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A Unit of the Institute for Health, Health Care Policy and Aging Research

Assessing the *ShapingNJ* Partnership Strategies:

A Pilot Project for Using the Centers for Disease Control and Prevention's Common Community Measures for Obesity Prevention

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Report to the Office of Nutrition and Fitness, New Jersey Department of Health and Senior Services

January 2011

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Executive Summary

Given the sharp increase in rates of overweight and obesity among children (Ogden et al., 2010), expert groups have called for public health approaches for curtailing this epidemic (IOM, 2005; CDC, 2009). While behavior change occurs at the individual level for diet and physical activity, environment and policy-related factors play an important role in preventing obesity by increasing the likelihood that individuals will adopt healthy eating and active living practices (Hill, 1998; Sallis & Glanz, 2009).

The Common Community Measures for Obesity Prevention project of the Centers for Disease Control and Prevention (CDC) recommends a set of 24 community-based obesity-prevention strategies that focus on environment and policy changes along with corresponding measures to assess their impact (Khan et al., 2009). In 2008, under the Nutrition, Physical Activity, and Obesity Program, the CDC awarded the New Jersey Department of Health and Senior Services' (NJDHSS) Office of Nutrition and Fitness (ONF) funding to develop an obesity-prevention plan for the state. ONF created the ***ShapingNJ*** partnership, a coalition of public and private agencies charged with developing and implementing a strategic plan for addressing obesity through environment and policy change approaches in New Jersey.

This report presents findings from a project that piloted the CDC's common measures to assess the current status of selected ***ShapingNJ*** strategies that overlap with the CDC recommendations. The three strategies addressed in this report are: increase support for breastfeeding; improve food and physical activity environment in child care centers; and increase availability of healthier food and beverage choices in schools.

To increase exclusivity of breastfeeding the ***ShapingNJ*** partnership aims to improve practices in maternity hospitals and facilities, including adoption of World Health Organization's 10 steps for successful breastfeeding, as part of the baby-friendly hospital initiative. For this pilot assessment, the research team selected five hospitals that were deemed early adopters of these policies, and that represented rural and urban communities in different parts of New Jersey.

The assessment shows that all the hospitals are working towards adopting these steps, but there is a wide range in the number of steps that are being implemented. All hospitals scored low on two of the steps that are particularly important in their effect on exclusivity of breastfeeding. These were: give newborn infants no food or drink other than breast milk, unless medically indicated; and give no artificial teats or pacifiers to breastfeeding infants. In the light of this assessment, the ***ShapingNJ*** partnership may wish to pay special attention to these two steps, as they have been more challenging for the hospitals to meet.

Recognizing that the worksite policies can play an important role in duration as well as exclusivity of breastfeeding among working mothers, the ***ShapingNJ*** partnership plans to increase the number of businesses that provide breastfeeding accommodations. Also, the recently passed Patient Protection and Affordable Care Act (P.L. 111-148) requires that employers provide for such accommodations. The research team surveyed six major employers in Newark, N.J., representing different sectors of the economy (public, private, and education). The results show that none of them had any formal policies in place that addressed breastfeeding accommodations. As the ***ShapingNJ*** partnership works to meet its goals regarding breastfeeding, it can provide technical assistance and guidance to help employers meet the federal mandate to establish policies that provide breastfeeding accommodations to working mothers.

Childcare centers are venues that can help instill healthy eating and active living behaviors among children who attend these facilities. The ***ShapingNJ*** partnership aims to encourage childcare and after-school programs to provide healthy food and drink, allow ample time for both structured and free play, and avoid using TV as an activity.

An assessment of licensed childcare centers' food and physical activity policies reveals that most centers follow state guidelines when available and only in the absence of such guidance create informal internal policies and practices. In assessing the childcare centers in New Brunswick, N.J., the research team found that in order to be consistent with the current Dietary Guidelines for Americans, the existing state-level licensing requirements for foods and beverages served in childcare centers need to be strengthened. Also, screen time limits should conform with the CDC and the American Academy of Pediatrics recommendations. With technical assistance and guidance, childcare center food and physical activity environments can be made more conducive to healthier behaviors.

The ***ShapingNJ*** partnership aims to ensure that students will eat more nutrient-rich foods and beverages and consume fewer energy-dense foods in school settings. An assessment of healthy eating and physical activity policies in five diverse, high-need communities of New Jersey reveals that school district policies fall short of the CDC recommendations. As in the case of childcare centers, schools follow the nutrition and physical activity guidelines established by the state. However, the state guidelines have not been updated to match the current Dietary Guidelines for Americans. Improvements in school environments can be made by updating the

guidance at the state level and by providing technical assistance to schools for implementing these guidelines.

As the ***ShapingNJ*** strategies take hold, it will be helpful to track these changes by monitoring the progress in communities across New Jersey. For several policy-based initiatives, where changes are made at the state level — as in the case of childcare centers and schools — documenting change through policy analysis should be supplemented with on-the-ground assessment of awareness and implementation changes at the community level. For others, such as those for breastfeeding promotion, individual hospital and employer policies and practices need to be tracked. Institutionalizing data collection efforts for these policies by using CDC's common measures will ensure that changes can be monitored on a regular basis.

Assessing the *ShapingNJ* Partnership Strategies:

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Chapter 1

Introduction

Background

The prevalence of overweight and obesity in the United States has increased sharply in the past four decades and in 2008 one third of all children and adolescents were overweight or obese (Ogden et al., 2010). Overweight and obesity rates are even higher among minority populations. Hispanic boys are significantly more likely to be overweight and obese compared to non-Hispanic White and non-Hispanic Black boys. Non-Hispanic Black girls are significantly more likely to be heavier than non-Hispanic White and Hispanic girls. Adolescents (aged 12–19 years) are more likely to be overweight and obese compared with preschool children (aged 2–5 years) (Ogden et al., 2010).

Higher rates of obesity among children is associated with serious co-morbidities including type 2 diabetes mellitus, hyperlipidemia, and hypertension, earlier puberty and menarche in girls, and increased incidence of metabolic syndrome in youth and adults (Freedman et al., 2007; Biro & Wien, 2010). Obesity in children also can lead to social discrimination, poor self-esteem, and depression (AACAP, 2008). In addition, heavier children have greater risk for school absenteeism than their normal-weight peers and this affects their academic performance (Geier et al., 2007; Story, Kaphingst & French, 2006). Childhood obesity is an important predictor of adult obesity regardless of whether or not the parents are obese (Whitaker et al., 1997; Serdula et al., 1993).

Overweight and obesity in children and adolescents generally is caused by lack of physical activity, unhealthy eating patterns, or a combination of the two, with genetics and lifestyle both playing important roles in determining a child's weight (DHHS, 2010). Recommendations from expert groups call for public health approaches to curtail this epidemic by reaching large

numbers of children in multiple settings — in communities, schools, and health care facilities and through parents' work sites (IOM, 2005; CDC, 2009). While diet and physical activity behaviors at the individual level are key drivers for influencing weight status, environment and policy-related factors play an equally important role in obesity prevention by improving the likelihood of healthy eating and active living (Hill 1998; Sallis and Glanz, 2009). Environment and policy change initiatives that make healthy food and physical activity choices readily available and affordable are needed to combat obesity (CDC, 2009).

By reducing the prevalence of overweight and obesity, we will not only help raise a new generation of children who are not at risk of associated co-morbidities but also will help reduce escalating obesity-related health care costs. The direct medical costs associated with childhood obesity is estimated to be $3 billion per year (Trasande & Chatterjee, 2009). With the White House now leading efforts at various levels to reverse the epidemic of childhood obesity in a generation (Presidential Memorandum, 2010) and to find and implement cost-containment strategies in light of recent health reform, the momentum to achieve these goals has never been greater.

A variety of efforts to improve policies and environments related to healthy eating and active living are currently underway, however, the absence of common measures to assess the impact of these changes has slowed progress in the field. Using the experience of pioneering communities that have worked in the area and with input from a group of experts, the Centers for Disease Control and Prevention (CDC) initiated the Common Community Measures for Obesity Prevention project. The aim of the project was to identify and recommend a set of environment and policy change based obesity-prevention strategies and corresponding measures to assess their impact (Khan et al., 2009).

The common measures project recommended 24 strategies that could be adopted at the community level for preventing obesity (see page 7). These strategies focus on six themes:

- Strategies to promote availability of affordable healthy food and beverages.
- Strategies to support healthy food and beverage choices.
- Strategies to encourage breastfeeding.
- Strategies to encourage physical activity or limit sedentary activity among children and youth.
- Strategies to create safe communities that support physical activity.
- Strategies to encourage communities to organize for change.

These broad themes are supported by sets of specific strategies that are more narrowly focused.

In 2008, the CDC awarded the New Jersey Department of Health and Senior Services' (NJ DHSS) Office of Nutrition and Fitness (ONF) funding to build a state-wide partnership and to develop, implement, and evaluate a state-wide plan to prevent and control obesity and other related chronic diseases in the state of New Jersey. This funding, provided under the Nutrition,

Physical Activity, and Obesity (NPAO) Program, focuses on using environment and policy changes approach to promote healthful eating and physical activity.

ONF created the ***ShapingNJ*** partnership with the primary goal to prevent obesity and improve the health of populations at risk for poor health outcomes through environment and policy changes that "make the healthy choice the easy choice." The ***ShapingNJ*** partnership plans to meet these goals by working with strategic public/private partners at the state and local levels. The CDC recommended six targeted behaviors for the NPAO funded states to focus on. These included:

- Increase breastfeeding initiation, duration, and exclusivity.
- Increase physical activity.
- Increase consumption of fruit and vegetables.
- Decrease television and screen viewing.
- Decrease consumption of sugar-sweetened beverages.
- Decrease consumption of energy-dense foods.

Over the past year, ***ShapingNJ*** has developed a strong coalition of some 100-partner organization and through an extensive engagement process created a strategic 10-year plan for addressing the six-targeted behaviors (see Appendix A.1).

This report presents findings from a project that piloted the CDC's common measures to assess the current status of three specific ***ShapingNJ*** strategies that overlap with the CDC recommendations. The CSHP research team, in partnership with the ONF, selected the following three strategies to be assessed:

- Increase support for breastfeeding (CDC Strategy 11).
- Improve the food and physical activity environment in childcare centers (CDC Strategies 1, 7, 10, 15).
- Increase availability of healthier food and beverage choices in public service venues, specifically in schools (CDC Strategy 1).

The research team chose the locations for the assessments based on input from the ONF and ***ShapingNJ*** partners and included communities where partners were currently working or planning to start obesity-prevention initiatives.

This report presents the results of the assessments, which used phone surveys, written surveys, self-assessments, and document reviews.

Common Community Measures for Obesity Prevention
Recommended by the Centers for Disease Control and Prevention

Communities should do the following:

1) Increase availability of healthier food and beverage choices in public service venues.
2) Improve availability of affordable healthier food and beverage choices in public service venues.
3) Improve geographic availability of supermarkets in underserved areas.
4) Provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas.
5) Improve availability of mechanisms for purchasing foods from farms.
6) Provide incentives for the production, distribution, and procurement of foods from local farms.
7) Restrict availability of less healthy foods and beverages in public service venues.
8) Institute smaller portion size options in public service venues.
9) Limit advertisements of less healthy foods and beverages.
10) Discourage consumption of sugar-sweetened beverages.
11) Increase support for breastfeeding.
12) Require physical education in schools.
13) Increase the amount of physical activity in physical education programs in schools.
14) Increase opportunities for extracurricular physical activity.
15) Reduce screen time in public service venues.
16) Improve access to outdoor recreational facilities.
17) Enhance infrastructure supporting bicycling.
18) Enhance infrastructure supporting walking.
19) Support locating schools within easy walking distance of residential areas.
20) Improve access to public transportation.
21) Zone for mixed-use development.
22) Enhance personal safety in areas where persons are or could be physically active.
23) Enhance traffic safety in areas where persons are or could be physically active.
24) Participate in community coalitions or partnerships to address obesity.

Chapter 2

Supporting Breastfeeding in New Jersey Hospitals and Worksites

Background

Breastfeeding plays a significant role in supporting health in both the breastfed child and the nursing mother. Evidence supports that breastfeeding can reduce the risk of pediatric obesity (Arenz et al., 2004). Higher rates of breastfeeding initiation, exclusivity, and duration have all been shown to decrease the risk of overweight among infants (CDC, 2007; Harder et al., 2005; Taveras et al., 2006).

Healthy People 2010 breastfeeding goals state that 75% of mothers should initiate breastfeeding, 50% should breastfeed at 6 months of age, 25% continue to breastfeed at 1 year of life, 40% exclusively breastfeed at 3 months, and 17% exclusively breastfeed at 6 months (DHSS, 2000). While the overall breastfeeding initiation and duration rates in New Jersey have reached the Healthy People 2010 targets, exclusive breastfeeding rates fall short of the recommendations and have continued to decline over time, with 35% of mothers exclusively breastfeeding at discharge from hospital in 2007 compared to 44% in 1997 (CDC). Despite high overall initiation rates in New Jersey, large disparities remain among women from different education and race/ethnic backgrounds. Compared to the state average of 75% initiation and 33% exclusive breastfeeding rates, non-Hispanic White and non-Hispanic Black women with no college education have lower initiation rates and lower exclusive breastfeeding rates. While initiation rates are above average for Hispanic women, persistence of exclusive breastfeeding rates are lowest, among this group, especially among foreign-born mothers with a college education (Feldman-Winter et al., 2009).

Hospital practices play an influential role in breastfeeding duration and exclusivity throughout the first year of an infant's life (DiGirolamo et al., 2001; Bartick et al., 2009). When supplemental feedings are received in the hospital, the persistence of any breastfeeding is lower at eight weeks post-partum (Feldman-Winter et al., 2009; Denk et al., 2008).

The Baby-Friendly Hospital Initiative (BFHI), a program launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), encourages hospitals to follow 10 evidence-based steps to improve breastfeeding outcomes (see Appendix B.1). Hospitals that have implemented the initiative have been shown to be effective in improving breastfeeding initiation, duration, and exclusivity (BFHI, USA; Philipp et al., 2001; Bartick et al., 2009). The more steps that a hospital follows, the higher the duration and exclusivity of breastfeeding (DiGirolamo et al., 2008). As of June 2010, 93 U.S. hospitals and birthing centers were designated as baby-friendly. None of these facilities are in New Jersey (BFHI).

For women who work outside of the home, the environment in the workplace influences both the initiation and duration of breastfeeding. Women who work during pregnancy and those who plan to work after the birth of their child have lower breastfeeding initiation rates (Feldman-Winter et al., 2009; Kimbro, 2006). Returning to work is cited as one of the main reasons by women who do not initiate breastfeeding (Feldman-Winter et al., 2009). Women who work full-time are less likely to be breastfeeding at 6 months than women who work part-time or are not employed (Ryan et al., 2006). Interventions aimed at supporting breastfeeding in the workplace demonstrate increased initiation rates as well as increased duration of breastfeeding (Shealy et al., 2005).

Women face several barriers to combining breastfeeding and working. To facilitate breastfeeding, women need to express breast milk or they need access to their child. Working women report that co-workers can present barriers to successful breastfeeding, criticizing breastfeeding mothers or pressuring them not to take a break to express milk. However, co-workers may also serve as role models and provide encouragement (Johnston & Esposito, 2007). Most employers do not have formal breastfeeding support policies; some however, accommodate breastfeeding employees as needed (Johnston & Esposito, 2007). Large employers are more likely to provide breastfeeding support than employers with fewer than 500 employees (Dunn et al., 2004). The CDC's recommended community strategies and measurements to prevent obesity in the United States include specific strategies for supporting breastfeeding in the workplace (Khan et al., 2009).

ShapingNJ has identified increasing exclusive breastfeeding for the first 6 months among New Jersey mothers as one of the goals for preventing obesity in New Jersey. The proposed strategy states that "***ShapingNJ*** partners will work to increase the number of businesses that accommodate breastfeeding women in the workplace using the Business Case for Breastfeeding as a resource." The Business Case for Breastfeeding is a comprehensive program designed to educate employers about the value of supporting breastfeeding.

Purpose and Objectives

This pilot project assesses the current status of the ***ShapingNJ*** strategy targeted at increasing worksite breastfeeding support provided by employers in one New Jersey city. This strategy overlaps with the CDC Strategy 11: Increase Support for Breastfeeding, which focuses on breastfeeding accommodations for employees. In addition, this report also assesses the status of the Baby-Friendly Hospital Initiative in selected hospitals in New Jersey.

