“The Baby-Friendly Hospital Initiative – a nightmare” was the headline on the front page of the largest newspaper in Norway in August 1993. A mother complained that she was exhausted after having experienced 24-hour rooming-in. The social acceptability of the Baby-Friendly Hospital Initiative (BFHI), launched in spring 1993, was at risk.

This paper describes the challenges, failures, strategies, and successes in implementing the BFHI in Norway.

A small notice about the World Health Organization/United Nations Children’s Fund (WHO/UNICEF) BFHI in the Norwegian Medical Journal in autumn 1992 triggered it all. The Norwegian Breastfeeding Council (the Council), a voluntary group of health professionals, immediately realized that BFHI was the tool we had been waiting for. The Council applied for funding from the Directorate of Health, letting them know that Sweden had already launched the initiative, and Norway should not lag behind. Use of basic human emotions, such as competitiveness, is always useful in lobbying.

Dialogue between the breastfeeding community and health authorities is crucial. As early as 1993, a white paper on public health included a recommendation for hospitals to become Baby-Friendly.

An obstetrician and a nutritionist worked as project coordinators from the beginning. Later, the project was strengthened with a neonatal intensive care (NICU) nurse and a public health nurse. Funded by the Directorate of Health, these members of the Project group were situated 2000 km apart, each working part-time from their private homes, using telephone and fax to communicate. The European Action Plan for the BFHI recommended that a national breastfeeding committee should be established; this committee was created in Norway and included the project group; a steering committee with 3 members from the Directorate of Health; an advisory group with 9 members from health professional associations; a nongovernmental mother-to-mother support group, “Ammehjelpen”; and a representative from the National Committee for UNICEF. In agreement with the national breastfeeding committee, the project group was responsible for drawing up and implementing the national BFHI action plan. Norway was organized into 5 health regions at that time, and the project group selected 16 assessors to represent all health regions.

The BFHI project was important in creating an understanding of the need for the Norwegian Resource Centre for Breastfeeding, which was established in 1999. All members of the project group continued to work in the Resource Centre.

Success with Side-Effects

When the Queen declined to attend the launch of the BFHI, we went step-wise down the hierarchy and ended up with a bureaucrat. As part of that process, we did receive many encouraging messages and photos of powerful ladies with their babies, we used these messages for all they were worth.

The launch of the BFHI, which took place at the National Hospital in March 1993, was a great success, attended by representatives from the Ministry of Health, WHO, and UNICEF, as well as charismatic lecturers. About 300 health professionals from all over the country reacted with enthusiasm, followed by positive media coverage, and some went straight back home intending to implement the Ten Steps. We quickly learned our first lesson, that implementing the BFHI in a rigorous and hasty way may be counterproductive. In the early stages, some birthing units implemented the new...
routines without sufficient preparations, resulting in conflicts among the staff and dissatisfied mothers.

**Mother-Friendly Adaptations**

Listening and learning was vital for successful implementation of the BFHI, and although compromising the standard was avoided, the project group decided some amendments were necessary. The reactions to obligatory 24-hour rooming-in from some mothers taught us that this requirement should instead be voluntary. Mothers should be informed about the benefits of this practice, the staff should offer to look after the baby if the mother needed to rest some hours in peace and quiet, and the maternity wards should introduce “siesta hours” with no activities or visitors. Two other steps were also perceived as “mother-unfriendly,” namely, avoidance of pacifiers and supplementation. Some mothers felt that they were deprived of remedies to calm the child and that they lost their opportunity for undisturbed sleep. Soon we realized that it was necessary to introduce a guiding principle: *Care for mother, enabling her to care for the baby.* This guiding principle was of profound importance for the successful implementation of the BFHI, and luckily it was already in place when we responded to the newspaper headlines accusing BFHI of being a nightmare for mothers.

At the time when BFHI was introduced, research was emerging on the importance of extended skin-to-skin contact, allowing time for the newborn to search for the breast. Therefore, Norway changed Step 4 to accommodate this new knowledge: *Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour: Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.*

Regarding Step 9 about avoidance of pacifiers, the evidence was not considered strong enough to recommend avoidance beyond the postnatal period. We therefore adapted this step, recommending that pacifiers should be avoided at least until breastfeeding was well established, defined as the time when mothers were producing enough milk and the baby had a good latch, normally within 2-4 weeks.

One mistake we believe we made was to allow a certain flexibility regarding Step 6 and the use of supplements to babies who went on crying even after frequent breastfeeds. It was registered as an acceptable “social” medical reason for use of breast milk substitutes.

**From Russia with Love—and Procedures**

In August 1993, WHO/UNICEF organized a course for European countries on the BFHI assessment tool in St. Petersburg. The assessment procedure seemed overwhelming. Generally, supervision of health care systems is a matter of controlling whether hospitals have systems to ensure that practices are according to laws and regulations. The BFHI assessment went far beyond this procedure, for example, by placing emphasis on mothers’ experiences. Still, the assessment team embarked on the task. People engaged in breastfeeding promotion and support seem to be of a special kind; they are willing to work on a modest salary and partly on a voluntary basis.

As in many other Western countries, breastfeeding rates in Norway increased during the 1970s and then leveled off in the 1980s. From a nadir in 1967, when only 13% breastfed for 6 months, the rate increased to about 55% around 1980. This plateau was, by many, perceived as the maximum achievable breastfeeding rate in a Western country.

The aim of the Norwegian BFHI was to increase breastfeeding rates and interaction between mother and child. Focus was on helping mothers to breastfeed with “less blood, sweat, toil, and tears.”

