Baby Friendly Health Initiative in Ireland – history and future.
Submitted to UNICEF/WHO for the 25 Year Global Review of the BFHI

Country overview

The Republic of Ireland, referred to hereafter as Ireland, is an independent country with an elected parliament and a central government structure. Ireland is a part of the European Union. GDP per capita is 54,464 USD (2013) which fell following the 2008 financial crisis. The Irish economy has transformed since the 1980s from being predominantly agricultural to a modern knowledge economy focused on high technology industries and services, with multinational corporations dominating the export sector. [Main source Wikipedia] Production of powdered infant formula is very important to the Irish economy and Ireland currently produces 15% of the total global output and is the largest exporter in Europe of powdered infant formula. [http://www.fdii.ie/Sectors/FDII/FDII.nsf/vPages/Food_Industry_in_Ireland~sector-profile?OpenDocument]

The population of Ireland in 2013 was 4.6 million. In 2015, 65,909 babies were born, a reduction of 1,500 in births from 2014.The birth rate in Ireland was one of the highest in Europe, at 15 per 1,000 population in 2013. The 2013 infant mortality rate was 3.31 /1000 live births [Central Statistics Officecso.ie]. The recent high emigration rate of predominately 20-35 year olds may reduce birth numbers over the coming years.

Irish is the national language with English used by most people as the day-to-day language. In 2015, Ireland was ranked as the joint sixth most developed country in the world by the United Nations Human Development Index. Education is provided without tuition fees and compulsory from age six to sixteen, over 90% complete second level and 37% of the population has a university or college degree.[Main source Wikipedia]

Ireland committed to promote children's rights when it signed up to the United Nations Convention on the Rights of the Child (UNCRC) in 1992, though the Convention has not been fully incorporated into national legislation nor its provisions required to be respected in state policies and procedures. The UN Committee on the Rights of the Child periodic reviews have highlighted (among other recommendations) the need for ensuring that business enterprises do not negatively affect the rights of the child and that rates of breastfeeding are low particularly among specific populations, training of health-care professionals related to breastfeeding is insufficient, the number of baby-friendly hospitals is insufficient and no national strategy on the feeding or breastfeeding of infants exists.[CRC/C/IRL/CO/3-4 March 2016].

Every woman who is pregnant and ordinarily resident in Ireland is entitled to free maternity care under the Maternity and Infant Care Scheme that provides an agreed programme of care provided by a family doctor of choice and under the direction of a hospital obstetrician with hospital midwives providing most of the care. The Scheme also provides for two post-natal visits to the general practitioner. Screening for metabolic disorders is routinely carried out. Birth registration is legally required. [www.hse.ie] Women can chose to attend an obstetrician and pay privately for medical care and to have a private room in the public hospital (subject to availability). The care during labour and the post-natal stay is mainly provided by the hospital midwives. All maternity units are located within hospitals. There is no longer any private hospital offering maternity care. Home births are available free of charge if a woman meets strict criteria and if there is a service available in their area. Home births were over 30% in 1956 and in 2013 the proportion of planned home births was less than 1%. Midwifery is a registered profession requiring 4 years direct entry training or eighteen months after general nurse training (and working experience) and is through approved university programmes.

In Ireland there currently are 16 general hospitals with maternity units and three solely maternity hospitals (which also include gynaecology services) and annual numbers of births ranging from 1,000 to over 9,000 per facility. Four of these hospitals provide tertiary neonatal care, four provide intermediate level neonatal care, and the remaining 11 provide routine newborn care. [National Maternity Strategy 2016 http://health.gov.ie/]

Infant feeding rates on discharge from maternity services are collated and reported as part of the National Perinatal Reporting System. [www.hpo.ie] All infants are scheduled to receive a free home visit

from a public health nurse (PHN) within 48 hours after hospital discharge and developmental checks are offered at a public clinic at 3 months, 9 months, 18 months and 2 years. Infant feeding rates are collected at 1st PHN visit and at 3 months. [www.hse.ie] .There is no infant and young child feeding or nutrition authority, or programme specifically related to implementation of the Global Strategy for Infant and Young Child Feeding.