Methods

Worksite Policies and Practices

In order to assess the worksite policies for breastfeeding accommodations, six major employers located in Newark, N.J., were selected, representing a range of businesses including private, public, and educational institutions. Given that large employers are more likely to have breastfeeding policies in place, the pilot was limited to six of the largest employers in Newark. CSHP research staff designed a survey to elicit information about policies related to workplace breastfeeding support (see Appendix B.2). It consisted of a 10-minute phone interview with a human resources representative from the selected employers and included questions about workplace breastfeeding accommodations such as the formal and informal policies related to providing time and space for breastfeeding mothers. The assessment also used the CDC's recommended measures of breastfeeding accommodations for employees regarding time and space for breastfeeding during working hours (Khan et al., 2009).

Baby-Friendly Hospitals

Five hospitals were identified for the pilot by the ***ShapingNJ*** breastfeeding workgroup. Self-assessment tools developed by Baby-Friendly USA and Baby-Friendly WHO/UNICEF were used for the assessments (see Appendices B.3 and B.4). The hospitals were contacted by phone and email to introduce the study and then were asked to complete the self-appraisal tool that was sent by email. All the participating hospitals were initially emailed the WHO/UNICEF self-assessment tool. However, two of the five hospitals had recently completed the Baby Friendly USA version. In order to keep the response burden to a minimum, these analyses used data from the USA version for those two hospitals and from the WHO/UNICEF version for the remaining three hospitals. The two forms were compared for each of the steps of the Baby-Friendly Hospital Initiative (BFHI). The U.S. version is shorter than the international version and does not include information on mother-friendly care, and HIV and infant feeding.

A human subject's protocol for the study was reviewed and approved by the institutional review board of Rutgers University New Brunswick/Piscataway campuses.

Results

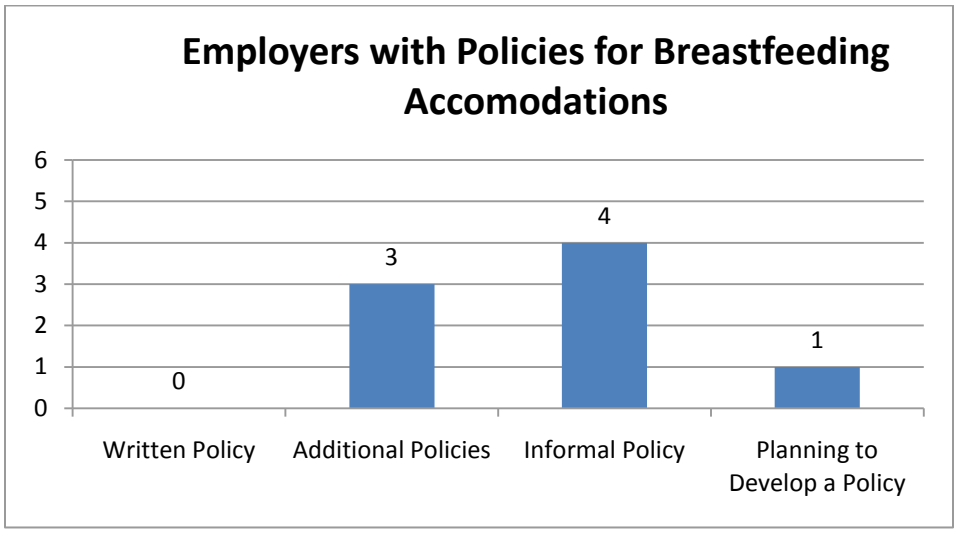
Results from the worksite survey and baby-friendly self-assessment are presented below.

Worksite Policies and Practices

Six large employers in Newark, N.J., were surveyed about organizational policies in place to support breastfeeding accommodations at their worksite. Figure 2.1 summarizes the results of the survey. The CDC measure associated with the strategies to encourage breastfeeding states

"Local government has a policy requiring local government facilities to provide breastfeeding accommodations for employees that include both time and designated space for breastfeeding and expressing breast milk during working hours." This measure was adapted to apply to all types of employers (public, private, and education) included in the study. None of the employers surveyed had a written policy in place to support these breastfeeding accommodations. Three employers indicated that breastfeeding accommodations were covered by additional organizational policies such as those related to medically documented requests and those that allow for flexible work arrangements.

Figure 2.1 Worksite Policies for Breastfeeding Accommodations



Four employers reported having informal policies to support breastfeeding accommodations. The range of supports in these policies varied. All organizations reported that requests for time to pump were usually handled at the supervisor or department level. Respondents reported that they thought it was reasonable for management to ask employees to make up time that was taken to breastfeed a child on site or to pump breast milk. Two of the organizations surveyed had a designated lactation room. This room was described as a private room with a locking door that was not a bathroom and did not always include a sink. Organizations that lacked a designated area for pumping reported that a room would be made available if there was a request. One organization had a hospital-grade pump in the lactation room and another provided a subsidy towards the purchase of a specified electric breast pump. Two employers provided educational resources about breastfeeding such as DVDs, printed materials, presentations at new employee orientations, outreach to pregnant staff, and education through onsite women's groups.

When asked if the organization was planning to develop a policy to provide breastfeeding accommodations for employees, one respondent indicated that there has never been a request for such accommodations. Another said "We would probably allow the employee's department to make accommodations if it did not interfere with the employee's ability to do the job or did not disrupt the department's operations." One employer responded that the company was considering a policy in response to the federal requirement for lactation support. Other points raised by respondents included issues related to collective bargaining, employees working in environments other than an office, need for approval from senior management/board, and the need for technical assistance in developing a worksite breastfeeding accommodation policy.

Baby-Friendly Hospitals

Figures 2.2a and 2.2b summarize the results from the self-appraisal undertaken by representatives from five New Jersey hospitals, urban and rural, and geographically dispersed across the state. Since the data were collected using two different types of forms, two separate graphs have been used to present the data – one for hospitals that used the Baby Friendly USA Self Appraisal tool (Figure 2.2a), and one for those filling out the Baby Friendly WHO/UNICEF version (Figure 2.2b).

All five hospitals reported involvement in some aspects of the baby-friendly practices measured in the self-appraisal tool. Of the 10 baby-friendly steps, all hospitals responded in affirmative for all items in Step 8 — encourage breastfeeding on demand. These items include placing no restrictions on the frequency or length of breastfeeding and advising mothers to breastfeed their babies whenever their babies are hungry. Items in Step 5 — show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants — also were frequently met by hospitals, with all hospitals meeting almost all of the items.

Items in Step 6 — give newborn infants no food or drink other than breast milk, unless medically indicated — were least frequently met by the hospitals, with all except one not meeting any or almost any of the items in this step. Step 9 — give no artificial teats or pacifiers to breastfeeding infants — was the second least frequently met step, with one hospital indicating that pacifiers are used for pain management.

Figure 2.2a Implementation of Baby-Friendly Hospital Steps by New Jersey Hospitals (Using Baby Friendly USA Self Assessment Tool)

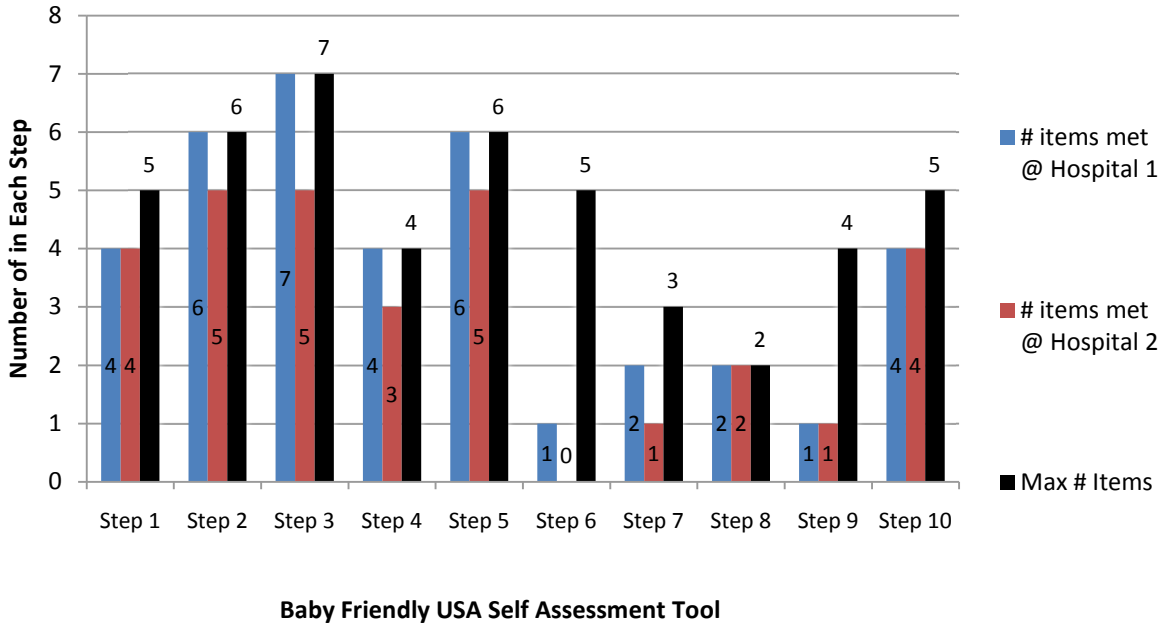
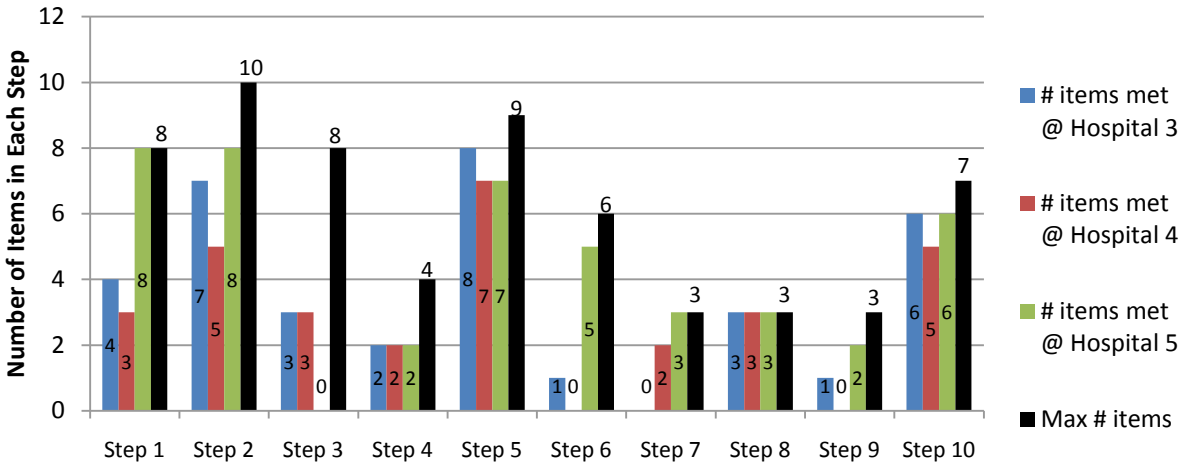


Figure 2.2b Implementation of Baby-Friendly Hospital Steps by New Jersey Hospitals (Using Baby Friendly WHO/UNICEF Self Assessment Tool)



Note: Hospital 5 did not have a prenatal clinic and a special care unit.

Discussion

In addition to numerous other benefits, breastfeeding initiation, duration, and exclusivity have been associated with reduced likelihood of overweight among infants. The policies and practices followed by hospitals and workplaces play a significant role in breastfeeding outcomes.

Research has shown that women who directly breastfeed their infants at work and/or pump breast milk at work, breastfed their infants at a higher intensity than women who do not breastfeed or pump at work (Arenz et.al., 2004). Working women need support at work in order to have time during the work day and a private place to pump or breastfeed. To consistently provide this kind of support and to make employees aware of these benefits, employers should have clear, written policies. None of the six large employers surveyed in Newark had written policies to support breastfeeding. Almost all those who responded, however, did indicate that breastfeeding accommodations would be made through an informal policy or additional workplace policy, such as making accommodations for medical disability.

Respondents stated that in the absence of set policies, decisions regarding accommodations are based on requests from employees and at the discretion of the supervisors on a case-by-case basis. Such informal arrangements may not help women working in unsupportive office environments, especially since employers do not always recognize the health benefits of breastfeeding or consider breastfeeding an employer responsibility (Johnston & Esposito, 2007). The employers surveyed also stated that while breastfeeding policies were not in place, additional organizational policies such as flexible work arrangements may be used to provide breastfeeding accommodations. However, studies show that flexibility varies by profession. Salaried employees are more likely to pump than hourly employees. Mothers with administrative or manual jobs had lower breastfeeding duration rates than professional mothers (Johnston & Esposito, 2007). This is a particular concern since the persistence of exclusive breastfeeding is lower among women with less education and among Hispanic women; both groups are less likely to hold jobs and positions that provide such informal benefits.

Participating in a corporate lactation program is shown to increase rates of breastfeeding initiation and duration. Among women who enrolled in an employer-sponsored lactation program, initiation rates were 97.5% with 57.8% breastfeeding at least 6 months (Ortiz et. al., 2004). Even in the absence of formal written policies, in the small sample of organizations interviewed for the survey, there was a wide range of support and recognition for breastfeeding accommodations. While one representative of a major employer with a large number of women employees noted that there have never been any requests for such accommodations, another employer provided a subsidy towards purchasing a high-quality electric breast pump. Another reported that a hospital grade pump was available for mothers to use in the lactation room.

In light of the new federal mandate to provide breastfeeding accommodations at the worksite, the responses from the survey for this study provide some valuable insights. Employers are considering developing such policies by engaging their board members and trying to establish the parameters of such policies in terms of what should be included in the policies, how a policy would affect issues related to collective bargaining, and how to create policies for employees who work in non-office settings. This is an opportune time for ***ShapingNJ*** to provide technical assistance to employers to help them develop policies and practices that support breastfeeding at the worksite in order to meet their goal of increasing the rate of exclusive breastfeeding for the first 6 months among New Jersey mothers.

New Jersey does not currently collect information about hospital practices related to breastfeeding (Denk et al., 2008). For this pilot, information on current hospital breastfeeding policies and practices was collected from five New Jersey hospitals. Hospital representatives completed a self-assessment tool to provide information on the status of practices implemented at their facilities. These five hospitals were chosen because of their high level of engagement with the ***ShapingNJ*** breastfeeding workgroup, and their current and future interest in implementing the baby-friendly initiative.

The results to the self-appraisal show that all five hospitals have initiated baby-friendly activities. Hospital practices varied considerably with regard to the different steps. For example, Step 6, giving newborn infants no food or drink other than breast milk unless medically indicated, was the least frequently met step. Literature shows that supplementing with formula in the hospital is associated with a decreased duration of breastfeeding (Declercq et al., 2009). New Jersey Pregnancy Risk Assessment Monitoring System (NJ-PRAMS) reported that the hospital policy that had the largest effect on exclusive breastfeeding duration was avoiding supplemental formula feeds in the hospital. A study of low-income women who initiated breastfeeding showed that the majority of in-hospital formula supplements were given to breastfed infants with no medical indication (Tender et al, 2009). As stated earlier, the hospitals in this pilot were those that had either initiated some work towards implementing BFHI or were interested in implementing it in the near future. Given that, the low rates of compliance to a step that is closely tied to exclusivity of breastfeeding is of particular concern, as one of the ***ShapingNJ*** partnership's goals' is to increase exclusivity rates of breastfeeding in New Jersey.

Limitations

There are some limitations to this worksite breastfeeding policy assessment. Only large employers were surveyed. Large employers provide more breastfeeding support than employers with fewer than 500 employees (Dunn et al., 2004). Therefore, smaller organizations may have even fewer policies in place to support breastfeeding. Future studies should examine policies for all sizes of organizations. Given that it was a pilot study, only a small number of employers were interviewed about breastfeeding accommodations, therefore, the results may not be rep-

resentative of all employer practices. The scope of the study was limited to workplace policies and did not examine on the effect of these policies on breastfeeding initiation, duration, or exclusivity.

Limitations of this pilot for assessing the status of the Baby-Friendly Hospitals Initiative include a selection bias since the results are based on an assessment of hospitals that had shown interest in implementation of the baby-friendly initiative. Also the results are based on self-assessment and the researchers did not visit the facilities or review written policies. Lastly, there was a variation in the self-appraisal tools used by the facilities completing the assessment. While the Baby-Friendly USA Self-Appraisal Tool and the Baby-Friendly International Self-Appraisal Tool were mostly similar, there were some differences that made comparisons challenging.

Conclusion and Implications

The inclusion of breastfeeding support for working women in the recently passed Patient Protection and Affordable Care Act (P.L. 111-148) provides a great impetus to the work that many grassroots agencies, state health departments, and the U.S. Department of Health and Human Services have been doing in this area. Worksite support for breastfeeding mothers will help improve exclusivity of breastfeeding among working mothers — a goal set forth by the ***ShapingNJ*** partnership.

