, the American Academy of Pediatrics recommends delaying the introduction of pacifiers to healthy infants born at term "until breastfeeding is well established," generally at three to four weeks after birth.[44] While BFHI practices support new mothers with breastfeeding, offering them the assistance of lactation consultants, midwives, and nurses, it is important that mothers who choose not to breastfeed are never made to feel guilty or uncomfortable.

RECOMMENDATIONS

At Jacobi Medical Center in New York City, before mothers give birth, we host "Baby Showers" for patients and their families. At these showers, we provide gifts, food, and extensive breastfeeding education. RNs and nursing students from a local university have been active participants in organizing and presenting at these events. Such experiences are invaluable. At a time when so much clinical learning occurs in simulation, this is one area in which hands-on learning is best.

Upon discharge after childbirth, breastfeeding mothers receive written information that includes telephone numbers they can call for support. We also invite new mothers to participate in a breastfeeding clinic within a week of giving birth. At the clinic, the mothers are evaluated by a lactation specialist, and the infants are weighed and examined by a pediatric health care provider. The lactation counselor observes breastfeeding, offering assistance as needed. This visit incorporates a support group, led by a health educator, in which mothers are encouraged to share what has helped them with breastfeeding. In addition to educating the mothers and families, the clinic provides an opportunity for medical and nursing students to participate and learn more about breastfeeding. Both RNs and local nursing students have led some of the groups.

Although the data suggest that the numbers of women breastfeeding exclusively are increasing, significant improvements must be made if we are to meet Healthy People 2020 targets. All nurses can help promote breastfeeding in their practice and in speaking with their friends and neighbors (see *Implications for Nursing Practice*). We must also work to include breastfeeding education in the curricula of nursing and medical education programs. ▼

For one additional continuing education activity on the Baby-Friendly Hospital Initiative, go to www.nursingcenter.com/ce.

Regina Cardaci is associate director of Women's Health Services at Jacobi Medical Center, Bronx, NY. *The author acknowledges Michael Zinaman, MD, chair of the Department of Obstetrics and Gynecology, North Bronx Health Network, for his support of this project.* *Contact author: regina.cardaci@nychhc.org.* *The author and planners have disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Hetzner NM, et al. Associations among feeding behaviors during infancy and child illness at two years. *Matern Child Health J* 2009;13(6):795-805.