The case study methodology

The National BFHI Coordinator has been in post since it started in Ireland (1998) and the majority of the information came from her records. The draft was then discussed with members of the BFHI National committee. Country overview information not specific to the BFHI was provided from government web sites or as specifically referenced. An external evaluation of the BFHI in Ireland commissioned by the main funder of the BFHI is taking place currently though the results of this evaluation will not be available until after the deadline for this case study. Sections of this case study were discussed with a member of that evaluation team.

Why the BFHI was needed in Ireland – Historical background

In the early-1960s breastfeeding was the norm in Ireland with some maternity hospitals recording 90% exclusive breastfeeding at discharge, at least one donor milk bank operated, and rooming-in was usual practice. By the late 1960s powdered artificial breast milk substitute was widely available, the milk bank was closed, and studies indicated breastfeeding rates of 10% in some maternity services. The 1970s saw enormous social change in Ireland particularly in the increasing role of women in society, access to free second level education for all, and movement from rural to urban living, availability of contraception resulting in a sharp decline in births and family size, plus the government decision to centralise all maternity services into large obstetric-led units. Ireland joined the European Economic Community, now known as the European Union (EU), bringing economic change including subsidies to increase dairy production and expand milk processing industries.

The 1980s were a busy time internationally with heightened awareness of the low breastfeeding rates and risks of breast milk substitutes and the need for action to support breastfeeding. At the end of the 1980s, Ireland had a voluntary Industry Code of Marketing though artificial feeding company representatives were still frequent visitors to maternity services providing information and small gifts to health staff. On the positive side, a Labour Court ruled that employers must accommodate mothers' needs, there was an infant formula action group formed, and following on from the 1986 World Health Assembly (WHA) resolution the unlimited free artificial milk supplies from manufacturers to hospitals ceased with hospitals now purchasing supplies, and the first group of twelve women had become International Board Certified Lactation Consultants. The Ottawa Charter for Health Promotion came into being and highlighted the need for broad societal supportive for health.

The 1990s was the decade of UN Conferences and Summits supportive of breastfeeding. In Ireland, the International Code of Marketing was partly put into Irish legislation via an EU directive and Resolution WHA 47.5 encouraging six months exclusive breastfeeding and continued into the second year was adopted as policy by the Department of Health. 1994 saw the launch of the National Breastfeeding Policy by a multidisciplinary committee (including volunteer mother to mother support group representatives) under the Department of Health. This policy endorsed the Innocenti Declaration and recommended the Baby Friendly Hospital Initiative be established in Ireland, among other recommendations.

As can be seen from the table, there have been significant changes in the maternity services in Ireland.

	1985	1992	1999#	2002	2011	2015
Number of hospitals reporting births	63	42	33	20	19	19
Number of live births	62,002	50,868	54,307	60,522	74,600	65,909 ~
Spontaneous vaginal birth	78%	72%	64%	62%	57%	NA*
National (any) breastfeeding rate at hospital discharge	31%	33%	36%	43%	55%	61%##
Average postnatal stay (days)	5 to 6	4 to 5	3 to 5	3 to 5	2.5	NA*
% births took place in units with less than 1000 births	12%	5.5%	6%	2%	0%	0%

% of births took place in units with more than 4000 births	38%	36%	46%	44%	56%	59%##

National Perinatal Reporting System of data collection, analysis and reporting changed from the Department of Health to a contracted agency – Economic and Social Research Institute (ESRI) and more recently to the HSE National Pricing Office (though the system and staff moved from ESRI to NPO)

~ Data from Central Statistics Office

* Not Available. Data will not be published until approximately 2017 from the National Perinatal Reporting System.

calculated from data returned by maternity units/hospitals directly to the BFHI national coordinator as any breastfeeding during hospital stay

Early structure of the BFHI in Ireland

BFHI finds a home with the Irish Health Promoting Hospitals Network

In 1998 the BFHI started in Ireland under the auspices of the Irish Health Promoting Hospitals Network (HPH) a WHO programme which was established in Ireland in 1993 by a group of interested people. There was a national HPH director and an executive committee and it was half funded by hospital network membership fees and half by the Department of Health. A health promoting hospital goes beyond merely giving people information about health and it implements a concerted and collaborative effort to ensure that all aspects of the hospital services empower and enable people to achieve their optimum health. The HPH flourished and developed a set of initiatives to assist hospitals to include health promotion activities as an integral part of a hospital's organisational development. These initiatives included smoking cessation, physical activity, staff wellness and other activities within the framework of a network of hospitals working to assist each other. The people interested in establishing the BFHI in Ireland were looking for a home and the Irish HPH network was interested as many HPH network hospitals had identified improving breastfeeding as one of their planned HPH projects.