Currently, none of the large employers surveyed had any formal policies in place to provide accommodations for breastfeeding mothers. Four of the six employers interviewed had informal policies that varied in scope. While some employers are addressing this need, others state that that there is no demand for such accommodations among their staff. In the absence of formal policies, the availability of such support often is decided on a case-by-case basis, and depends upon the relationship between an employee and her supervisor. It is possible that women, especially those not highly educated or holding secure jobs, as well as those from racial and ethnic minority populations, may not feel comfortable bringing their needs forward to their supervisors. Creating strong worksite policies will help working women continue to breastfeed their infants after they return to work. As the health care reform regulation is implemented in New Jersey, the ***ShapingNJ*** partnership can play an important role in helping businesses develop breastfeeding support policies as well as provide technical assistance for businesses to implement these policies.

The Baby-Friendly Hospital Initiative — launched by the WHO and UNICEF and adopted by more than 90 U.S. hospitals and birthing centers — has been shown to improve the rates of breastfeeding initiation, duration, and exclusivity. Currently no facilities in New Jersey have the BFHI certification. However, there is a great interest among the hospitals surveyed for this report in moving toward becoming baby-friendly facilities. Two areas that the ***ShapingNJ*** part-

nership can address are supplemental feeding at the hospital and use of artificial teats or pacifiers by breastfeeding infants. Both these in-hospital practices have been shown to impact exclusivity rates.

It is recommended that future assessments use the Baby Friendly USA assessment tool as it has been specifically tailored for US hospitals, is shorter in length, and the hospitals are more likely to be familiar with it. The CDC recommended measures for assessing breastfeeding support at worksite can be easily incorporated into a brief phone survey as was done for this study.

Chapter 3

Overcoming Obesogenic Environments in Childcare Facilities

Background

New Jersey has higher prevalence of overweight and obesity among low-income preschool children (17.9%) compared to the national average (14.6%) (Sharma et al., 2009). Obese children between the ages of 2 and 5 are more likely to become obese adults (Freeman, 2005). Reducing the prevalence of childhood obesity has many benefits, both from individual and public health perspectives. Such outcomes can best be achieved by interventions that support healthy eating and active living starting at a young age (Nickals et al., 2001). One place where policies and environments can be changed to make healthy eating and active living a norm among young children is the childcare facility.

More than 60% of U.S. preschool children spend time in childcare facilities (Story et al., 2006). The amount of time children spend at these facilities has increased in the past decades (Benjamin, 2008). New Jersey has more than 3,800 childcare facilities and 87 % of the children attending these facilities are in full-time childcare (NACCRRA, 2009). Given the large number of children served, these facilities are an important venue for combating childhood obesity. Children who attend these facilities consume 50% to 100% of their nutritional requirements at these facilities (Fox et al., 1997). They also acquire screen time and nutrition-related behaviors (Addessi et al., 2005). Childcare facilities, therefore, have the potential to help curb obesity by creating environments that support healthy behaviors through the types of food and beverages served, and by limiting the amount of sedentary time children are allowed.

Based on evidence of association with overweight and obesity as well as their impact on healthy behaviors, a number of childcare policies and practices have been identified as critical to preventing obesity. They include offering healthy meals at childcare facilities, eliminating sugar-sweetened beverages and other foods of minimal nutritional value (Benjamin et al., 2008), not forcing children to eat when they do not want to (Lumberg & Burke, 2006), not using food as a reward (Birch et al., 1980), and limiting screen time.

Under New Jersey childcare licensing rules, New Jersey Department of Children and Family Services (NJDCFS) established nutritional guidelines that require centers to provide meals that include food items for all food groups (NJDCFS, 2009). These rules apply to all meals and foods served, except those served on special occasions, such as holidays and birthdays. There are no requirements that explicitly limit foods of minimal nutritional values such as sugar-sweetened beverages and energy-dense snacks. Drinking water is to be available to all child-

ren. Staff members are not to force a child to eat against his or her will. The licensing rules have no provision for limiting television or screen time.

Recognizing that childcare facilities can play an important role in preventing childhood obesity, and the state's licensing requirements, the ***ShapingNJ*** partnership set a goal to "ensure all childcare and after-school programs provide healthy food and drink, allow ample time for both structured and free play, and avoid using TV as an activity." One of the strategies proposed to address this goal states that "child care providers and advocates will work with the Department of Children and Families' Office of Licensing to change the licensing requirements so that childcare and after-school programs follow evidence-based practices in child health, nutrition, physical activity, and TV viewing."

Purpose and Objectives

This pilot project assesses the current status of the ***ShapingNJ*** strategy targeted at changing the licensing requirements so that childcare programs follow evidence-based practices in child health, nutrition, physical activity, and TV viewing. The CHSP research team focused on assessing nutritional offering and screen time policies and practices at licensed childcare facilities. These overlap with CDC Strategy 1 (increase availability of healthier options), Strategy 7 (restrict availability of less healthy foods), Strategy 10 (reduce consumption of sugar-sweetened beverages), and Strategy 15 (reduce screen time). The status of policies related to the availability of water, using food as reward, and providing support to mother's breastfeeding their children was also assessed.

Methods

The research team selected New Brunswick, N.J., as the site for this pilot because of its relatively small size, which allowed the team to include all center-based childcare facilities in their analysis. A list of licensed childcare facilities was obtained from the New Jersey Department of Children and Family Services. Of the 36 facilities in New Brunswick, 14 were excluded because they represented in-home childcare centers, school-based centers offering only afterschool care, or those with HeadStart affiliation. The school-based centers were excluded to keep the focus on preschool age children attending licensed center-based facilities. The HeadStart centers were excluded because they follow federal regulations rather than state and local regulations that can be impacted by statewide efforts such as ***ShapingNJ***. The remaining 22 licensed childcare centers were included in the assessment.

A 10-item survey questionnaire was designed to assess childcare center policies related to obesogenic environments, including screen time and nutrition guidelines (see Appendix C.1).

A 15-minute phone interview with the director of the center was conducted during a three-week period in April 2010. The measures for assessing the strategies were derived directly from CDC's common measures (Khan et al., 2009). Supplemental questions were based on the literature that investigated specific obesogenic environmental features of childcare centers (Benjamin et al., 2008).

A human subject's protocol for the study was reviewed and approved by the institutional review board of Rutgers University New Brunswick/Piscataway campuses.

Results

Results from the phone interviews conducted to collect data on childcare obesogenic environments and policies are presented below. Responses were obtained from 15 of the 22 facilities selected for the survey, yielding an overall response rate of 68.2%. Childcare facilities in New Brunswick were fairly homogeneous in their obesogenic environment regulations. However, the facilities varied considerably at the level and formality of each specific policy.

Table 3.1 Types of Meals Served by Childcare Facilities in New Brunswick, N.J.

Type of Meal Served	Number of Centers Serving Meals N (%)
Breakfast	13 (87)
Lunch	13 (87)
Snack	15 (100)
Dinner/Supper	1 (7)
Parents send food	6 (40)

Availability of Healthy Foods and Beverages (CDC Strategy 1)

The CDC-proposed measure for this strategy states that a "policy exists to apply nutrition standards that are consistent with the Dietary Guidelines for Americans to all food sold within local government facilities in a local jurisdiction or on public school campuses during the school day within the largest school district in a local jurisdiction." This measure was adapted to apply to all licensed childcare facilities in New Brunswick. All 15 facilities surveyed offered some type of snacks or meals to the children attending childcare (Table 3.1). Thirteen of the 15 facilities surveyed had a policy in place regarding the nutritional quality of meals served, and from the description provided; these policies were consistent with the New Jersey childcare licensing requirements. None of the responses indicated that the policies were based on the most current Dietary Guidelines for Americans. All these 13 centers reported that the policies were required at the federal (53%) or state (47%) level. Of these 13 facilities, 10 (77%) indicated that these were written policies (Table 3.2).

When the childcare facilities were asked to elaborate on the policies in place, a variety of answers were provided. Common themes, however, included a notion of a "balanced meal." The description of the balanced meal was fairly uniform and consistent with the New Jersey Department of Children and Family (NJDCF, 2009) required regulations, which include types and quantities of foods and beverages to be provided from different food groups. One facility stated that no "fried food" was served and that most snacks provided had "limited to no sugar." For the facilities where parents send food for their children (40%), 33% of those centers stated that the policy applies for meals, snacks, and beverages parents send with their children.

Limit Foods of Low Nutritional Value (CDC Strategy 7)

The CDC-proposed measure for this strategy states that a "policy exists that prohibits the sale of less healthy foods and beverages within local government facilities in a local jurisdiction or on public school campuses during the school day within the largest school district in a local jurisdiction." This measure was adapted to apply to all licensed childcare facilities in New Brunswick. Eleven (73%) of the 15 childcare facilities had a policy in place that limited foods of low nutritional value (Table 3.2). The level of policy was split fairly evenly between federal, state, local/internal — with 36% of the policies reported as being required at the state level and 27% of the policies reported as being required at the federal level. Nine facilities reported that the policy in place was a written policy.

When asked to elaborate on the policy, the responses were consistent with NJDCFS and included specific food groups and amounts to be offered as snack. In addition, many facilities stated that sugar could not be one of the first three ingredients listed on the nutrition facts panel. One facility reported that they make their own "treats" for a special occasion, while others do not regulate food brought in for special occasions such as birthdays and holidays.

Limit Sugar-Sweetened Beverages (CDC Strategy 10)

The CDC-proposed measure for Strategy 10 states that "licensed childcare facilities within the local jurisdiction are required to ban sugar-sweetened beverages, including flavored/sweetened milk, and limit the portion size of 100% juice." All 15 surveyed facilities indicated that a regulation was in place that limited sugar-sweetened beverages (Table 3.2). Nine centers indicated that the policy was required at the local/internal level, while two respondents indicated that this was some combination of federal, state, local, or internal policy.

When asked to elaborate on the policy, the responses were varied. Three facilities said they do not allow any sugar-sweetened beverages. In some facilities, parents are able to send sugar-sweetened beverages with their children. One facility served no juice, while another three indicated that they ban soda and limit sugar-sweetened beverages. Two facilities specifically indicated that sugar cannot be within the first three ingredients. Eleven (73%) of the 15 childcare facilities surveyed limited the portion size of 100% juice. Five stated that the policy

was an internal one, while another four indicated that the policy was federal, with the remaining either state or local. Ten of the 11 (91%) stated they had a written policy.

Make Water Freely Available to Children

Having water freely available to children at all times represents the second most common food and beverage issue for which the childcare facilities surveyed had a policy in place. Fourteen (93%) of the 15 had regulations that ensured availability of water of to all children in their childcare facilities (Table 3.2). Eight of the 14 (57%) stated that this regulation was an internal policy, while the remaining 43% indicated that the policy was either federal, state, or a local requirement. Six (43%) of the 14 facilities revealed that this policy was written.

Do Not Use Food as a Reward

Ten (67%) of 15 childcare facilities surveyed did not allow food to be used as a reward. Many facilities indicated that this policy occurred at multiple levels — with a majority, 58%, occurring at the local/internal level. Eight (80%) of the 10 indicated that this policy was written. When asked to elaborate on this policy, a majority of the respondents indicated that food couldn't be withheld as punishment (Table 3.2).

Table 3.2 Childhood Obesity-Prevention Polices in Childcare Centers

Food and Beverages	Numbers with a Policy N (%)	Type of Policy N (%)				Numbers with Written Policy N (%)
		Federal	State	Local	Internal	
Childcare center offers meals and beverages consistent with Dietary Guidelines for Americans	15 (100)	8 (53)	7 (47)	0 (0)	0 (0)	10 (67)
Childcare center limits foods of low nutritional value	11 (73)	3 (20)	4 (27)	2 (13)	3 (20)	9 (60)
Childcare center limits sugar-sweetened beverages	15 (100)	5 (33)	3 (20)	1 (7)	8 (53)	10 (67)
Childcare center limits portion size of 100% juice	11 (73)	4 (27)	3 (20)	1 (7)	4 (27)	10 (67)
Childcare center makes water freely available	14 (93)	1 (7)	3 (20)	2 (13)	8 (53)	6 (40)
Childcare center does not use food as a reward	10 (67)	2 (13)	3 (20)	2 (13)	7 (47)	8 (53)
Childcare center limits screen time	13 (87)	0 (0)	0 (0)	1 (7)	12 (80)	6 (40)
Childcare center provides support to breastfeeding mothers	5 (33)	0 (0)	0 (0)	1 (7)	4 (27)	1 (7)

Limit Screen Time (CDC Strategy 15)

The CDC measure for Strategy 15 states that "licensed childcare facilities within the local jurisdiction are required to limit screen time to no more than 2 hours per day for children 2 years of age or older." Thirteen (87%) of the 15 childcare facilities surveyed limited screen time for children 2 years of age or older to no more than two hours per day (Table 3.2). Of those 13 childcare centers, six had a written policy that stated screen time would be limited. All of the facilities indicated that these policies were internal or local.

When the childcare facilities elaborated on the specifics of the policy, eight (62%) limited screen time to no more than 30 minutes per day and the remaining five limited screen time to between 30 minutes and two hours. Respondents also indicated an important nuance within the definition of screen time. In addition to watching television, screen time refers to time spent watching a video/DVD and time spent using a computer. Seven (54%) reported that there was no television viewing, but one of that seven said that a television was used for showing an occasional video. Two facilities reported that there were no computers available for children.

Provide Support for Breastfeeding Mothers

Of the 15 childcare centers surveyed, five represented facilities that served infants ages 6 weeks and older. All the five centers had policies that supported breastfeeding mothers whose children attended these facilities (Table 3.2). The respondents indicated that the breastfeeding support policy was a local or internal requirement. One of these five childcare facilities stated that the policy was written. When elaborating on the type of support, one specifically indicated that a room was designated for breastfeeding. Two indicated having a pump available for mothers. The remaining descriptions ranged from stating that the center accepted breast milk for feeding children to "making any reasonable effort" to support breastfeeding mothers.

Discussion

Childcare facilities play an important role in setting the foundation for healthy behaviors that can be maintained for life. With the heightened urgency to tackle the childhood obesity epidemic, childcare centers, now more than ever, are being urged to promote environments that are conducive to helping children consume healthy foods and be physically active. This study examined what policies childcare facilities in New Brunswick had in place that impacted the obesogenic environments. The key factors reviewed included nutritional standards for meals, beverage, and snack; screen time; and breastfeeding support. Generally, most childcare centers responded affirmatively to having specific policies related to the aforementioned variables, but most of the variation was in the levels at which the policies were instituted, whether or not the policies were written, and in the description of the policies. Written policies, if clearly stated can promote adherence to a specific policy over time, especially if they are part of ongoing reporting or assessments. As apparent from the name, federal, and state policies are required by some type of federal or state agency. Local and internal policies are those that were required either by some local jurisdiction, a childcare franchise, or were internal to the specific childcare center facility.

Food environments in childcare centers were assessed in three areas: the center serves food according to nutrition standards are consistent with dietary guidelines, the center limits foods of low nutritional value, and the center does not use food as a reward.

All of the center directors interviewed stated that they followed state or federal guidelines for types of foods that can be served as meals and snacks at their facilities and provided details that were somewhat consistent with the New Jersey state requirements. Even though the state of New Jersey has specific requirements based on food groups to be served at licensed childcare facilities, only 10 of the childcare center directors interviewed indicated that there was a written policy in this regard. While the New Jersey guidelines emphasize the food groups to be included in meals, they fall short of the Dietary Guidelines for Americans because they do not include specifics on types of foods to be encouraged within each food group, foods

to be limited or avoided, and other details. Childcare centers also did not always have policies in place to provide guidance to parents about the food they sent in. One facility surveyed indicated the difficulty of following the guidelines because their center serves a specific cultural group that has certain food requirements not necessarily recognized in the Dietary Guidelines for Americans.

When respondents were asked to elaborate on whether they served food of low nutritional value, most of those explanations usually involved discussion on the type of snacks facilities could provide such as "sugar could not be within the first three ingredients" or "no fried food is served." In addition, the centers tended to follow the state regulations for food groups to be included in snacks. Consistent with the New Jersey state policy, these formal and informal guidelines did not apply to foods served at special occasions such as holidays and birthdays.

Lastly, 10 childcare facilities indicated that food cannot be used as a reward for children. On further elaboration, the policy also included that food cannot be withheld, used as a bribe, and children could not be force-fed.

Stronger guidelines, in line with the Dietary Guidelines for Americans are needed to help childcare centers serve healthy meals and snacks to children attending their facilities. The centers also need technical assistance to translate the guidelines into menu plans, to address issues related to meals and snacks brought in by parents, and to accommodate serving children from specific cultural groups.