**Hard to Become a Prophet in Your Own Hospital**

To convey new knowledge to experienced staff and change established routines was a challenge throughout Norway. Generally, it is easier to be an expert from the outside than to lead a reform in your own hospital. A main task for the project group was to legitimize the BFHI standard and to support the staff. The implementation of the BFHI demanded courage, diplomatic skills, and staying power. The self-assessment tool was useful in pinpointing needs for improvements. But how to make these improvements happen? Staff in some hospitals felt they were losing their professional identity and control. We heard comments like, “What I have been doing for years has all of a sudden become unacceptable practice.” Our strategy was ongoing reassurance: “Any routine formerly used was well-intended, based on the available knowledge at that time.”

**A Special Challenge: The Crying Baby**

Data collected in Norwegian hospitals since 1860 show a breastfeeding initiation rate around 98%-99%. Still, the hospital’s BFHI self-appraisal tool often documented reasons for supplementation that were not medically acceptable, according to the global criteria. The most common reason for giving supplements was “crying.” We questioned why normal newborn behavior was perceived as a problem and dealt with in this way. Many hospitals had to change their practice and make sure that the staff had a clear understanding of the acceptable medical reasons for giving supplements. Still, Step 6 is the most challenging for our hospitals and may also be the most sensitive indicator of a Baby-Friendly standard.

**Assessment**

No external assessment was performed until the health facility had a written breastfeeding policy that addressed all Ten Steps and protected breastfeeding.
If, after assessment, 1 or more steps proved unsatisfactory, hospitals were given a set time period to improve the implementation before another assessment of these steps. Our aim was to support, encourage, and keep hospitals on track, not to alienate them.

**Expansion to the Neonatal Intensive Care Unit**

In 2004, the BFHI in Norway was broadened to include the neonatal intensive care unit (NICU). Guidelines for a Baby-Friendly NICU were developed, based on the original Ten Steps from WHO/UNICEF, also including an adapted assessment tool. By 2012, 19 out of 21 NICUs were designated Baby-Friendly neonatal units. Norway is now active in a group from the Nordic countries and Quebec working on an international draft document on the expansion of the BFHI to neonatal units.

**Expansion to Baby-Friendly Community Health Services**

As postpartum lengths of stay have become shorter in recent years, the responsibility of the community health services for lactation counseling has increased. In 2005, the BFHI was adapted to maternal and child health centers in the Community Health Services. Based on the Ten Steps to Successful Breastfeeding, 6 Guidelines for Breastfeeding Counseling in the Norwegian Community Health Services were developed (Figure 1). The process starts with a survey of breastfeeding rates and a self-assessment by the maternal and child health center. As in the BFHI, the centers must develop a breastfeeding policy and offer in-service training. The Norwegian Resource Centre for Breastfeeding is responsible for the external assessment, which consists of 2 elements: evaluation of the policy and an assessment based on a postal questionnaire to mothers. By February 2012, 22 municipalities out of 430 had been designated as Baby-Friendly, and more than 100 municipalities are in the process. An ongoing cluster-randomized controlled trial will assess the effect of the Baby-Friendly Community Health Services.

From the beginning, the BFHI has sought cooperation with the media. Any institution being designated has been advised to organize celebrations, covered by the local media, and if possible having a celebrity deliver the plaque honoring staff, hospitals, and the cause. According to staff, BFHI has raised their status and made the work more satisfying.

**Outcomes**

In 1996, after a 4-year project period, 35 of approximately 60 birthing units were designated as Baby-Friendly. As most of the larger hospitals were designated, approximately 75% of all babies were born in designated units. By 2012, 43 of 53 birthing units have been designated, accounting for >90% of all newborns. An evaluation study on the effect of BFHI from Tromsø, a midsized city in northern Norway, found that rates of exclusive breastfeeding and the overall duration of breastfeeding increased between 1992 to 1997, probably as a result of BFHI (Figure 2).

National data on breastfeeding rates document a significant increase in breastfeeding duration in the wake of the implementation of the BFHI. The most recent national survey from 2006-2007 documented that 80% of infants are breastfed for 6 months and 46% for at least 12 months.

In 2009, the Norwegian Resource Centre for Breastfeeding did a survey in which all maternity wards were asked to answer a questionnaire and register use of supplementation to healthy, term newborns. Exclusive breastfeeding was defined according to the WHO definition. The results showed that 70% of healthy, term breastfed newborns were supplemented, most of them born in a designated Baby-Friendly hospitals (Norwegian Resource Centre for Breastfeeding, unpublished data). Instead of supplements being an exception for calming crying babies, it seems to have become the usual solution. A tendency of designated health facilities to backslide somewhat, and even to revert to old patterns of maternity care, has been noted. Reasons for deterioration vary, and our next step is therefore to look even more closely at the breastfeeding routines in the first 48 hours after birth, with more focus on skin-to-skin contact, not only rooming-in, and on normal newborn behavior. A crying breastfed baby is most certainly not crying for breast milk substitutes.
Next Step: www.re-assessment

A new electronic method for reassessment of compliance with the BFHI Ten Steps will be piloted in 2012. Data will be collected by inviting mothers in the maternity unit to answer an electronic questionnaire. A second element in the assessment is the Infant Feeding Record and Report to assess the use of supplements. Reports will be requested on an annual basis by the Norwegian Resource Centre for Breastfeeding.

Keeping the Chain of Breastfeeding Warm

“A Warm Chain for Breastfeeding” was the title of a famous editorial in the Lancet in 1994, stressing the importance of supportive care and counseling.6 We would like to honor the pioneers who created the BFHI and the WHO/UNICEF for giving us such an effective tool. After more than 20 years, the time has come for extending the warm chain for breastfeeding beyond birthing units to neonatal units and to the community.

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Figure 2. Breastfeeding before and after BFHI.