The national HPH director approached an International Board Certified Lactation Consultant (IBCLC) who was a BFHI assessor doing some contract work with UNICEF and WHO in other countries assessing hospitals and training towards BFHI as well as work with health promotion and breastfeeding support in Ireland. A contract position as BFHI coordinator was established in HPH initially at as one day a month with secretarial assistance provided by the HPH Coordinating Centre, though the BFHI coordinator worked mostly from her own home (200 km away). The coordinator contract was as self-employed (with no holiday pay, sick pay or social insurance benefits) and with incurred expenses reimbursed.

A formal proposal was written with aim, rationale, objectives, targets, and evaluation method and cost implications for an 18 month first phase. Initial objectives were to: establish the HPH Network as the recognised authorising body for the WHO-UNICEF Baby Friendly Award in Ireland, conduct a rapid baseline survey of country-level hospital breastfeeding rates, establish a national register of hospitals participating in the Baby Friendly Hospital Initiative, award Certificates of Commitment as the first step to the Baby Friendly Award. Funding for the BFHI establishment was provided by the HPH Network. The BFHI coordinator was to give an annual report to the HPH governing committee and in the published HPH annual report, in addition to regular updates with the HPH director.

BFHI fits with HPH and the Ottawa Charter for Health Promotion

The BFHI involves reorientation of the health services to recognise breastfeeding as the norm and implement practices that facilitate it including a supportive hospital policy. Staff training and parent education develops personal skills so mothers are enabled to breastfeed. The BFHI specifically recognises the importance of strengthening community activities to increase both the awareness of the value of breastfeeding and to give women community networks of support. The BFHI helps to create a supportive environment for mothers using their service as well as for mothers on their staff.

The BFHI advisory committee

In June 1998 the first meeting of the interim advisory committee of the BFHI project was held to discuss how the BFHI process would function in Ireland, how to involve hospitals currently less interested in improving breastfeeding supportive practices, to develop an information pack for hospitals, and to highlight potential barriers. From the beginning there were plans for expansion, firstly for a supportive workplace programme for staff in hospital that were breastfeeding, and then widening to include paediatric units, general hospitals where breastfeeding mothers might be for care not connected with

maternity, community health services. There was a launch workshop held May 1999 with all maternity units participating and an obstetrician guest speaker who was active in the BFHI in Norway.

The interim advisory committee included representatives from the two national voluntary mother to mother support groups (La Leche League and Cuidiu-Irish Childbirth Trust), the Association of Lactation Consultants in Ireland, and interested individuals from midwifery education, public health nursing, a paediatrician, IBCLCs from two very interested hospitals, and two members of the HPH national committee. After the interim stage the committee decided to move to an Advisory Committee that additionally had some members directly representing hospitals or health boards and the breastfeeding committee of each health board (8 regions) was asked to send a representative. The UNICEF National Committee Executive Director was encouraging and supportive though no funding was provided and UNICEF did not wish to be part of the Advisory Committee. The BFHI in Ireland was assisted by other countries which were ahead in establishing their initiatives, particularly BFI UK.

Encouraging involvement - Adding a certificate of membership stage

From the start in 1998 it was recognised by the committee that no maternity unit was likely to meet all the global criteria in the next few years. In the spirit of a network supporting moving in a structured way towards a hospital that is a health promoting setting, rather than focused on assessment, a Membership Certificate was instigated. This certificate indicates that the hospital has carried out a self-appraisal and developed at least one structured Action Plan to address a gap, has a named contact person, and agrees to report on their action plan and breastfeeding rates annually to the national BFHI Coordinator. Member hospitals received a copy of the quarterly BFHI newsletter (BFHI Link), were invited to any BFHI (or HPH) workshops or events and the national BFHI Coordinator would answer queries about how to improve practices and encourage linking with another hospital further along the path to baby-friendly. There was no charge for this level of participation. The majority of the hospitals with maternity services were already members of the HPH network (and paying an HPH membership fee) and for those who were not yet network members participating in the BFHI was seen as a way to encourage HPH network membership.