Beverage policy questions focused on three areas: limiting sugar-sweetened beverages, limiting portion size of 100% juice, and making drinking water available to children at all times. All of the childcare facilities limited sugar-sweetened beverages by banning soda and offering only those beverages where sugar was not one of the first three ingredients listed. Some also indicated that if the juice was not 100%, then it could not be provided to the children. In addition to limiting sugar-sweetened beverages, 11 of the 15 childcare facilities limited the portion size of 100% juice to four ounces. One facility stated that the children could "have more if they want." While all facilities had a policy on this, a third of the centers interviewed did not have a formal written policy that was followed. The facilities did not have policies in place that prohibited less healthy beverages sent in by parents. Fourteen of the 15 had a policy in place that made drinking water available to children at all times. Many center directors were not aware of the availability of water being a state-mandated policy with written guidance as two thirds of them indicated that making water available was a local or internal policy. Stronger guidelines and increased awareness about importance of adhering to these policies among childcare administrators will help these facilities limit beverage offerings to water, low-fat milk, and small portions of 100% juice.

Although no consistent relationship has been established between screen time and physical activity, studies have shown that when children spend time watching television, the child has less time for physical activity (Hancock et al., 2004). Television viewing is also asso-

ciated with increased consumption of unhealthy foods and increased advertising exposure to unhealthy foods (Khan, et.al, 2009). In a review of the data of the childcare facilities, only one facility of the 15 did not have a policy with regard to screen time. It was inconclusive whether or not that facility limited screen time to less than two hours per day, but the director of the facility mentioned that they "rotate" activities in order to not stay fixated on a screen all day. The remaining 14 did have policies and their responses varied in terms of level and whether it was a formal written policy. More than half of the childcare centers surveyed did not allow screen time to exceed 30 minutes per day. However, a common themed answer was that if there was TV time, it was often used to supplement an educational experience. In the absence of federal or state guidelines all childcare centers have local or internal policies to limit screen time and half of these were reported as written policies. These findings suggest that there is recognition of the importance of reducing screen time for children attending childcare facilities. A uniform statewide policy as part of the New Jersey childcare licensing system would help providers meet the guidelines set forth by the American Academy of Pediatrics and recommended by the CDC. Such guidelines would be especially helpful in limiting screen time at home-based childcare facilities where television viewing by children may be more prevalent.

All five facilities that served children who could be breastfed made some effort to provide support for breastfeeding mothers. Four of these policies were internal, indicating that the facility has taken on the responsibly to help such mothers. These policies were largely informal, as only one facility reported having it written. For those that responded affirmatively to this question, the descriptions of the policy usually focused on general support. One facility specifically stated that they had a breastpump, while another indicated that a mother was welcome to come in during her work hours to pump breast milk. One childcare center had designated a room for breastfeeding mothers.

There are a few important limitations to this assessment of childcare facilities. Given the scope of the pilot, only licensed center-based facilities in New Brunswick were surveyed, limiting the generalizability of the study. In addition, the researchers relied on the self-reports from center directors and did not review policy documents.

Conclusions and Implications

Based on the results of this survey, childcare facilities would benefit from having stronger formal policies in place to help create healthy eating environments and reduce screen time to promote healthy behaviors among children served by these facilities. The ***ShapingNJ*** partnership aims to ensure that childcare centers provide healthy food and drink, allow ample time for both structured and free play, and avoid using TV as an activity. All the childcare centers surveyed followed the nutritional guidance provided by the state of New Jersey. These requirements however, are not consistent with the latest Dietary Guidelines for Americans. Revising

the New Jersey guidelines to align them with the latest federal recommendations would help assure that centers provide healthier meals and snacks to children attending their facilities. The guidelines should be updated every five to 10 years to keep them current with the latest recommendations. Regarding screen time, in the absence of state or federal guidelines, many childcare centers have instituted informal internal policies for limiting the time children spent in front of a television or computer. Since there is strong traction for this policy among the facilities surveyed, this may be an opportune time to include guidance on limiting screen time in the childcare licensing regulations for the state of New Jersey. This guidance should be based on the recommendations of the CDC and the American Academy of Pediatrics.

The four measures proposed by the CDC: availability of healthy foods and beverages, limiting foods of low nutritional value, and limiting sugar sweetened beverages, and limiting screen time; and the three supplemental measures: availability of drinking water, using food as reward, and support for breastfeeding mothers worked well to assess the overall obesogenic environments in childcare settings. Information could be easily collected over the phone from childcare centers with a response rate close to 70%. Future assessments can use the same measures to monitor progress of policies related to food and sedentary activities in childcare centers.

Chapter 4

Improving Food and Physical Activity Environments in New Jersey Schools

Background

One third of the school age children in America are either overweight or obese (Ogden et al. 2010). The growing childhood obesity epidemic calls for urgent action to help change policies and environments in places where children live, learn, and play (IOM, 2005). Schools have been recognized as an important partner in the fight against childhood obesity as they play an important role in shaping the dietary and physical activity behaviors of children (IOM, 2005; Story et al., 2006). Approximately 50 million children ages 5–19 years old attend elementary and secondary schools — a number that represents more than 80 percent of all children in the United States (Stallings & Yaktine, 2007). During the school year, children spend more time at school than at any other location besides their home. As much as 40% of their daily energy intake comes from foods consumed at school (Briefel et al., 2009). This means that foods and beverages available at school have a substantial influence on children's overall intake.

Recognizing the role schools can play in modeling healthy eating behaviors, Congress included language in the Child Nutrition and WIC Reauthorization Act of 2004 that required school districts participating in the National School Lunch Program or other child nutrition programs to adopt and implement a wellness policy by the first day of the 2006-07 school year. The act required wellness policies to include goals for nutrition education; nutrition standards for school foods; assurance that reimbursable school meals meet the minimum federal school meal standards; guidelines for foods and beverages sold or served outside of school meal programs (i.e., "competitive foods"); goals for physical activity; a plan for measuring implementation; and involvement of parents, students, food service professionals, and the public in developing the wellness policy (USDA, 2009).

In addition to the federal requirements, states also have implemented school nutrition policies. New Jersey has two state-mandated requirements that apply to all public and private schools that participate in any of the federally funded child nutrition programs, and also for any other nonparticipating public school that has 5% or more of students eligible for free or reduced-price meals. The first New Jersey state mandate required schools to adopt a nutrition policy by September 2006 that conforms to the U.S. Department of Agriculture (USDA) nutrition standards and the Dietary Guidelines for Americans for national school lunch and breakfast and/or after-school snack programs, and regulated the types of food items offered outside the federal meal requirements, such as a la carte sales, vending machines, school stores, and fun-

draisers. The second state mandate required districts to adopt a nutrition policy that is consistent with the New Jersey Department of Agriculture's (NJDA) Model School Nutrition Policy by September 2007 to promote healthier eating habits. The policy contained very specific directives as to the percentages of sugars, fats, and other ingredients that may be contained in foods served in ala carte lines, vending machines, snack bars, school stores, and fundraisers. To ensure compliance, districts were required to submit their policy at the same time they submitted their annual contract for the school meal programs. In addition, the NJDA monitored compliance during its administrative review process. By October 2007, all public schools in New Jersey had implemented the NJDA's Model School Nutrition Policy (School Board Notes, 2005).

Two of the goals of the ***ShapingNJ*** partnership focus on schools — one aims to improve the diets of students so they eat more healthy foods and consume less sugary and energy-dense foods and beverages and the second aims to strengthen school wellness policies and their implementation.

Purpose and Objectives

The primary focus of this pilot project was to assess the policies that impact the availability of healthier food and beverage choice in schools. This aligns with the ***ShapingNJ*** strategies to advocate for an increased school meal subsidy to enable schools to provide healthier choices and to enhance the minimum standards in school wellness policy and coincides with CDC Strategy 1 (increase availability of healthier options in public places) and Strategy 7 (restrict availability of less healthy foods). In addition, the strength of various components of school district wellness policies in the selected New Jersey communities were assessed as was the status of CDC-recommended physical activity Strategy 12 (require physical education in schools) and Strategy 13 (increase amount of physical activity in physical education programs in schools).

Methods

The strategies and the target communities for this pilot were selected in consultation with the ONF and the ***ShapingNJ*** partnership. The five communities selected for this study were the public school districts of Camden, Newark, New Brunswick, Trenton, and Vineland. These communities were selected because the ***ShapingNJ*** partnership was already engaged with schools in obesity-prevention efforts through projects funded by the Robert Wood Johnson Foundation.

CSHP research team staff conducted telephone interviews to collect information on nutrition policies and practices followed in these five school districts. The phone survey questions were developed using CDC's proposed common measures associated with Strategies 1 and 7

(see Appendix D.1). The respondents were requested to share their school wellness policy. Internet searches also were conducted to obtain copies of the wellness policy and any other additional policies and procedures on health and physical education followed by the school districts. The New Jersey Model School Nutrition Policy and the related documents were obtained from the NJDA website. The health and physical education policies, regulations, and standards were obtained from the New Jersey Department of Education (NJDOE) website.

The district wellness policies were coded using the WellSAT tool. WellSAT is a 50-item online tool that assesses the district wellness policies on the following dimensions: nutrition education and wellness promotion; standards for USDA school meals; nutrition standards for competitive foods; physical education and physical activity; and evaluation. The tool calculates two scores: a comprehensiveness score and a strength score for each section. The comprehensiveness score reflects the extent to which USDA recommendations are covered in the policy. The strength score describes how strongly the content is stated. Both scores range from 0 to 100, with lower scores indicating less content and weaker language, and higher scores indicating more content and use of specific and directive language. This tool also provides an overall comprehensiveness and strength score for the policy. The physical activity/education components of the WellSAT tool were used to answer questions pertaining to CDC Strategy 12 (require physical education in schools) and Strategy 13 (increase amount of physical activity in physical education programs in schools).

A human subject's protocol for the study was reviewed and approved by the institutional review board of Rutgers University New Brunswick/Piscataway campuses.

Results

Three school districts answered the survey and shared their wellness policy with the researchers. One school district refused to answer and one did not respond. The school district wellness policies for the non-responders were obtained from their websites. All the schools in the five school districts followed the nutrition standards as defined by the New Jersey Model School Nutrition Policy and the Health and Physical Education curriculum standards as defined by NJDOE (N.J. S.A 18A:35-7; N.J. S.A 18A:35-8; N.J. S.A 18A:35-9). None of the schools had additional nutrition or physical activity related district-level policies. The information from these statewide policies was used to answer questions in the CDC-proposed measures for Strategies 1, 7, 12, and 13 (see page7).

Availability of Healthier Food and Beverage (CDC Strategy 1)

The CDC-proposed measure for this strategy states that "a policy exits to apply nutrition standards that are consistent with the Dietary Guidelines for Americans to all food sold within local government facilities in a local jurisdiction or on public school campuses during the school day

within the largest school district in a local jurisdiction." All school districts studied have policies in place requiring that school meals meet nutritional standards established by the USDA for Child Nutrition Programs (NJDA, 2006). The NJDA has set standards for snacks and beverages sold or served in the school property during the school day. All the five school districts follow the same policy, which states that all snacks and beverages must meet the NJDA standards. The policy also applies to food sold in a la carte lines, vending machines, snack bars, school stores, and fundraisers; and the reimbursable after-school snack program (NJDA 2006; NJDA 2007).

Restrict Availability of Less Healthy Foods and Beverages (CDC Strategy 7)

The CDC-proposed measure for this strategy states that "a policy exists that prohibits the sale of less healthy foods and beverages within local government facilities in a local jurisdiction or on public school campuses during the school day within the largest school district in a local jurisdiction." The NJDA prohibits the sale of less healthy foods and beverages on public school campuses during the school day. All the five school districts adopted this policy, which prohibits the following items from being served, sold, or given out as free promotion anywhere on school property at any time before the end of the school day: foods of minimal nutritional value (FMNV) as defined by USDA regulations; all food and beverage items listing sugar, in any form, as the first ingredient; all forms of candy. The policy also requires that schools should reduce the purchase of products containing trans fats (NJDA, 2006).

Require Physical Education in Schools (CDC Strategy 12)

The CDC-proposed measure for this strategy states that "the largest school district located within the local jurisdiction has a policy that requires a minimum of 150 minutes per week of physical education in public elementary schools and a minimum of 225 minutes per week of physical education in public middle and high schools throughout the school year." All of the five school districts studied follow the state-wide standards set forth by the NJDOE in the form of Health and Physical Education curriculum standards. These require only 150 minutes of physical education per week for all grade levels. In addition to being physically active, this time can also be devoted to health and safety education (NJDOE, 2009). Local districts decide on how many minutes per week are necessary in each area in order to achieve the core standards.

Increase the Amount of Physical Activity in Physical Education Programs in Schools (CDC Strategy 13)

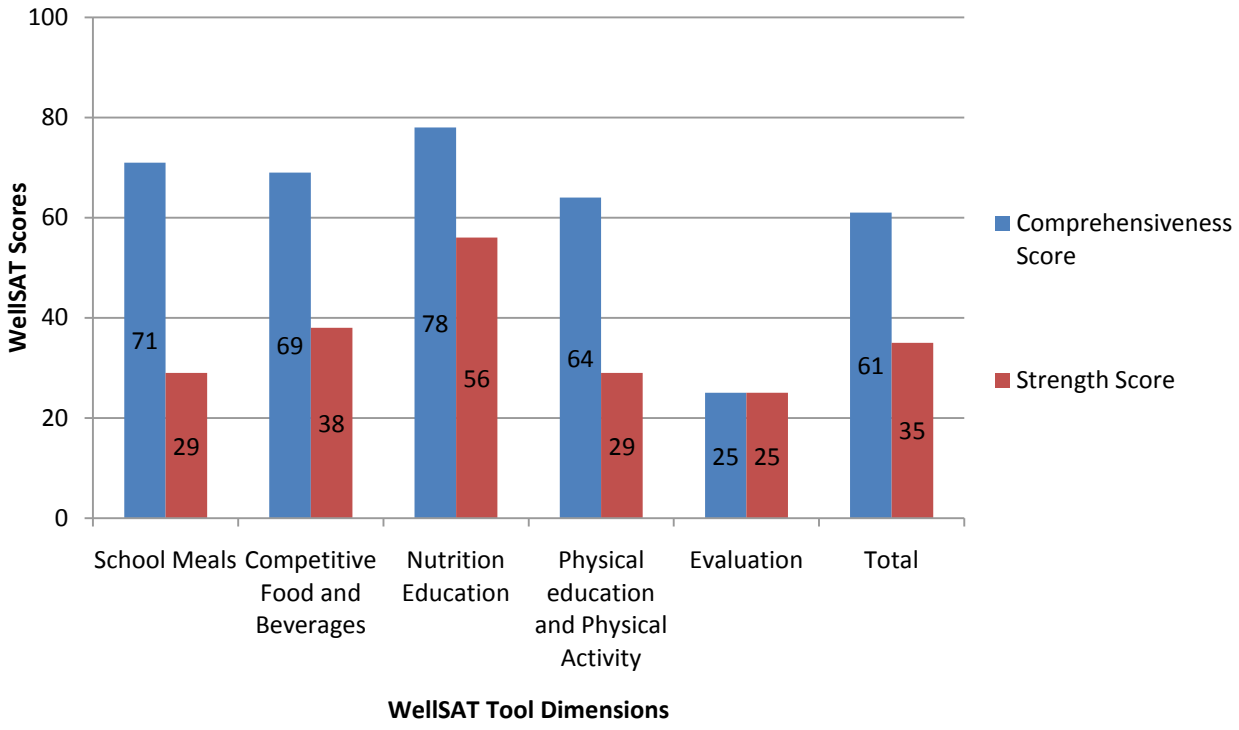
The CDC-proposed measure for this strategy states that "the largest school district located within the local jurisdiction has a policy that requires K–12 students to be active for at least 50% of time spent in physical education classes in public schools." The NJDOE's N.J.S.A. 18A:35-7&8 requires that students in grades 1 through 12 receive 150 minutes of health, safety, and physi-

cal education per week, prorated for school holidays. The actual time to be spent in active physical education is not specified in the policy.

Assessment of School Wellness Policy

All the schools in the five school districts followed the nutrition policy as prescribed by the New Jersey Model School Nutrition Policy and the Health and Physical Education curriculum standards as set forth by the NJDOE. Therefore, these two policies were assessed in lieu of the district wellness policies using the WellSAT tool. Out of a maximum score of 100, the comprehensiveness score of the school wellness policies in New Jersey is 61 and the total strength score is 35 (see Figure 4.1). Results for each of the five dimensions are presented below. Figure 4.2 provides a visual summary of the results for each of the five dimensions.

Figure 4.1. Comprehensiveness and Strength Score of School Wellness Policy



Standards for School Meals

The overall comprehensiveness score is 71 and the strength score is 29. There are seven items in this section and the NJDA policy has both strengths and weaknesses related to standards for school meals. The NJDA policy is strong for two items addressing nutrition standards for school meals served or sold to students and in providing a pleasant dining environment for students. The policy, however, is weak for 3 items addressing access to and/or promotion of the school breakfast program, ensuring adequate time to eat, and making nutrition information available for school meals (e.g., calories, saturated fat, sugar). There is no policy for two items, which

specify strategies to increase participation in school meal programs and ensure nutrition training for the food service director and/or onsite manager (or other person responsible for menu planning) (see Figure 4.2).