2. Ladomenou F, et al. Protective effect of exclusive breastfeeding against infections during infancy: a prospective study. *Arch Dis Child* 2010;95(12):1004-8.
3. Assunção ML, et al. Protective effect of breastfeeding against overweight can be detected as early as the second year of life: a study of children from one of the most socially-deprived areas of Brazil. *J Health Popul Nutr* 2015;33(1):85-91.
4. Ip S, et al. *Breastfeeding and maternal and infant health outcomes in developed countries.* Rockville, MD: Agency for Healthcare Research and Quality; 2007 Apr AHRQ Publication No. 07-E007. Evidence report/technology assessment no. 153; https://archive.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf.
5. Moss BG, Yeaton WH. Early childhood healthy and obese weight status: potentially protective benefits of breastfeeding and delaying solid foods. *Matern Child Health J* 2014;18(5):1224-32.
6. Kanazawa S. Breastfeeding is positively associated with child intelligence even net of parental IQ. *Dev Psychol* 2015;51(12):1683-9.
7. Papp LM. Longitudinal associations between breastfeeding and observed mother-child interaction qualities in early childhood. *Child Care Health Dev* 2014;40(5):740-6.
8. Figueiredo B, et al. Breastfeeding is negatively affected by prenatal depression and reduces postpartum depression. *Psychol Med* 2014;44(5):927-36.
9. Yusuff AS, et al. Breastfeeding and postnatal depression: a prospective cohort study in Sabah, Malaysia. *J Hum Lact* 2016;32(2):277-81.
10. Henshaw EJ, et al. Breastfeeding self-efficacy, mood, and breastfeeding outcomes among primiparous women. *J Hum Lact* 2015;31(3):511-8.
11. McCarter-Spaulding D, Gore R. Breastfeeding self-efficacy in women of African descent. *J Obstet Gynecol Neonatal Nurs* 2009;38(2):230-43.
12. Bartick M, Reinhold A. The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis. *Pediatrics* 2010;125(5):e1048-e1056.
13. Centers for Disease Control and Prevention. *Breastfeeding report card, progressing toward national breastfeeding goals: United States, 2016*. Atlanta; 2016. Breastfeeding report cards; https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf.
14. Abrahams SW, Labbok MH. Exploring the impact of the Baby-Friendly Hospital Initiative on trends in exclusive breastfeeding. *Int Breastfeed J* 2009;4:11.
15. Hawkins SS, et al. Compliance with the Baby-Friendly Hospital Initiative and impact on breastfeeding rates. *Arch Dis Child Fetal Neonatal Ed* 2014;99(2):F138-F143.
16. Pérez-Escamilla R. Evidence based breast-feeding promotion: the Baby-Friendly Hospital Initiative. *J Nutr* 2007;137(2):484-7.
17. World Health Organization, Division of Child Health and Development. *Evidence for the ten steps to successful breastfeeding*. Geneva, Switzerland; 1998. WHO/CHD/98.9. http://www.who.int/nutrition/publications/evidence_ten_step_eng.pdf.
18. Perrine CG, et al. Baby-friendly hospital practices and meeting exclusive breastfeeding intention. *Pediatrics* 2012;130(1):54-60.
19. Tarrant M, et al. Effect of a hospital policy of not accepting free infant formula on in-hospital formula supplementation rates and breast-feeding duration. *Public Health Nutr* 2015;18(14):2689-99.
20. Brown A. What do women really want? Lessons for breastfeeding promotion and education. *Breastfeed Med* 2016;11:102-10.
21. Centers for Disease Control and Prevention. *Breastfeeding report card, United States, 2014*. Atlanta; 2014 Jul. Breastfeeding report cards; https://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf.
22. Centers for Disease Control and Prevention. *Hospital actions affect breastfeeding*. Atlanta; 2015. CDC vital signs; https://www.cdc.gov/vitalsigns/breastfeeding2015.
23. Joint Commission. Questions and answers: the perinatal care core measure set. *Jt Comm Perspect* 2013;33(11):12-4.
24. Baby-Friendly USA. *Guidelines and evaluation criteria for facilities seeking baby-friendly designation*. Albany, NY; 2016. https://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria.
25. Baby-Friendly USA. *Get started*. n.d. https://www.babyfriendlyusa.org/get-started.
26. Walsh AD, et al. An examination of maternity staff attitudes towards implementing Baby Friendly Health Initiative (BFHI) accreditation in Australia. *Matern Child Health J* 2011;15(5):597-609.
27. Vasquez MJ, Berg OR. The baby-friendly journey in a US public hospital. *J Perinat Neonatal Nurs* 2012;26(1):37-46.
28. Amick MS. Education program improves knowledge of maternity staff regarding breastfeeding. *J Obstet Gynecol Neonatal Nurs* 2015;44:S29.
29. Centers for Disease Control and Prevention. *Breastfeeding report card—United States, 2007*. Atlanta; 2007. Breastfeeding report cards; https://www.cdc.gov/breastfeeding/pdf/2007breastfeedingreportcard.pdf.
30. Siggia G, Rosenberg S. Does breastfeeding education of nurses increase exclusive breastfeeding rates in a large academic medical institution? *J Obstet Gynecol Neonatal Nurs* 2014;43(Suppl 1):S38.
31. Schoenfelder SL, et al. Engaging Chicago hospitals in the Baby-Friendly Hospital Initiative. *Matern Child Health J* 2013;17(9):1712-7.
32. American College of Obstetricians and Gynecologists, Committee on Obstetric Practice and Breastfeeding Expert Work Group. *Committee opinion number 658. Optimizing support for breastfeeding as part of obstetric practice*. Washington, DC; 2016 Feb. Committee opinions; http://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co658.pdf?dmc=1&ts=20170413T1701581488.
33. American Public Health Association. *An update to 'A call to action to support breastfeeding: a fundamental public health issue.'* Washington, DC; 2013 Nov 5. Policy number 20132. Policy statements; https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/15/26/an-update-to-a-call-to-action-to-support-breastfeeding-a-fundamental-public-health-issue.
34. Agostino MR. Post-discharge telephone support for the first-time, low-risk breastfeeding mother. *J Obstet Gynecol Neonatal Nurs* 2012;41:S142-S143.
35. Simonetti V, et al. A structured telephonic counselling to promote the exclusive breastfeeding of healthy babies aged zero to six months: a pilot study. *Int J Nurs Pract* 2012;18(3):289-94.
36. Olson BH, et al. A quasi-experimental evaluation of a breastfeeding support program for low income women in Michigan. *Matern Child Health J* 2010;14(1):86-93.
37. Joanna Briggs Institute. Best practice information sheet: women's perceptions and experiences of breastfeeding support. *Nurs Health Sci* 2012;14(1):133-5.
38. Cross-Barnet C, et al. Long-term breastfeeding support: failing mothers in need. *Matern Child Health J* 2012;16(9):1926-32.
39. Balkam JA, et al. Effect of components of a workplace lactation program on breastfeeding duration among employees of a public-sector employer. *Matern Child Health J* 2011;15(5):677-83.
40. Karin M, Runge R. Breastfeeding and a new type of employment law. *Cathol Univers Law Rev* 2014;63(2):332-70.
41. Mulready-Ward C, Hackett M. Perception and attitudes: breastfeeding in public in New York City. *J Hum Lact* 2014;30(2):195-200.
42. National Conference of State Legislatures. *Breastfeeding state laws*. 2016. http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx.
43. Bass JL, et al. Unintended consequences of current breastfeeding initiatives. *JAMA Pediatr* 2016;170(10):923-4.
44. Meek JY, Noble L. Implementation of the Ten Steps to Successful Breastfeeding saves lives. *JAMA Pediatr* 2016;170(10):925-6.