As with all new programmes there were some hospitals that were early adopters. They filled in self-appraisal forms, conducted training (training is not provided directly from the national BFHI programme), addressed gaps and wanted to move forward. In mid- 1999 the first two hospital visits were undertaken for a Certificate of Commitment award. This level indicated that the hospital was in accordance with Steps 1 and 10, had a management agreed plan of action to address other criteria needing attention that would be improved within 24 months, and could show supportive and appropriate documentation (curriculum for staff, antenatal education materials, process for recording feeding statistics etc). The hospital was charged for the site visits at a level to cover travel expenses of the 1-2 assessors, a day rate for the BFHI coordinator (as site visits were additional to the contract for general BFHI coordination); assessors were released for assessment work on a paid day by their own hospital. At that time, assessment team wrote their report and sent it to HPH Exceutive Committee for approval. All certificates were presented at HPH events to emphasise that the BFHI was a part of the HPH network activities. All certificates had an expiry date (3 years for membership, 2 years for commitment).

Developing and progressing the BFHI in Ireland

The network of BFHI national coordinators in industrialised countries was established around 2000 and provided a network of information and support in BFHI coordination. The association with the Irish HPH Network was working well and also provided links internationally. The 10th International Conference on Health Promoting Hospitals was held in Bratislava, Slovakia in 2002 with five posters displayed from Irish maternity units, a five-country workshop co-ordinated by the BFHI Ireland national coordinator on how BFHI activities can link with Health Promoting Hospitals and particular interest at the five-country joint display from many health promoting hospital national coordinators in exploring how to link their BFHI and HPH programmes. The BFHI in Ireland responded to requests from the paediatric services to support the continuation of breastfeeding when an infant or young child was admitted to a paediatric

ward or out-patient service and a set of criteria and a self-appraisal tool for was developed in conjunction with 3 other countries and piloted.

The early 2000s saw the Department of Health and Children busy publishing policies and strategies on women's health, pre-school healthy eating, health promotion and others, most of which referred to the need to support breastfeeding, though not specifically mentioning BFHI. Legislation came into effect for paid lactation breaks until the baby was 26 weeks old. Following on the recommendation of the 1994 National Breastfeeding Policy to implement the Innocenti Declaration, a National Breastfeeding Coordinator was appointed and the second national Breastfeeding (Ministerial) Committee formed in 2002 with a Five Year Strategic Action Plan for Breastfeeding developed and launched in 2005. The BFHI national coordinator was active on this committee that included representatives of health professions, volunteer breastfeeding groups, food safety, health promotion, and women's health.

The BFHI had been an early leader in standards and assessment of practice for external accreditation and as quality in health care programmes became more common in Ireland it was noted that the hospitals active in the BFHI already had the standards, process, documents and people experienced in quality programmes. The HPH/BFHI Breastfeeding Supportive Hospital Workplace programme had self-appraisal tools and three levels of award for a breastfeeding supportive workplace, were in use and fitted well with the trade union activities around partnership for a healthy workforce and workplace based wellness programs.

Designation as a Baby Friendly Hospital (National Award)

Breastfeeding rates were rising however they were still below the level of the global BFHI criteria of 75% exclusive breastfeeding from birth to discharge. Similar to some other countries at this time, the decision was taken by the BFHI Committee to have a BFHI National Award where the maternity unit fully met all the criteria and the Code though did not have a 75% exclusive breastfeeding rate. This adaptation was in recognition that attitudes to breastfeeding were influenced by the wider community and socio-economic factors in the population served by the hospital and that a maternity hospital could not be held responsible for changing general community attitudes.