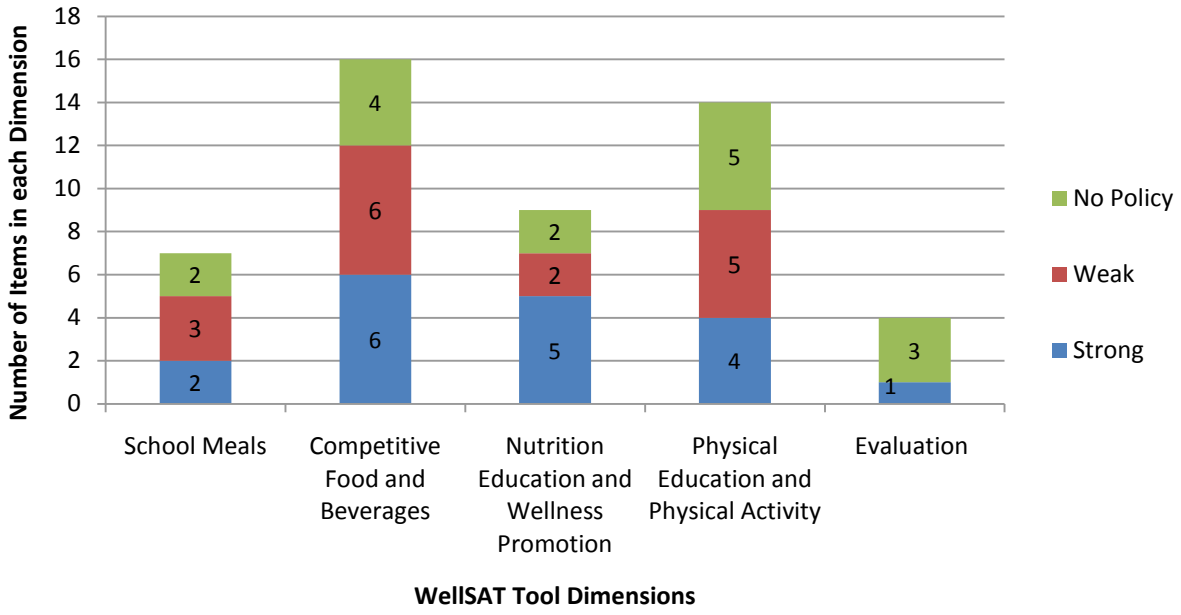
Nutrition Standards for Competitive Foods and Beverages

The overall comprehensiveness score for this dimension is 69 and the strength score is 38. There are 16 items in this section and NJDA policy has both strengths and weaknesses related to nutritional standards for competitive foods and beverages. The NJDA policy strong for the following items: regulating vending machines, school stores, a la carte food service, or food sold as an alternative to the reimbursable school meal program; limiting sugar content of foods sold/served outside of USDA meals; limiting fat content of foods sold/served outside of USDA meals; and limiting regular (sugar-sweetened) soda sold/served outside of USDA meals. The policy is weak in regulating food served at class parties and other school celebrations; in addressing food used as a reward; in limiting sugar content of beverages sold/served outside of USDA meals; in limiting serving size for beverages sold/served outside of school meals; and in regulating food sold for fundraising at all times (not only during the school day). The policy weakly encourages increased consumption of "whole foods" (whole grains, unprocessed foods, or fresh produce) sold/served outside of USDA meals. There is no policy for limiting sodium content of foods sold/served outside of USDA meals; for limiting calorie content per serving size of foods sold/served outside of USDA meals; for limiting fat content of milk sold/served outside of school meals; and for providing access to free drinking water (see Figure 4.2).

Nutrition Education and Wellness Promotion

The overall comprehensiveness score for this dimension is 78 and the strength score is 56. There are nine items in this section and the assessment shows that the NJDA policy has strengths and weaknesses related to nutrition education and wellness promotion. The wellness policy is strong in providing nutrition curriculum for each grade level and teaching skills that are behavior-focused. It follows a comprehensive health and physical education curriculum and specifies restrictions on marketing of unhealthful choices. It encourages staff to be role models for healthy behaviors. The policy is weak in linking nutrition education with the school food environment, and also in specifying how districts could engage families to provide information and/or solicit input to meet district wellness goals. There are no policies for promoting healthy choices and for establishing an advisory committee to address health and wellness (see Figure 4.2).

Figure 4.2 Summary of NJDA wellness policy strengths and weaknesses based on WellSAT assessment



Physical Education and Physical Activity

The overall comprehensiveness score for this dimension is 64 and the strength score is 29. There are 14 items in this section and NJDOE policy has both strengths and weaknesses. The policy strongly addresses physical education curriculum/program for each grade level, teacher-student ratio, qualifications required for physical education instructors, and physical education training for physical education teachers. The policy weakly addresses time per week of physical education for all grade levels, physical education waiver requirements (e.g., substituting physical education requirement with other activities), and not restricting physical activity as punishment. There is no policy for addressing adequate equipment and facilities for physical education; structured physical activity for before- or after-school programs through clubs, classes, intramurals, or interscholastic activities; community use of school facilities for physical activity outside of the school day; provision of daily recess in elementary school; and provision of regular physical activity breaks for elementary school students during classroom time (not including physical education and recess) (see Figure 4.2).

Evaluation

The comprehensiveness score is 25 and the strength score is 25. There are four items in this section and the assessment shows that the policy is strong for one item. No policies were found for the other three items. The policy in place includes a strong plan for implementing nutrition standards as required by federal regulations and incorporating nutrition education

and physical activity consistent with the NJDOE core curriculum standards. The policy does not address any plans for policy evaluation nor for providing a progress report for a specific audience. It also does not address any plans to revise or update the policy (see Figure 4.2).

Discussion

In lieu of establishing school district wellness policies, the five communities studied follow the NJDA's New Jersey Model School Nutrition Policy and the Health and Physical Education curriculum standards set forth by NJDOE. Information from these policies was used to assess the status of the CDC strategies that address school meals, availability of less healthy options, and physical education. The NJ Model School Nutrition Policy does not meet the CDC recommended strategies, as it is not based on the most current Dietary Guidelines for Americans. The NJDA Model School Nutrition Policy is based on the 1995 Dietary Guidelines for Americans and meets the USDA guidelines for Child Nutrition Programs (USDA, 2009). These policies have not been updated to be in line with the Dietary Guidelines which have been updated twice (2000 and 2005) and the 2010 guidelines are soon to be released. Additional guidance on school meals has also been provided in a recent report from Institute of Medicine (Stallings, Suitor, & Taylor, 2010). As a result, the schools limit the purchase of unhealthy foods using NJDA and USDA's definition of foods of minimal nutritional value, which do not restrict energy-dense nutrient poor foods unless they meet some very limited criteria (sugar as the first ingredient, soda, water ices, chewing gum, hard candy, jellies, gum, etc). Following these guidelines, cookies, chips, fruit drinks where sugar is not the first ingredient, though high in calories and low in nutrients, are allowed to be served at schools. Similarly, the physical activity guidelines laid out in the NJDOE policies and followed by the five school districts do not meet the CDC recommendations. The CDC recommendations are based on the National Association for Sports and Physical Education in terms of total time for middle and high school students and active time for all students.

This assessment of the New Jersey Model School Nutrition Policy and the Health and Physical Education curriculum standards using the WellSAT school wellness policy assessment tool indicates that these policies are strongest for the nutrition education component, followed by nutrition standards for competitive food and beverages. The policies are comparatively weak for standards followed for school meals, physical education and physical activity, and evaluation. These findings suggest that there are many opportunities to strengthen the comprehensiveness and specificity of language of these statewide policies that have been adopted by individual school districts as their federally required school wellness policy. These analyses provide the ***ShapingNJ*** partnership with specific targets to explore for strengthening the statewide Model School Nutrition Policy.

The study has some limitations. These analyses are based on a survey of five school districts and may not be representative of all schools in New Jersey. Also, while every effort was made to acquire additional policy documents that may address nutrition and physical activity from each of the school districts, it is possible that individual schools may have additional policies that were not captured by the study. It is important to note that these analyses are based on types of policies in place in the five school districts and do not reflect what is implemented in schools.

Conclusion and Implications

Schools are one of the most crucial partners in addressing the obesity crisis: children spend significant amounts of time at school and can consume two to three meals a day there; schools have the mechanisms in place for educating students and for reinforcing healthy behaviors; and schools can be effective entry points into the community. The results from this pilot assessment indicate that the school districts in the five New Jersey communities — Camden, Newark, New Brunswick, Trenton, and Vineland — have adopted the state-mandated policies with regard to meals served at school and for setting physical education standards. These state-mandated policies and practices however, are not based on the most current science, and need to be revised and updated based on the recommendations from the CDC, the IOM, the USDA, and other professional bodies.

Specifically, the guidelines for school meals should be updated so they are consistent with the Dietary Guidelines for Americans and with the recommendations from the IOM's special report on school meals. It recommends that the meals provided by the federally reimbursable program should be the main source of nutrition at school and opportunities for competitive foods should be limited, and, when competitive foods are made available, they should mainly consist of nutritious choices. Current New Jersey policies governing food and beverage served at schools do not address access to free, safe drinking water. To help achieve the ***ShapingNJ*** partnership's goal to reduce consumption of sugar-sweetened beverages, policy language should be included that requires school districts to provide free, unlimited access to safe drinking water, in addition to limiting access to sugar-sweetened beverages.

The CDC recommendations for physical education based on the National Association for Sports and Physical Education guidelines call for 150 minutes per week of quality physical education program for elementary schools and 225 minutes per for middle and high school with at least 50% of the physical education time be active time. The policies should be adapted for students with disabilities or chronic health conditions.

Finally, the research team recommends that a process be established to measure policy implementation fidelity and policy effectiveness on a regular basis so that barriers to implementation can be identified and revision made accordingly. There should be a provision to up-

date these policies every five to 10 years to keep them current with the recent recommendations.

WellSAT is an easy to use tool that can be used in conjunction with the CDC recommended measures to assess the presence and strength of policies related to availability of healthy and unhealthy foods in school setting as well as policies related to physical education in schools.

Chapter 5

Recommendations for Future Assessments

Background

The CDC has identified 24 community-based obesity-prevention strategies and corresponding measures to assess their impact. This pilot project investigated the feasibility of using several of those measures to assess the current status of obesity-prevention strategies planned and promoted by the ***ShapingNJ*** partnership.

Can CDC's common measures be used for large-scale assessments?

CDC's common measures are designed for assessing community-based strategies. From the analysis done for this report, it is evident that some policies and practices followed at the community level are closely linked to the recommendations and guidance provided by the state, federal, or other jurisdictions. For example, schools and childcare centers follow guidance provided by the NJDA and NJDCF for providing meals and beverages to children in attendance. In such instances, for large-scale assessments, changes in policies and recommended practices should be tracked by reviewing the requisite documents laying out rules, requirements, and recommendations at the state or federal level. In addition, CDC's common measures should be used to assess the uptake and implementation of these policies at the local level, in a selected sample. Researchers also, however, should determine if additional policies or practices are being promoted locally.

In instances where policies and practices are established by the institutions individually, such as breastfeeding support policies at worksites, the primary source of information for answering questions associated with CDC's common measures should be the representatives from these institutions. To facilitate future large-scale assessments, information on CDC's common measures should be included as part of regular institutional reporting.

Are similar assessments necessary in more communities?

For policies and practices that are recommended and required at the state level, the research team did not find much variability in practice between different sites and it is likely that these policies and practices are consistently followed across communities in New Jersey. For example, it would be safe to assume that the responses to CDC measures about school nutrition standards would be similar across all public schools in New Jersey because they follow guidance included in NJDA's model nutrition policies. However, in instances where such policies are not available, institutions and organizations create local formal or informal policies, which can vary

substantially. For example, in the absence of state-level mandates about limiting screen time, some childcare centers had developed informal policies. In instances where there are local differences, more communities would need to be assessed to get accurate statewide data.

Is collecting data for CDC common measures feasible?

This report assessed a number of CDC strategies based on data collected from a variety of sources — schools, childcare centers, public and private businesses, and hospitals. These data were collected in a limited span of time using brief telephone interviews, self-administered surveys, and reviews of policy documents. Because some of the sites selected for this pilot were already engaged in the ***ShapingNJ*** partnership efforts, response rates were extremely high. All five hospitals, all six employers, and 73% of childcare facilities responded to requests to participate in the assessment. While only three of the five school districts responded to the survey request, information on schools policies could be obtained for all five districts from their websites. The CDC measures are developed such that detailed primary data need not be collected and much of the information required to answer questions associated with these common measures can be collected through brief interviews with knowledgeable personnel or from review of existing documents.

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Appendix A

- **ShapingNJ Strategies**

ShapingNJ: The State Partnership for Nutrition, Physical Activity and Obesity
April 2010

ShapingNJ Strategies

Please note: These strategies reflect a 10-year vision. Some will likely be able to be implemented in the short term while others will be for later implementation.

Communities

Goal: Residents of every New Jersey neighborhood will be able to buy affordable fruits, vegetables and other nutrient-rich foods and beverages* as alternatives to sugar-sweetened beverages and fatty, sugary foods.**

Proposed strategies:
ShapingNJ partners will:

- Work with the Food Trust, the New Jersey Economic Development Agency and other key stakeholders to develop incentives for grocery stores and supermarkets to sell a variety of fruits, vegetables and other nutrient-rich foods and beverages and to locate and stay in underserved neighborhoods, especially in cities.

- Work with the Food Trust and other partners to provide assistance such as refrigeration, marketing, product placement and point-of- purchase signage to corner stores and bodegas to market and sell-- at a reasonable price-- "ready-to-eat" or easy-to-prepare fruits, vegetables and other nutrient-rich foods and beverages.

- Work to create comprehensive community food systems that offer easy access to a variety of fruits, vegetables and other nutrient-rich foods and beverages. These may include, but are not limited to, farmers markets, farm stands, grocery stores, mobile markets, businesses that process local food, community gardens, urban farms, food pantries, "farm to where you are programs", community- supported agriculture*** and Edible School Yard programs.

**Other nutrient-rich foods and beverages include low-fat dairy products, whole grains and lean meats such as chicken and fish.*

********Sugar-sweetened beverages as defined by* ***ShapingNJ*** *are beverages with sugar added during processing or preparation by the consumer. These include: non-diet carbonated soft drinks (soda), fruit drinks/ades, tea, coffees and sports drinks. These do not include 100 percent fruit juice or flavored milk.*

****Community supported agriculture means a community of individuals who pledge support to a farm operation where the growers and consumers share the risks and benefits of food production.*

Goal: All New Jersey residents—especially those women and teens most at risk of not being physically active or having unhealthy weight—will be more physically active every day and will spend much less time engaged in TV and other electronic screen viewing.

Proposed strategies:

- Municipalities, school districts, community-based agencies and other ***ShapingNJ*** partners will work together to increase opportunities and choices in all neighborhoods for indoor and outdoor physical activity and active alternatives to TV and other screen time.

- ***ShapingNJ*** partners will work with municipalities to encourage them to locate new and keep existing public facilities and spaces—including schools, libraries, parks and playgrounds--within easy walking distance of where people live.

- ***ShapingNJ*** partners including the Department of Transportation will work with county and municipal agencies to assess their existing infrastructure and prioritize changes to ensure that walking and biking are safe and easy modes of transportation to daily destinations, for example, through implementation of a local Complete Streets policy.

- ***ShapingNJ*** partners will work with state, county and municipal agencies to reduce dangers from traffic, physical hazards and crime in areas where people walk and bike and in places where they are or could be physically active, such as school playing fields and neighborhood parks.

<u>Schools</u>

Goal: Students will eat more fruits, vegetables and nutrient-rich foods and beverages at school and consume fewer sugar-sweetened beverages and fatty, sugary foods.

Proposed strategies:
ShapingNJ partners and others will:

- Advocate for an increased school meal subsidy to enable schools to add a variety of fruits, vegetables and other nutrient–rich foods and beverages and to prepare appealing school meals.

- Create/ensure adequate school infrastructure to prepare a variety of healthy, appealing, kid-friendly fruits and vegetables or provide schools with adequate access to resources to purchase such fruits and vegetables.

Goal: School districts will be responsible for putting into practice an effective, comprehensive and enhanced school wellness policy.

Proposed strategies:

- ***ShapingNJ*** partners, including the Departments of Education, Agriculture, Transportation and others, will work to enhance the minimum standards in the state school wellness policy so that every school is encouraged to provide a variety of fruits, vegetables and other nutrient-rich foods and beverages, offer high-quality physical activity and physical education and reduce students' time watching TV. The policy will also encourage local districts to locate schools where students can safely and easily walk and bike to school.

    - School Districts will take the lead in coordinating school wellness policy customization, adoption and monitoring.

- ***ShapingNJ*** partners and other stakeholders will promote and support active school-based wellness councils that implement school wellness policies; councils will include community and school representatives.

    - Every school will have a wellness council responsible for implementation and monitoring of the district wellness policy. The school district will help to facilitate and support wellness councils.

Goal: All students will participate in a daily, high-quality*, standards-based physical education program to gain the skills, knowledge and values they need to foster a lifelong commitment to a healthy, active lifestyle.

Proposed strategies:

The Department of Education and other ***ShapingNJ*** partners will work to:

- Ensure that all students are actively engaged in their Physical Education class.

- Provide students with diverse and developmentally appropriate activities to meet individual needs and interests.

- Provide facilities that are conducive to learning (with respect to class size, equitable space, sufficient equipment and technology and safe and clean facilities).

** A high-quality Physical Education program is highly active, instructional, developmentally and culturally appropriate, regularly assesses student progress and is taught by certified physical education teachers.*

Goal: All students will have daily opportunities, in addition to Physical Education class, to be physically active at school.

- The Department of Education and other ***ShapingNJ*** partners will work to ensure that schools provide a variety of quality***** activities during the school day

to encourage students to be physically active (such as recess, activity breaks, energizers and before- and after-school physical activity programs).

** Physical activity that supplements, supports and reinforces skills learned in physical education class.*

Child and After-School Care

Goal: Ensure all childcare and after-school programs provide healthy food and drink, allow ample time for both structured and free play and avoid using TV as an activity.

Proposed strategies:

- Child care providers and advocates will work with the Department of Children and Families' Office of Licensing to change the licensing requirements so that childcare and after-school programs follow evidence-based practices in child health, nutrition, physical activity and TV viewing.

- ***ShapingNJ*** and other partners will arrange training for childcare providers about healthy child nutrition and physical activity and how to limit TV time for children in their care.

Business/Worksite

Goal: Increase exclusive breastfeeding for the first six months among New Jersey mothers.

Proposed strategies:

- ***ShapingNJ*** partners will work to increase the number of businesses that accommodate breastfeeding women in the workplace using the Business Case for Breastfeeding* as a resource.

**A toolkit for creating a breastfeeding-friendly worksite developed by the Health Resources and Services Administration of the U. S. Department of Health and Human Services.*

Goal: Increase advertising for healthy choices and reduce advertising for less healthy food and beverages, especially to young children.

Proposed strategies:

- ***ShapingNJ*** partners, including the New Jersey Food Council, will work with the food and beverage industry and the New Jersey Better Business Bureau to expand participation from companies serving New Jersey in the national bureau's voluntary Children's Food and Beverage Advertising Initiative. This program includes a pledge that *at least* 50 percent of advertising aimed at children under 12 years old will be about healthy food choices and that there will be no food or beverage advertising in elementary schools.

- ***ShapingNJ*** will work with the Better Business Bureau and/or others to create a customized initiative for New Jersey that includes all forms of advertising and covers a wide variety of local and regional food retailers.

Health Care/Maternity Hospitals

Goal: Increase exclusive breastfeeding for the first six months among New Jersey mothers.

Proposed strategies:

- ***ShapingNJ*** partners will encourage all New Jersey delivery facilities to adopt the Joint Commission's Perinatal Care Core Measure Set, which includes exclusive breast milk feeding.

- All New Jersey delivery facilities will have policies and practices in compliance with the World Health Organization's "Ten Steps for Successful Breastfeeding"*.

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

Appendix B

- **The Ten Steps To Successful Breastfeeding**
- **The Center for State Health Policy Workplace Lactation Support Telephone Questionnaire**
- **Baby-Friendly USA: Using the Self-Appraisal Tool to Review Policies and Practices**
- **Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool**

The Ten Steps To Successful Breastfeeding

The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, 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 pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

The Center for State Health Policy Workplace Lactation Support Telephone Questionnaire

NAME OF THE ORGANIZATION _____

ADDRESS _____

RESPONDENT NAME: _____

DESIGNATION: _____

PHONE NUMBER: _____

Date: _____

Preamble/Consent

Greeting: Hello, my name is _____. I am calling from the Rutgers Center for State Health Policy where we are undertaking a study to understand the current status of policies and procedures being followed in organizations in Newark. For this work, we are working in partnership with the Department of Health and Senior Services.

I would like to ask you a few questions about breastfeeding accommodations in your organization. This interview will take less than 10 minutes.

Your participation in this study is completely voluntary and there will be no penalty for not participating. If you participate, you may still choose not to answer any specific questions. The names of the people who participate in the interviews will be kept confidential by Rutgers. All information will be reported in ways that maintain anonymity of the respondents.

If you have any questions or concerns after the interview, please call the Project Coordinator for this study, Manisha Agrawal, at 732-932-4631.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University. Would you like me to give you that contact information?

If needed read: Rutgers University, the State University of New Jersey, Institutional Review Board for the Protection of Human Subjects, Office of Research and Sponsored Programs, 3 Rutgers Plaza, New Brunswick, NJ 08901-8559. Tel: 732-932-0150 ext. 2104, E-mail: human-subjects@orsp.rutgers.edu

May I proceed?

Yes / No (circle the appropriate response) If Yes, RESPONDENT **GAVE VERBAL CONSENT TO PROCEED WITH THE INTERVIEW:**

Survey outcome:

Survey conducted…. Yes / No

Respondent refused to participate… Yes / No (Explain_____)

Respondent unable to participate…. Yes / No (Explain_____)

INTERVIEWER ONLY ITEMS

Interviewer:

- ____ _____*(name/initials)*
- _____*(Date)*

Data Entry:

- ____ _____*(name/initials)*
- _____ *(Date)*

1. Does your organization have a written policy to provide breastfeeding accommodations for employees?

   - YES
   - NO (Skip to question 3)

If yes to question 1 ask:

1a. Does it include both time and designated space for breastfeeding or expressing during working hours?

- Provide reasonable time (read if needed: time includes a reasonable break time for an employee to express breast milk for her nursing child or allowing flexible scheduling to support milk expression during work)
- Space (read if needed: designated space includes a private location for breastfeeding or expressing milk, other than a bathroom, that is shielded from view and free from intrusion from workers and the public)
- Both
- Facility to temporarily store breast milk (by providing a refrigerator or allowing the employee to bring portable cold storage)

1b. Is this part of a federal policy?

- Yes
- No

1c. May we have a copy of the written policy?

2. Please describe any additional policies that your institution has to support breast feeding mothers in your organization.

   - No additional policies
   - Description of additional policies:

2a. Is this part of a federal policy?

□ YES
□ NO

If no to question 1 ask:

3. Is there any informal policy in place to provide breastfeeding accommodations for employees?

□ YES
□ NO

If yes to question 3 ask:

a. Please describe the informal policy.

4. Is your organization planning to develop a policy to provide breastfeeding accommodations for employees?

□ YES
□ NO (end the interview)

4a. Is this in response to a federal requirement?
□ Yes
□ No

If yes, please describe your plan.

USING THE SELF-APPRAISAL TOOL TO REVIEW POLICIES AND PRACTICES

Any hospital or birth center that is interested in entering the pathway to designation as a Baby-Friendly™ Hospital must appraise its current practices in relation to the *Ten Steps to Successful Breastfeeding.*

The checklist that follows will permit a hospital, birthing center, or other health facility giving maternity care to make a quick initial appraisal or review of its practices in support of optimal infant feeding policies and practices. Completion of this initial self-review form is the first stage of the process of meeting the requirements of the discovery phase of the journey to Baby-Friendly.

Facilities are encouraged to bring their key management and clinical staff together to complete the Self-Appraisal Tool and, in the Development phase, create a plan of action based on the results of the self appraisal.

Facilities participating in the 4-D Pathway to Baby-Friendly are encouraged join the program to participate in the Certificate of Intent program early in their journey toward Baby-Friendly status in order to access technical assistance.

To move from the Discovery phase to the Development phase, a facility must indicate to Baby-Friendly USA a desire to move toward designation. This is achieved by:

1. Submitting the Development Path Application
2. Submitting the Application Fee
3. Completing and submitting the self assessment tool
4. Submitting letter of support from the CEO
5. Signing Development Path Agreement

Upon completing these 5 items the facility will be presented with the *"Discovery Path – Registry of Intent"*.

The receipt of Discovery Path – Registry of Intent Completion Certificate is but the first step along the formal pathway to the Baby-Friendly award. Participating in the program allows a facility to access technical support from Baby-Friendly USA regarding the implementation of all aspects of the award process. An on-site external assessment culminates the Designation phase. If assessment results are satisfactory, the Baby-Friendly designation may be granted. The designation is renewable with re-designation projects consisting of on-going collection of QI data pertaining to 2 steps annually (assigned by BFUSA) plus evaluation of any steps determined by ERB at designation. At the end of the Designation period, a reassessment of all standards is carried out during an on-site assessment visit.

For more information, please contact:

Baby-Friendly USA, 327 Quaker Meeting House Road, E. Sandwich, MA 02537
Tel (508) 888-8092 Fax (508) 888-8050
Email: Info@babyfriendlyusa.org website: http:www.babyfriendlyusa.org

FACILITY DATA SHEET

Date: _____

Facility Name: _____

Address: _____

City: _____State_____ ZIP _____

Billing address (if different) _____
_____

Primary Baby-Friendly contact person: _____
Title & Department: _____
Phone number: _____ Fax: _____
Email address: _____

Secondary contact person: _____
Title & Department: _____
Phone number: _____ Fax: _____
Email address: _____

Facility Chief Administrative Officer: _____
Title: _____
Phone: _____
Email address: _____

Type of Facility:
❑ Free standing Birth Center
❑ Hospital—government funded (type: _____)
❑ Hospital—private not for profit
❑ Hospital—private for-profit

System membership: _____

Teaching Facility for:
- ❑ nursing
- ❑ internship
- ❑ residency (specialities):_____

FACILTY CENSUS DATA
Total beds in hospital: _____

Number of beds:

_____ in LDRP area
_____ in labor & delivery area
_____ in postpartum area
_____ in well baby nursery

_____ in special care
_____ in Level I
_____ in Level II
_____ in Level III

Total deliveries in prior year (20____): _____

Number of births:

_____ were by Cesarean Section — Cesarean rate: _____%
_____ were low birth weight babies (<2,500 g) — Low birth weight rate: _____%
_____ were in special care during their stay — Special care rate: _____%

Infant feeding data for deliveries from records or staff reports:

_____ mother/infant pairs discharged in the past month
_____ mother/infant pairs breastfeeding at discharge in the past month _____%
_____ mother/infant pairs breastfeeding exclusively from birth to discharge in the past month _____%
_____ infants discharged in the past month who had received at least one formula feeding during their stay _____%

How was this infant feeding data obtained?
❑ from records ❑ estimated by _____

Name and contact information of person(s) filling out this form:

_____

_____

STEP 1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

1.1 Does the health facility have an explicit written policy for protecting, promoting, and supporting breastfeeding that addresses all *Ten Steps to Successful Breastfeeding* in maternity services? . . . . . ❑ Yes ❑ No

1.2 Does the policy protect breastfeeding by prohibiting all promotion of and group instruction for using breast milk substitutes, feeding bottles and nipples? . . ❑ Yes ❑ No

1.3 Is the breastfeeding policy available so all staff who take care of mothers and babies can refer to it? . . . . . ❑ Yes ❑ No

1.4 Is the breastfeeding policy posted or displayed in all areas of the health facility that serve mothers, infants, and/or children? . . . . . ❑ Yes ❑ No

1.5 Is there a mechanism for evaluating the effectiveness of the policy? . . . . . ❑ Yes ❑ No

STEP 2. Train all health care staff in skills necessary to implement this policy.

2.1 Are all staff aware of the advantages of breastfeeding and acquainted with the facility's policy and services to protect, promote, and support breastfeeding? . . . . ❑ Yes ❑ No

2.2 Are all staff caring for women and infants oriented to the breastfeeding policy of the hospital on their arrival? . . . . . ❑ Yes ❑ No

2.3 Is training on breastfeeding and lactation management given to all staff caring for women and infants within six months of hiring? . . . . . ❑ Yes ❑ No

2.4 Does the training cover at least eight of the *Ten Steps?* . . . . . ❑ Yes ❑ No

2.5 Is the training on breastfeeding and lactation management at least 18 hours in total, including a minimum of 3 hours of supervised clinical experience?. . . . ❑ Yes ❑ No

2.6 Has the health care facility arranged for specialized training in lactation management of specific staff members? . . . . . ❑ Yes ❑ No

STEP 3. Inform all pregnant women about the benefits and management of breastfeeding.

3.1 Does the facility include a prenatal care clinic? A prenatal inpatient unit? . . . . . ❑ Yes ❑ No

3.2 If yes, are most pregnant women attending these prenatal services informed about the benefits and management of breastfeeding? . . . . . ❑ Yes ❑ No

3.3 Do prenatal records indicate whether breastfeeding has been discussed with the pregnant woman? . . . . . ❑ Yes ❑ No

3.4 Is a mother's prenatal record available at the time of delivery? . . . . . ❑ Yes ❑ No

3.5 Are pregnant women protected from oral or written promotion or group instruction for artificial feeding? . . . . . ❑ Yes ❑ No

STEP 4. Help mothers initiate breastfeeding within an hour of birth.

4.1 Are mothers who have had normal, vaginal deliveries given their babies to hold skin-to-skin within 30 minutes of delivery, and allowed to remain with them for at least an hour? . . . . . ❑ Yes ❑ No

4.2 Are the mothers offered help by a staff member to initiate breastfeeding during this first hour? . . . . . ❑ Yes ❑ No

4.3 Are mothers who have had cesarean deliveries given their babies to hold, with skin contact, within a half hour after they are able to respond to their babies?. . . . ❑ Yes ❑ No

4.4 Do the babies born by cesarean stay with their mothers, with skin contact, at this time for 60 minutes? . . . . . ❑ Yes ❑ No

STEP 5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

5.1 Does nursing staff offer all mothers further assistance with breastfeeding within six hours of delivery? . . . . . ❑ Yes ❑ No

5.2 Are most breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding? . . . . . ❑ Yes ❑ No

5.3 Are breastfeeding mothers shown how to express their milk or given information on expression and/or advised of where they can get help should they need it? . . . . . ❑ Yes ❑ No

5.4 Are staff members or counselors who have specialized training in breastfeeding and lactation management available full-time to advise mothers during their stay in health care facilities and in preparation for discharge? . . . . . ❑ Yes ❑ No

5.5 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding receive special attention and support from the staff of the health care facility? . . . . . ❑ Yes ❑ No

5.6 Are mothers of babies in special care helped to establish and maintain lactation by frequent expression of milk? . . . . . ❑ Yes ❑ No

STEP 6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

6.1 Do staff have a clear understanding of what the few acceptable reasons are for prescribing food or drink other than breast milk for breastfeeding babies? . . . . . ❑ Yes ❑ No

6.2 Do breastfeeding babies receive no other food or drink (than breast milk) unless medically indicated? Breast milk only. .. . . Yes ❑
Some other food/drink . . . . . No ❑

6.3 Are any breast milk substitutes, including special formulas, that are used in the facility purchased in the same way as any other foods or medicines? . . . . . ❑ Yes ❑ No

6.4 Does the health facility and staff refuse free or low-cost[1] supplies of breast milk substitutes, paying close to retail market price for formula? . . . . . ❑ Yes ❑ No

6.5 Is all promotion of infant foods or drinks other than breast milk absent from the facility? . . . . . ❑ Yes ❑ No

STEP 7. Practice rooming-in—allow mothers and infants to remain together—24 hours a day.

7.1 Do mothers and infants remain together (rooming-in) 24 hours a day, except for periods of up to an hour for hospital procedures or if separation is medically indicated? . . . . . ❑ Yes ❑ No

7.2 Does rooming-in start within an hour of a normal birth? . . . . . ❑ Yes ❑ No

7.3 Does rooming-in start within an hour of when a cesarean mother can respond to her baby? . . . . . ❑ Yes ❑ No

STEP 8. Encourage breastfeeding on demand.

8.1 By placing no restrictions on the frequency or length of breast feedings, do staff show they are aware of the importance of breastfeeding on demand? . . . . ❑ Yes ❑ No

8.2 Are mothers advised to breastfeed their babies whenever their babies are hungry and as often as their babies want to breastfeed? . . . . . ❑ Yes ❑ No

[1] Low –cost: below 80% open-market retail cost.

STEP 9. Give no artificial teats or pacifiers to breastfeeding infants.