Hospitals voluntarily seek external assessment. The application for external assessment signed by the hospital management team lists the responsibilities and requirements that the hospital agrees to uphold once they are designated as a Baby Friendly Hospital. The first two hospitals to be externally assessed, meet the criteria and receive designation as a Baby Friendly Hospital (National Award) occurred in 2004. The hospital was charged for the assessment at a level to cover travel and accommodation expenses of the assessment team, a day rate for the BFHI coordinator (as site visits were additional to the contract for general BFHI coordination), and assessors were released on a paid day by their own hospital. The cost varied by the size of the hospital. A model of peer assessment rather than from outside the country was used. This kept costs down and assessors were aware of common issues and cultural aspects. Assessors undertake a structured training programme with self-study, observation and supervised practice. Regular appraisal of skills is done. External assessment is a team of 2-5 assessors over 2.5 to 4 days depending on the size of the hospital (with additional desk time to assess documents before on-site visits).

The financial aspects were administered by the HPH. The National BFHI Coordinator gained agreement from the Minister of Health to present these first awards at a ceremony as a part of the EU Ministers of Health meeting during the Irish Presidency of the EU. This gave very positive media coverage to the BFHI.

Annual plans, monitoring and reassessment

From the beginning, the BFHI in Ireland added the HPH activity that all participating hospitals had an annual structured action plan to progress towards a fully breastfeeding supportive environment in the maternity services. Actions were wide ranging, including providing meals times that respected the baby's needs and did not require that the mother to choose between missing her own meal or feeding her baby; an audit of information parents receive antenatally; staff education and skill development;

linking of community mother-to-mother support networks with hospital services; as well as clinical aspects and many more.

When the monitoring and reassessment process was being developed input was sought from the hospitals who were designated or approaching designation. A process for monitoring of services designated as Baby Friendly was included through the annual reporting from participating hospitals including annual audit of practice; annual Action Plan including evaluation process, and breastfeeding statistics; sharing experience of achieving and maintaining BFHI status with other hospitals. If the three aspects were met each year there was a short hospital visit and review at year 3 and then full external assessment before the end of year 5 since the designation. The process is on the BFHI Ireland web site and was shared in a workshop in 2007 with the international network of BFHI National Coordinators.

Everything was going well. There was interest from hospitals, government support, the BFHI fitted well in the health promotion focus, and BFHI in Ireland was linked internationally. The BFHI Link newsletter was produced regularly, and a health promotion student on a work placement established the BFHI web site as her work placement project.

The structure changes

In 2005 the Irish health service was restructured, from a regional health structure and a number of different agencies answerable to the Department of Health, now all under one agency known as the Health Service Executive (HSE). This structure continues to evolve with on-going change. Some of the effects of the change included that the implementation of the Department of Health's cross-government Five Year Strategic Action Plan for Breastfeeding now became the responsibility of the HSE and changes resulted in the loss of involvement of the wider structure of education, media, and other non-health sectors. For example, the National Breastfeeding Coordinator was relocated away from an office in the Department of Health (which was linked to other government departments) to working within the health sector and accommodated in a HSE office.

The HPH had been part-funded and answerable to the Department of Health as well as to its network member hospitals. It now came under the HSE and was no longer self-governing and no longer had a means of charging membership fees, or charging for BFHI site visits and assessments. The HSE Health Promotion section agreed to pay for the hospital assessments. New health promotion structures were set up within HSE and gradually the future of the HPH network became in doubt and during 2010 it ceased to be active with staff leaving or being reassigned. The BFHI coordinator, who was a contractor not a HSE staff member and the BFHI advisory committee were directed by HSE Health Promotion to keep functioning though there was no longer the HPH network, the administrative support or managerial oversight that had been provided by the HPH. Expansion programmes of Breastfeeding Supportive Paediatric unit, Hospital Staff Breastfeeding Support and plans for supportive general hospital and community health services ceased with the ending of HPH. Funding of BFHI also changed, it now being financed by the HSE Health Promotion section but on a less firm footing than under HPH.

Surviving

During the unsettled and 'homeless' period BFHI coordination activity continued as usual with support to hospitals, newsletters, website updates, site visits, assessments, monitoring and reassessment. In a separate employment contract, the BFHI National Coordinator lead the 2006-2009 review and revision of the global BFHI which meant that the new aspects such as breastfeeding supportive labour and birth practices (mother-friendly criteria) and support for non-breastfeeding babies and their mothers became an integral part of the BFHI Ireland information and assessment criteria from 2009, as well as keeping morale high about the BFHI.

The BFHI focus was on including baby-friendly practices as sustainable core practice rather than participation in the BFHI as an optional extra for a maternity service. The development of a HSE/BFHI National Infant Feeding Policy that applied to all maternity and neonatal units and contained all the criteria of the BFHI as the expected standard of care was one activity. A new national healthcare maternity record included an antenatal list with all the supportive practices to be discussed thus

meeting Step 3 requirements, and areas for recording skin to skin timing and supplement use were included. Efforts were made to blend baby-friendly practices into the national health quality improvement programmes being introduced so as to reduce the burden of multi-programme activity and reporting. Specific baby friendly activities were linked to quality reporting themes so that quality managers could easily see how these activities helped to show evidence the hospital was active in quality audits and improvements. This broadened involvement and increased the profile of BFHI in many hospitals as well as moving from the image of a programme solely to increase breastfeeding rates. Undergraduate midwifery programmes were encouraged to include all the BFHI practices as normal maternity care with the UNICEF/WHO Breastfeeding Promotion and Support in a Baby Friendly Maternity Hospital encouraged as the basic information. The BFHI in Ireland does not provide training courses itself.

The future for BFHI in Ireland

In late 2011 the BFHI coordinator and advisory committee were encouraged by the HSE Health Promotion section (now restructured and titled Health Promotion & Improvement, Health and Wellbeing Division, HSE) to become an independent organisation that could be funded through annual grant aid. This meant the former advisory committee to the BFHI coordinator now needed to become a governance and management committee - and still on volunteer time. The legal structure of an unincorporated organisation was decided to be the quickest, cheapest and easiest. The name was changed from Hospital to Health (from a BFHI Australia idea) to allow for future expansion into community health. Business skills rapidly improved and a constitution was written, committee restructured, a bank account opened, Baby Friendly Health Initiative in Ireland registered as a business name and with the revenue department, a postal address established, annual reports and future plans written and by the end of 2012 the BFHI in Ireland were ready to apply for its own grant aid.

Sustainable funding

Grant aid means that the BFHI National Committee applies on an annual basis for funding to the HSE Health Promotion section for its activities towards assisting health facilities in implementing strategies and programmes of the HSE through the facilities involvement in the BFHI activities. The BFHI National Committee must then wait to see if the funding is granted; applications for 2013 and 2014 were granted, application for 2015 was a little below what was sought and in 2016 funding was significantly below what was applied for and is currently being appealed. At the time of this report the reduction in funding has meant that among other reduced activities, that work by the BFHI Coordinator on assisting hospitals to implement the neonatal practices of the recently updated national infant feeding policy, develop neonatal audit tools and the inclusion of neonatal aspects in BFHI assessments has paused; four hospitals are due for reassessment starting into the process in late 2016 and a means of funding those re-assessments needs to be found, two hospitals are in the assessment process and one in reassessment, for which there is funding currently preserved. No new hospitals will be taken into the assessment process until funding to complete their process is available.

The BFHI National Committee completed the process to become a registered charitable organisation in mid-2016. This will allow other sources of funding to be explored as well as being seen as an established organisation. A wide variety of funding ideas are being discussed including remaining with the HSE as sole funder and tailoring BFHI coordination and assessment to stay within whatever funding is granted; seeking funds from trusts funds, from private health insurance companies or other companies with activities not in conflict with the BFHI ideals; to charge hospitals for support and assessment and monitoring services with fees set at a level that also provides funds for the management costs; generate income through conferences and training courses or even by selling advertising space on BFHI materials and website; or a mixture of funding sources. Funding applications and financial management take a lot of time to do, perhaps needing to hire a person skilled in this area and therefore have a cost implication. Administration work now takes up a high percentage of the BFHI budget reducing the amount available for support and assessment of health facilities.

Activity continues

The Certificate of Commitment is no longer being used as it was found that hospitals acquired it and then did not take action to implement the remaining criteria and progress to external assessment.