9.1 Are babies who have started to breastfeed cared for without any bottle feedings? . ❑ Yes ❑ No

9.2 Are babies who have started to breastfeed cared for without using pacifiers?. . . . . ❑ Yes ❑ No

9.3 Do breastfeeding mothers learn that they should not give any bottles or pacifiers to their babies? . . . . . ❑ Yes ❑ No

9.4 By accepting no free or low-cost[2] feeding bottles, nipples, or pacifiers, does the facility and its staff demonstrate that these should be avoided? . . . . . ❑ Yes ❑ No

STEP 10. Foster the establishment of breastfeeding support and refer mothers to them on discharge from the facility.

10.1 Does the facility give education to key family members so that they can support the breastfeeding mother at home? . . . . . ❑ Yes ❑ No

10.2 Are breastfeeding mothers referred to breastfeeding support groups, if any are available? . . . . . ❑ Yes ❑ No

10.3 Does the facility have a system of follow-up support for breastfeeding mothers after they are discharged, such as early postnatal or lactation clinic check-ups, home visits, telephone calls? . . . . . ❑ Yes ❑ No

10.4 Does the facility encourage and facilitate the formation of mother-to-mother or health care worker-to-mother support groups? . . . . . ❑ Yes ❑ No

10.5 Does the facility allow breastfeeding counseling by trained mother-to-mother support group counselors in its maternity services? . . . . . ❑ Yes ❑ No

For more information, please contact:

Baby-Friendly USA
327 Quaker Meeting House Road, E. Sandwich, MA 02537
Tel (508) 888-8092 Fax (508) 888-8050
Email: Info@babyfriendlyusa.org website: http:www.babyfriendlyusa.org

RUTGERS
Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
55 Commercial Avenue, 3rd Floor
New Brunswick, NJ 08901-1340

cshp.rutgers.edu
cshp_info@ifh.rutgers.edu
732-932-3105
Fax: 732-932-0069

Baby-Friendly Hospital Initiative
Facility Self-Appraisal Tool

The Center for State Health Policy at Rutgers University is working with the New Jersey Department of Health and Human Services (DHSS) to assess the current status obesity prevention strategies proposed by the NJDHSS lead coalition, ShapingNJ. These strategies will be assessed using the Centers for Disease Control (CDC) measures. One of the strategies being assessed is breastfeeding promotion. As part of that, we are requesting you to fill out the attached Self Appraisal Tool for the Baby-Friendly Hospital Initiative. Data from this self assessment will help us understand the progress hospitals are making in implementing Baby-Friendly Hospital Initiative and the steps being taken to promote breastfeeding.

Your participation in the survey is completely voluntary. If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at: Rutgers University, the State University of New Jersey, Institutional Review Board for the Protection of Human Subjects, Office of Research and Sponsored Programs, 3 Rutgers Plaza, New Brunswick, NJ 08901-8559. Tel: 732-932-0150 ext. 2104, Email: humansubjects@orsp.rutgers.edu

Please provide your candid responses to all of the questions that follow. Feel free to add comments or explanations of your answers next to the questions provided. If you have any questions about the Survey, please contact Manisha Agrawal at the Center for State Health Policy. Manisha can be reached at magrawal@ifh.rutgers.edu or 732-932-4631. Please return the survey via fax (732-932-0069) or mail it back to Rutgers Center for State Health Policy, 55 Commercial Avenue, 3rd Floor, New Brunswick, NJ 08901.

BABY-FRIENDLY HOSPITAL INITIATIVE

Revised Updated and Expanded
for Integrated Care

SECTION 4

HOSPITAL SELF-APPRAISAL AND MONITORING

2009

Original BFHI Course developed 1992

unicef

World Health Organization

The Self Appraisal Questionnaire

Hospital data sheet

General information on hospital and senior staff:

Hospital name and address: _____

Name and title of hospital director or administrator: _____
Telephone or extension: _____ E-mail address: _____

The hospital is: *[tick all that apply]*

- ☐ a maternity hospital
- ☐ a general hospital
- ☐ a teaching hospital
- ☐ a tertiary hospital
- ☐ a government hospital
- ☐ a privately run hospital
- ☐ other (specify:) _____

Total number of hospital beds: ____ Total number of hospital employees: ____

Information on antenatal services:

Hospital has antenatal services (either on or off site): ☐Yes ☐No
(if *"No"*, skip all but the last question in this section)

Name and title of the director of antenatal services/clinic: _____
Telephone or extension: _____ E-mail address: _____

What percentage of mothers delivering at the hospital attends the hospital's antenatal clinic? ___%

Does the hospital hold antenatal clinics at other sites outside the hospital? ☐Yes ☐No
[if "Yes"] Please describe when and where they are held: _____
_____

Are there beds designated for high-risk pregnancy cases? ☐Yes ☐No *[if "Yes"]*
How many?____

What percentage of women arrives for delivery without antenatal care? _____% ☐ Don't know

Information on labour and delivery services:

Name and title of the director of labour and delivery services: _____
Telephone or extension: _____ E-mail address: _____

Information on maternity and related services:

Name and title of the director of maternity services: _____
Telephone or extension: _____ E-mail address: _____

Number of postpartum maternity beds: _____

Average daily number of mothers with full term babies in the postpartum unit(s): _____

Does the facility have unit(s) for infants needing special care (LBW, premature, ill, etc.)?
☐Yes ☐No
[if "Yes"] Name of first unit: _____ Average daily census: _____
Name of director(s) of this unit: _____
Name of additional unit: _____ Average daily census: ____
Name of director(s) of this unit: _____

Are there areas in the maternity wards designated as well baby observation areas? ☐Yes ☐No
[If "Yes"] Average daily census of each area: _____
Name of head/director(s) of these areas: _____

Staff responsible for breastfeeding/infant feeding

The following staff has direct responsibility for assisting women with breastfeeding (BF), feeding breast-milk substitutes (BMS), or providing counselling on HIV and infant feeding): *[tick all that apply]*

	BF	BMS	HIV		BF	BMS	HIV
Nurses	☐	☐	☐	Paediatricians	☐	☐	☐
Midwives	☐	☐	☐	Obstetricians	☐	☐	☐
SCBU/NICU nurses	☐	☐	☐	Infant feeding counsellors	☐	☐	☐
Dieticians	☐	☐	☐	Lay /peer counsellors	☐	☐	☐
Nutritionists	☐	☐	☐	Other staff (specify):			
Lactation consultants	☐	☐	☐ ____	_____	☐	☐	☐ General
physicians	☐	☐	☐ _	_____	☐	☐	☐

[use information for completing I.C. 10, 13 and 17]

Are there breastfeeding and/or HIV and infant feeding committee(s) in the hospital? ☐Yes ☐No
[if "Yes"] Please describe: _____

_____

Is there a BFHI coordinator at the hospital? ☐Yes ☐No (if "*Yes*", name:) _____

Statistics on births:

Total births in the last year: _____ of which:

____% were by C-section without general anaesthesia

____% were by C-section with general anaesthesia

____% infants were admitted to the SCBU/NICU or similar units

Statistics on infant feeding:

Total number of babies discharged from the hospital last year: ____ of which:

____% were exclusively breastfed (or fed human milk) from birth to discharge.

____% received at least one feed other than breast milk (formula, water or other fluids) in the hospital because of documented medical reason. (if a mother knew she was HIV positive and made an informed decision to replacement feed, this can be considered a medical reason).

____% received at least one feed other than breast milk without any documented medical reason.

[Note: the total percentages listed above should equal 100%]

The hospital data above indicates that at least 75% of the babies delivered in the past year were exclusively breastfed or fed human milk from birth to discharge, or, if they received any feeds other than human milk this was because of documented medical reasons:
[Note: add the percentages in categories one and two to calculate this percentage]

☐Yes ☐No

6.1

Statistics on HIV/AIDS:

Percentage of pregnant women who received testing and counselling for HIV: _____%

Percentage of mothers who were known to be HIV-positive at the time of babies' births: _____%

Data sources:

Please describe sources for the above data: _____

_____

_____

STEP 1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

	YES	NO
1.1 Does the health facility have a written breastfeeding/infant feeding policy that addresses all 10 Steps to Successful Breastfeeding in maternity services and support for HIV-positive mothers?	☐	☐
1.2 Does the policy protect breastfeeding by prohibiting all promotion of breast-milk substitutes, feeding bottles, and teats?	☐	☐
1.3 Does the policy prohibit distribution of gift packs with commercial samples and supplies or promotional materials for these products to pregnant women and mothers?	☐	☐
1.4 Is the breastfeeding/infant feeding policy available so all staff who take care of mothers and babies can refer to it?	☐	☐
1.5 Is a summary of the breastfeeding/infant feeding policy, including issues related to the 10 Steps, The International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions, and support for HIV-positive mothers posted or displayed in all areas of the health facility which serve mothers, infants, and/or children?	☐	☐
1.6 Is the summary of the policy posted in language(s) and written with wording most commonly understood by mothers and staff?	☐	☐
1.7 Is there a mechanism for evaluating the effectiveness of the policy?	☐	☐
1.8 Are all policies or protocols related to breastfeeding and infant feeding in line with current evidence-based standards?	☐	☐

Note: See "Annex 1: Hospital Breastfeeding/Infant Feeding Policy Checklist" for a useful tool to use in assessing the hospital policy. Tools for auditing or evaluating the policy should be developed at health system or hospital level.

Global Criteria - Step One

The health facility has a written breastfeeding or infant feeding policy that addresses all 10 Steps and protects breastfeeding by adhering to the International Code of Marketing of Breast-milk Substitutes. It also requires that HIV-positive mothers receive counselling on infant feeding and guidance on selecting options likely to be suitable for their situations. The policy should include guidance for how each of the "Ten Steps" and other components should be implemented (see Section 4.1, Annex 1 for suggestions).

The policy is available so that all staff members who take care of mothers and babies can refer to it. Summaries of the policy covering, at minimum, the Ten Steps, the Code and subsequent WHA Resolutions, and support for HIV-positive mothers, are visibly posted in all areas of the health care facility which serve pregnant women, mothers, infants, and/or children. These areas include the labour and delivery areas, antenatal care in-patient wards and clinic/consultation rooms, post partum wards and clinic/consultation rooms, all infant care areas, including well baby observation areas (if there are any), and any special care baby units. The summaries are displayed in the language(s) and written with wording most commonly understood by mothers and staff.

STEP 2. Train all health care staff in skills necessary to implement the policy.

	YES	NO
2.1 Are all staff members caring for pregnant women, mothers, and infants oriented to the breastfeeding/infant feeding policy of the hospital when they start work?	☐	☐
2.2 Are staff members who care for pregnant women, mothers and babies both aware of the importance of breastfeeding and acquainted with the facility's policy and services to protect, promote, and support breastfeeding?	☐	☐
2.3 Do staff members caring for pregnant women, mothers and infants (or all staff members, if they are often rotated into positions with these responsibilities) receive training on breastfeeding promotion and support within six months of commencing work, unless they have received sufficient training elsewhere?	☐	☐
2.4 Does the training cover all Ten Steps to Successful Breastfeeding and The International Code of Marketing of Breast-milk Substitutes?	☐	☐
2.5 Is training for clinical staff at least 20 hours in total, including a minimum of 3 hours of supervised clinical experience?	☐	☐
2.6 Is training for non-clinical staff sufficient, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants?	☐	☐
2.6 Is training also provided either for all or designated staff caring for women and infants on feeding infants who are not breastfed and supporting mothers who have made this choice?	☐	☐
2.7 Are clinical staff members who care for pregnant women, mothers, and infants able to answer simple questions on breastfeeding promotion and support and care for non-breastfeeding mothers?	☐	☐
2.8 Are non-clinical staff such as care attendants, social workers, and clerical, housekeeping and catering staff able to answer simple questions about breastfeeding and how to provide support for mothers on feeding their babies?	☐	☐
2.9 Has the healthcare facility arranged for specialized training in lactation management of specific staff members?	☐	☐

The Global Criteria for Step 2 are on the next page.

Global Criteria - Step Two

The head of maternity services reports that all health care staff members who have any contact with pregnant women, mothers, and/or babies, have received orientation on the breastfeeding/infant feeding policy. The orientation that is provided is sufficient.

A copy of the curricula or course session outlines for training in breastfeeding promotion and support for various types of staff is available for review, and a training schedule for new employees is available.

Documentation of training indicates that 80% or more of the clinical staff members who have contact with mothers and/or infants and have been on the staff 6 months or more have received training at the hospital, prior to arrival. or through well-supervised self study or on-line courses that cover all 10 Steps, and the Code and subsequent WHA resolutions. It is likely that at least 20 hours of targeted training will be needed to develop the knowledge and skills necessary to adequately support mothers. At least three hours of supervised clinical experience are required.

Documentation of training also indicates that non-clinical staff members have received training that is adequate, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants.

Training on how to provide support for non-breastfeeding mothers is also provided to staff. A copy of the course session outlines for training on supporting non-breastfeeding mothers is also available for review. The training covers key topics such as:

- the risks and benefits of various feeding options;
- helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances;
- the safe and hygienic preparation, feeding and storage of breast-milk substitutes;
- how to teach the preparation of various feeding options; and
- how to minimize the likelihood that breastfeeding mothers will be influenced to use formula.

The type and percentage of staff receiving this training is adequate, given the facility's needs.

Out of the randomly selected clinical staff members*:

- At least 80% confirm that they have received the described training or, if they have been working in the maternity services less than 6 months, have, at minimum, received orientation on the policy and their roles in implementing it.
- At least 80% are able to answer 4 out of 5 questions on breastfeeding support and promotion correctly.
- At least 80% can describe two issues that should be discussed with a pregnant woman if she indicates that she is considering giving her baby something other than breast milk.

Out of the randomly selected non-clinical staff members**:

- At least 70% confirm that they have received orientation and/or training concerning the promotion and support of breastfeeding since they started working at the facility.
- At least 70% are able to describe at least one reason why breastfeeding is important.
- At least 70% are able to mention one possible practice in maternity services that would support breastfeeding.
- At least 70% are able to mention at least one thing they can do to support women so they can feed their babies well.

** These include staff members providing clinical care for pregnant women, mothers and their babies.*

*** These include staff members providing non-clinical care for pregnant women, mother and their babies or having contact with them in some aspect of their work.*

STEP 3. Inform all pregnant women about the benefits and management of breastfeeding.

	YES	NO
3.1 Does the hospital include an antenatal clinic or satellite antenatal clinics or in-patient antenatal wards? *	☐	☐
3.2 If yes, are the pregnant women who receive antenatal services informed about the importance and management of breastfeeding?	☐	☐
3.3 Do antenatal records indicate whether breastfeeding has been discussed with pregnant women?	☐	☐
3.4 Does antenatal education, including both that provided orally and in written form, cover key topics related to the importance and management of breastfeeding?	☐	☐
3.5. Are pregnant women protected from oral or written promotion of and group instruction for artificial feeding?	☐	☐
3.6. Are the pregnant women who receive antenatal services able to describe the risks of giving supplements while breastfeeding in the first six months?	☐	☐
3.7 Are the pregnant women who receive antenatal services able to describe the importance of early skin-to-skin contact between mothers and babies and rooming-in?	☐	☐
3.8 Is a mother's antenatal record available at the time of delivery?	☐	☐

**Note: If the hospital has no antenatal services or satellite antenatal clinics, questions related to Step 3 and the Global Criteria do not apply and can be skipped.*

Global Criteria - Step Three

If the hospital has an affiliated antenatal clinic or in-patient antenatal ward:

A written description of the minimum content of the breastfeeding information and any printed materials provided to all pregnant women is available.

The antenatal discussion covers the importance of breastfeeding, the importance of immediate and sustained skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24-hour basis, feeding on cue or baby-led feeding, frequent feeding to help assure enough milk, good positioning and attachment, exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given.

Out of the randomly selected pregnant women in their third trimester who have come for at least two antenatal visits:

- At least 70% confirm that a staff member has talked with them individually or offered a group talk that includes information on breastfeeding.
- At least 70% are able to adequately describe what was discussed about two of the following topics: importance of skin-to-skin contact, rooming-in, and risks of supplements while breastfeeding in the first 6 months.

STEP 4. Help mothers initiate breastfeeding within a half-hour of birth.

This Step is now interpreted as:

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.