Support to hospitals, newsletters, website updates, site visits, assessments, monitoring and reassessment continues to happen. A set of audit tools was developed to assist hospitals to monitor and audit practices of the national infant feeding policy and of the BFHI criteria (Ten Steps and Code) and to easily fit with other quality programmes in the hospital. A policy and procedure manual is being updated and further developed for support, assessments, monitoring as well as management of the BFHI in Ireland. The BFHI National Committee has also registered with the national Governance Code programme which indicates commitment to effective and transparent governance of the organisation.

	2002	2004	2008	2011	2015
Designation as a Baby Friendly Hospital (National Award)	0	3	7	6 re-assessed and re-designated (one hospital did not seek re-designation)	9 3 new + 6 re-assessed and re-designated
% of births occurring in a Baby Friendly facility	0	13.5%	41%	35%	43%
Certificate of Commitment	6	8	6	4	not used
Certificate of Membership	14	9	6	9	9
Non-participating	2	2	1	1	1
Programmes active beyond core maternity BFHI	Paediatric	Paediatric Workplace	Paediatric Workplace	none	none
Contracted days for BFHI coordinator/year	35	45	60	57	146#

Some of the previous year's funding arrived late in the year and was not used until 2015 giving an unusually high number. Additional days needed from 2013 as the administration and management was no longer being done by the HPH network

Possible future enablers for the BFHI in Ireland

The first national Maternity Strategy was launched in early 2016 and included many references to participation in the BFHI as a best practice standard, plus there is a focus on quality and monitoring; the implementation plan for this strategy is due to be published in July 2016.

A new national health and wellbeing programme to support parents of infants and young children (Nurture) is being developed with funding from a charitable trust, though administered by the HSE, which will focus on building relationships and this mentions supporting breastfeeding. Practices of the BFHI would fit easily with this programme.

A new national breastfeeding strategy is being discussed by the HSE, though as yet the BFHI National Committee is not involved in its planning. The BFHI committee hopes to be a part of this HSE breastfeeding strategy as it was a key contributor in the previous two Department of Health national breastfeeding strategies.

Maintaining links with the BFHI in other countries and with WHO and UNICEF helps the BFHI in Ireland to feel a part of something global, though with insufficient funding to attend meetings maintaining the links becomes harder.

Challenges for the BFHI in Ireland implementation and sustainability

Challenges for the running of the Initiative

Mainstreaming the BFHI or remaining as an Initiative. Situating the BFHI into the future has raised the discussion should we be aiming towards baby friendly practices incorporated into routine health worker training, standards of practice, policy and audit and that the BFHI fades out as an independent initiative, or sustaining and expanding the BFHI as a standard setting, external monitoring and assessment quality programme?

Positioning and Funding. The BFHI was not involved in the development and implementation plans of the forthcoming HSE national breastfeeding and maternal and infant strategies and it is not apparent where (or if) the BFHI fits in future HSE plans. Funding is provided as short term grant aid (one year or less) with no commitment for the following year which makes it difficult to plan a strategy.

People. The BFHI in Ireland has been built and sustained by a small group of people of whom all are volunteers except the part-time contracted coordinator. Keeping up the motivation of the volunteer committee to find time in their lives to give to working with the BFHI is a challenge, as is the upcoming need to find a new coordinator who will be able and willing to provide their own office, and a wide range of skills as needed with no job security and no employee benefits.

Marketing the BFHI accurately. Though efforts have been made to position the BFHI as a quality initiative that enables informed decisions to be made and carried out and as relevant to all babies and their mothers, a perception is still there among some health workers that the aim of the BFHI is to force all mothers to breastfeed and to prevent artificial formula being available in maternity units. Social media is widely used by Irish mothers but the BFHI current funding level does not allow the BFHI to have a modern media presence, to issue media statements, to respond to negative or inaccurate comments about the BFHI, provide information to health worker training or to have a BFHI display at events.

Hospital interest and time. Many programmes, initiatives and changes keep coming to hospital managers and front-line staff who are already overstressed by lack of funding, lack of staff and increased regulation, reports and meetings. Particularly when managers do not have a midwifery background, the BFHI can seem like just one more pressure. A new programme often comes with some short-term funding so attracts more interest that established programmes such as the BFHI.

Challenges for the hospitals in implementing and sustaining BFHI practices and designation

Low staffing levels in maternity services mean there may be no-one to assist a mother and baby in learning skills of breastfeeding or overcoming any difficulties and a bottle of breastmilk substitute is seen as a quick solution. The staff may have knowledge and willingness but not time/facilities to carry out best practice. Low staffing also makes it difficult to release staff for training and to allocate a staff member to coordinate activities to implement and sustain baby friendly practices.

Marketing of breast milk substitutes, though no longer present in maternity units, is very widespread on TV, magazines, websites and other media, as well as to some community health personnel. This marketing fuels attitudes of parents, families and health workers that breastfeeding is for young babies, hard work and "when you move on" that substitutes are very nearly as good as mother's milk. Jobs are put before health with government subsidies and financial incentives to the breastmilk substitute industry because it provides jobs, and hesitancy about effectively monitoring and enforcing existing legislation about marketing of breastmilk substitutes or extending legislation to include all aspects of the International Code.

Lack of clarity between support and promotion of breastfeeding means funds and energy are spent on leaflets and posters telling pregnant women or new mothers that breastfeed is good and developing more means of data collection of breastfeeding rates as the easy and measurable option rather than spending on skilled support being easily available and an enabling environment provided so that women actually can breastfeed.

Inconsistent systems between hospital and community health services. A Baby Friendly hospital may have excellent practices but if there is no support available after hospital discharge or there is conflicting information this can undermine the good practices in the hospital.

The language used in health materials often refers to breastfeeding as a choice and a benefit with additional advantages – above the perceived norm of artificial feeding. Risks of not breastfeeding are rarely mentioned. About a decade ago there was effort put into using breastfeeding normal language but this dropped away when key people retired. Language used may suggest that breastfeeding is an illness condition needing treatment or particularly difficult, needing classes, books and additional time from health workers.

Not recognising the longer term importance of children. Our children are our nation's future and their health and wellbeing decides that future. Ireland has no inclusive infant and young child feeding strategy or coordination body for infants and young children nutrition (only health service actions related to breastfeeding of young infants is referred to).

Lessons learned and best practices for BFHI implementation and sustainability of the Ten Steps.
Standards need to be maintained to protect babies and mothers, value the hospitals that are keeping to standards and support the importance of the designation. Ensure there is an agreed and written policy and process for hospitals not achieving or not maintaining the standards before an individual hospital needs to be discussed as below standard.

Monitoring and Reassessment need to be planned before the first assessments start as the time for reassessment comes very quickly. Ideal timing needs to be balanced with feasibility as regards cost, availability of assessors, and health facility time for completing documentation.

Remind of the relevance of the BFHI to those directing and funding maternal and infant services of the holistic aspects of care including assisting the mother to be confident, skilled and comfortable with nurturing her baby, as well as the quality improvement aspects of the BFHI, and to focus broader than the provision of clinical practices only.

Ensure reliable funding. The BFHI is a complete on-going package of raising awareness and implementing best practice, preparation for assessment, assessment, and monitoring and then reassessment. It needs coordination, trained assessors, contact with hospitals and other organisations. To keep the BFHI functioning effectively it needs to know funding will be sustained so that hospitals are supported, and that the national coordinator and committee do not use large amounts of time seeking funds each year.

Position the BFHI broadly and be flexible to fit with other programmes and issues gaining attention so as to show the BFHI as relevant and up-to-date across a range of programmes.

Develop national documents and tools. The achievement with perhaps the most lasting effect was the development by the BFHI of a National Infant Feeding Policy that was adopted by the HSE and applies to all maternity and neonatal units and situated BFHI practices as the norm. The BFHI Coordinator developed audit tools for the BFHI practices which also serve as audit tools for most of the policy.

Highlight to the people involved and their managers how participation in BFHI activity planning and evaluation, governance, committees and assessment team is continuing professional and personal development with transferable skills and therefore a valuable use of their time.

Further information, resource and tools can be found on www.babyfriendly.ie or by email to contact@babyfriendly.ie