	YES	NO
4.1 Are babies who have been delivered vaginally or by caesarean section without general anaesthesia placed in skin-to-skin contact with their mothers immediately after birth and their mothers encouraged to continue this contact for an hour or more?	☐	☐
4.2 Are babies who have been delivered by caesarean section with general anaesthesia placed in skin-to-skin contact with their mothers as soon as the mothers are responsive and alert, and the same procedures followed?	☐	☐
4.3 Are all mothers helped, during this time, to recognize the signs that their babies are ready to breastfeed and offered help, if needed?	☐	☐
4.4 Are the mothers with babies in special care encouraged to hold their babies, with skin-to-skin contact, unless there is a justifiable reason not to do so?	☐	☐

Global Criteria - Step Four

Out of the randomly selected mothers with vaginal births or caesarean sections without general anaesthesia in the maternity wards:

- At least 80 % confirm that their babies were placed in skin-to-skin contact with the m immediately or within five minutes after birth and that this contact continued without separation for an hour or more, unless there were medically justifiable reasons.
  (Note: It is preferable that babies remain skin-to-skin even longer than an hour, if feasible, as they may take longer than 60 minutes to be ready to breastfeed)
- At least 80% also confirm that they were encouraged to look for signs for when their babies were ready to breastfeed during this first period of contact and offered help, if needed.
  (Note: The baby should not be forced to breastfeed but, rather, supported to do so when ready. If desired, the staff can assist the mother with placing her baby so he or she can move to her breast and latch when ready)

If any of the randomly selected mothers have had caesarean deliveries with general anaesthesia, at least 50% should report that their babies were placed in skin-to-skin contact with them as soon as the mothers were responsive and alert, with the same procedures followed.

At least 80% of the randomly selected mothers with babies in special care report that they have had a chance to hold their babies skin-to-skin or, if not, the staff could provide justifiable reasons why they could not.

Observations of vaginal deliveries, if necessary to confirm adherence to Step 4, show that in at least 75% of the cases babies are placed with their mothers and held skin-to-skin within five minutes after birth for at least 60 minutes without separation, and that the mothers are shown how to recognize the signs that their babies are ready to breastfeed and offered help, or there are justified reasons for not following these procedures (optional).

STEP 5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

	YES	NO
5.1 Does staff offer all breastfeeding mothers further assistance with breastfeeding their babies within six hours of delivery?	☐	☐
5.2 Can staff describe the types of information and demonstrate the skills they provide both to mothers who are breastfeeding and those who are not, to assist them in successfully feeding their babies?	☐	☐
5.3 Are staff members or counsellors who have specialized training in breast-feeding and lactation management available full-time to advise mothers during their stay in healthcare facilities and in preparation for discharge?	☐	☐
5.4 Does the staff offer advice on other feeding options and breast care to mothers with babies in special care who have decided not to breastfeed?	☐	☐
5.5 Are breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding?	☐	☐
5.6 Are breastfeeding mothers shown how to hand express their milk or given information on expression and advised of where they can get help, should they need it?	☐	☐
5.7 Do mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support from the staff of the healthcare facility, both in the antenatal and postpartum periods?	☐	☐
5.8 Are mothers who have decided not to breastfeed shown individually how to prepare and give their babies feeds and asked to prepare feeds themselves, after being shown how?	☐	☐
5.9 Are mothers with babies in special care who are planning to breastfeed helped within 6 hours of birth to establish and maintain lactation by frequent expression of milk and told how often they should do this?	☐	☐

The Global Criteria for Step 5 are on the next page.

Global Criteria - Step Five

The head of maternity services reports that mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support both in the antenatal and postpartum periods.

Observations of staff demonstrating how to safely prepare and feed breast-milk substitutes confirm that in 75% of the cases, the demonstrations are accurate and complete, and the mothers are asked to give "return demonstrations".

Out of the randomly selected clinical staff members:

- At least 80% report that they teach mothers how to position and attach their babies for breastfeeding and are able to describe or demonstrate correct techniques for both, or, if not, can describe to whom they refer mothers on their shifts for this advice.
- At least 80% report that they teach mothers how to hand express and can describe or demonstrate an acceptable technique for this, or, if not, can describe to whom they refer mothers on their shifts for this advice.
- At least 80% can describe how non-breastfeeding mothers can be assisted to safely prepare their feeds, or can describe to whom they refer mothers on their shifts for this advice.

Out of the randomly selected mothers (including Caesarean):

- At least 80% of those who are breastfeeding report that someone on the staff offered further assistance with breastfeeding within six hours of birth.
- At least 80% of those who are breastfeeding report that someone on the staff offered them help with positioning and attaching their babies for breastfeeding.
- At least 80% of those who are breastfeeding are able to demonstrate or describe correct positioning of their babies for breastfeeding.
- At least 80% of those who are breastfeeding are able to describe what signs would indicate that their babies are attached and suckling well.
- At least 80% of those who are breastfeeding report that they were shown how to express their milk by hand or given written information and told where they could get help if needed.
- At least 80% of the mothers who have decided not to breastfeed report that they have been offered help in preparing and giving their babies feeds, can describe the advice they were given, and have been asked to prepare feeds themselves, after being shown how.

Out of the randomly selected mothers with babies in special care:

- At least 80% of those who are breastfeeding or intending to do so report that they have been offered help to start their breast milk coming and to keep up the supply within 6 hours of their babies' births.
- At least 80% of those breastfeeding or intending to do so report that they have been shown how to express their breast milk by hand.
- At least 80% of those breastfeeding or intending to do so can adequately describe and demonstrate how they were shown to express their breast milk by hand.
- At least 80% of those breastfeeding or intending to do so report that they have been told they need to breastfeed or express their milk 6 times or more every 24 hours to keep up the supply.

STEP 6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

	YES	NO
6.1 Does hospital data indicate that at least 75% of the full-term babies discharged in the last year have been exclusively breastfeed (or exclusively fed expressed breast milk) from birth to discharge or, if not, that there were acceptable medical reasons?	☐	☐
6.2 Are babies breastfed, receiving no food or drink other than breast milk, unless there were acceptable medical reasons or fully informed choices?	☐	☐
6.3 Does the facility take care not to display or distribute any materials that recommend feeding breast-milk substitutes, scheduled feeds, or other inappropriate practices?	☐	☐
6.4 Do mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options, and helped them to decide what was suitable in their situations?	☐	☐
6.5 Does the facility have adequate space and the necessary equipment and supplies for giving demonstrations of how to prepare formula and other feeding options away from breastfeeding mothers?	☐	☐
6.6 Are all clinical protocols or standards related to breastfeeding and infant feeding in line with BFHI standards and evidence-based guidelines?	☐	☐

Global Criteria - Step Six

Hospital data indicate tha t at least 75% of the babies delivered in the last year have been exclusively breastfed or exclusively fed expressed bre ast milk from birth to discharge or, if not, that there were documented medical reasons.

Review of all clinical protocols or standards re lated to breastfeeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.

No m aterials that recommend feeding breast m ilk substitutes , scheduled feeds or other inappropriate practices are distributed to mothers.

The hospital has an adequate facility/space and the necessary equipment for giving demonstrations of how to prepare formula and other feeding options away from breastfeeding mothers.

Observations in the postpartum wards/rooms and any well baby observation areas show that a t least 80% of the babies are being fed only breast milk or there are acceptable medical rea sons for receiving something else.

At least 80% of the randomly selected mothers report that their babies had re ceived only breast milk or expressed or ban ked hum an milk or, if they had rece ived any thing else, it wa s for acceptable medical reasons, described by the staff.

At least 80 % of the random ly selected m others who have decided not to breastfe ed report that the staff disc ussed with the m the vario us feedi ng options and helped them to decide what was suitable in their situations.

At least 80% of the randomly selected mothers with babies in special care who have decided not to breastfeed report that staff has talked with them about risks and benefits of various feeding options.

STEP 7. Practice rooming-in - allow mothers and infants to remain together – 24 hours a day.

	YES	NO
7.1 Do the mother and baby stay together and/or start rooming-in immediately after birth?	☐	☐
7.2 Do mothers who have had Caesarean sections or other procedures with general anaesthesia stay together with their babies and/or start rooming in as soon as they are able to respond to their babies' needs?	☐	☐
7.3 Do mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, unless separation is fully justified?	☐	☐

Global Criteria - Step Seven

Observations in the postpartum wards and any well-baby observation areas and discussions with mothers and staff confirm that at least 80% of the mothers and babies are together or, if not, have justifiable reasons for being separated.

At least 80% of the randomly selected mothers report that their babies have been in the same room with them without separation, or, if not, there were justifiable reasons.

STEP 8. Encourage breastfeeding on demand.

	YES	NO
8.1 Are breastfeeding mothers taught how to recognize the cues that indicate when their babies are hungry?	☐	☐
8.2 Are breastfeeding mothers encouraged to feed their babies as often and for as long as the babies want?	☐	☐
8.3 Are breastfeeding mothers advised that if their breasts become overfull they should also try to breastfeed?	☐	☐

Global Criteria - Step Eight

Out of the randomly breastfeeding selected mothers:

- At least 80% report that they have been told how to recognize when their babies are hungry and can describe at least two feeding cues.
- At least 80% report that they have been advised to feed their babies as often and for as long as the babies want or something similar.

STEP 9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

	YES	NO
9.1 Are breastfeeding babies being cared for without any bottle feeds?	☐	☐
9.2 Have mothers been given information by the staff about the risks associated with feeding milk or other liquids with bottles and teats?	☐	☐
9.3 Are breastfeeding babies being cared for without using pacifiers?	☐	☐

Global Criteria - Step Nine

Observations in the postpartum wards/rooms and any well baby observation areas indicate that at least 80% of the breastfeeding babies observed are not using bottles or teats or, if they are, their mothers have been informed of the risks.

Out of the randomly selected breastfeeding mothers:

- At least 80% report that , as far as they know, their infants have not been fed using bottles with artificial teats (nipples).
- At least 80% report that, as far as they know, their infants have not sucked on pacifiers.

STEP 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

	YES	NO
10.1 Do staff discuss plans with mothers who are close to discharge for how they will feed their babies after return home?	☐	☐
10.2 Does the hospital have a system of follow-up support for mothers after they are discharged, such as early postnatal or lactation clinic check-ups, home visits, telephone calls?	☐	☐
10.3 Does the facility foster the establishment of and/or coordinate with mother support groups and other community services that provide support to mothers on feeding their babies?	☐	☐
10.4 Are mothers referred for help with feeding to the facility's system of follow-up support and to mother support groups, peer counsellors, and other community health services such as primary health care or MCH centres, if these are available?	☐	☐
10.5 Is printed material made available to mothers before discharge, if appropriate and feasible, on where to get follow-up support?	☐	☐
10.6 Are mothers encouraged to see a health care worker or skilled breastfeeding support person in the community soon after discharge (preferably 2-4 days after birth and again the second week) who can assess how they are doing in feeding their babies and give any support needed?	☐	☐
10.7 Does the facility allow breastfeeding/infant feeding counselling by trained mother-support group counsellors in its maternity services?	☐	☐

Global Criteria - Step Ten

The head/director of maternity services reports that:

- Mothers are given information on where they can get support if they need help with feeding their babies after returning home, and the head/director can also mention at least one source of information.
- The facility fosters the establishment of and/or coordinates with mother support groups and other community services that provide breastfeeding/infant feeding support to mothers, and can describe at least one way this is done.
- The staff encourages mothers and their babies to be seen soon after discharge (preferably 2-4 days after birth and again the second week) at the facility or in the community by a skilled breastfeeding support person who can assess feeding and give any support needed and can describe an appropriate referral system and adequate timing for the visits.

A review of documents indicates that printed information is distributed to mothers before discharge, if appropriate, on how and where mothers can find help on feeding their infants after returning home and includes information on at least one type of help available.

Out of the randomly selected mothers at least 80% report that they have been given information on how to get help from the facility or how to contact support groups, peer counsellors or other community health services if they have questions about feeding their babies after return home and can describe at least one type of help that is available.

Compliance with the International Code of Marketing of Breast-milk Substitutes

	YES	NO
Code.1 Does the healthcare facility refuse free or low-cost supplies of breast-milk substitutes, purchasing them for the wholesale price or more?	☐	☐
Code.2 Is all promotion for breast-milk substitutes, bottles, teats, or pacifiers absent from the facility, with no materials displayed or distributed to pregnant women or mothers?	☐	☐
Code.3 Are employees of manufacturers or distributors of breast-milk substitutes, bottles, teats, or pacifiers prohibited from any contact with pregnant women or mothers?	☐	☐
Code.4 Does the hospital refuse free gifts, non-scientific literature, materials or equipment, money or support for in-service education or events from manufacturers or distributors of products within the scope of the Code?	☐	☐
Code.5 Does the hospital keep infant formula cans and pre-prepared bottles of formula out of view unless in use?	☐	☐
Code 6 Does the hospital refrain from giving pregnant women, mothers and their families any marketing materials, samples or gift packs that include breast-milk substitutes, bottles/teats, pacifiers or other equipment or coupons?	☐	☐
Code.7 Do staff members understand why it is important not to give any free samples or promotional materials from formula companies to mothers?	☐	☐

The Global Criteria for Code Compliance are on the following page.

Global Criteria – Code compliance

The head/director of maternity services reports that:

- No employees of manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers have any direct or indirect contact with pregnant women or mothers.
- The hospital does not receive free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers.
- No pregnant women, mothers or their families are given marketing materials or samples or gift packs by the facility that include breast-milk substitutes, bottles/teats, pacifiers, other infant feeding equipment or coupons.

A review of the breastfeeding or infant feeding policy indicates that it uphold the Code and subsequent WHA resolutions by prohibiting:

- the display of posters or other materials provided by manufacturers or distributors of breast-milk substitutes, bottles, teats and dummies or any other materials that promote the use of these products;
- any direct or indirect contact between employees of these manufacturers or distributors and pregnant women or mothers in the facility;
- distribution of samples or gift packs with breast-milk substitutes, bottles or teats or of marketing materials for these products to pregnant women or mothers or members of their families;
- acceptance of free gifts (including food), literature, materials or equipment, money or support for in-service education or events from these manufacturers or distributors by the hospital;
- demonstrations of preparation of infant formula for anyone that does not need them; and
- acceptance of free or low cost breast-milk substitutes or supplies.

A review of records and receipts indicates that any breast-milk substitutes, including special formulas and other supplies, are purchased by the health care facility for the wholesale price or more.

Observations in the antenatal and maternity services and other areas where nutritionists and dieticians work indicate that no materials that promote breast-milk substitutes, bottles, teats or dummies, or other designated products as per national laws, are displayed or distributed to mothers, pregnant women, or staff.

Observations indicate that the hospital keeps infant formula cans and pre-prepared bottles of formula out of view unless in use.

At least 80% of the randomly selected clinical staff members can give two reasons why it is important not to give free samples from formula companies to mothers.

Mother-friendly care

Note: These criteria should be required only after health facilities have trained their staff on policies and practices related to mother-friendly care (see Section 5.1 "Assessors Guide", p. 5, for discussion)

	YES	NO
MF.1 Do hospital policies require mother-friendly labour and birthing practices and procedures, including:		
Encouraging women to have companions of their choice to provide constant or continuous physical and/or emotional support during labour and birth, if desired?	☐	☐
Allowing women to drink and eat light foods during labour, if desired?	☐	☐
Encouraging women to consider the use of non-drug methods of pain relief unless analgesic or anaesthetic drugs are necessary because of complications, respecting the personal preferences of the women?	☐	☐
Encouraging women to walk and move about during labour, if desired, and assume positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother?	☐	☐
Care that avoids invasive procedures such as rupture of the membranes, episiotomies, acceleration or induction of labour, instrumental deliveries, caesarean sections unless specifically required for a complication and the reason is explained to the mother?	☐	☐
MF.2 Has the staff received orientation or training on mother-friendly labour and birthing policies and procedures such as those described above?	☐	☐
MF.3 Are women informed during antenatal care (if provided by the facility) that women may have companions of their choice during labour and birth to provide continuous physical and/or emotional support, if they desire?	☐	☐
MF.4 Once they are in labour, are their companions made welcome and encouraged to provide the support the mothers want?	☐	☐
MF.5 Are women given advice during antenatal care (if provided by the facility) about ways to use non-drug comfort measures to deal with pain during labour and what is better for mothers and babies?	☐	☐
MF.6 Are women told that it is better for mothers and babies if medications can be avoided or minimized, unless specifically required for a complication?	☐	☐
MF.7 Are women informed during antenatal care (if provided by the facility) that they can move around during labour and assume positions of their choice while giving birth, unless a restriction is specifically required due to a complication?	☐	☐
MF.8 Are women encouraged, in practice, to walk and move around during labour, if desired, and assume whatever positions they want while giving birth, unless a restriction is specifically required due to a complication?	☐	☐

The Global Criteria for mother-friendly care are on the following page.

Global Criteria – Mother-friendly care

Note: These criteria should be required only after health facilities have trained their staff on policies and practices related to mother-friendly care.

A review of the hospital policies indicates that they require mother-friendly labour and birthing practices and procedures including:

- Encouraging women to have companions of their choice to provide continuous physical and/or emotional support during labour and birth, if desired.
- Allowing women to drink and eat light foods during labour, if desired.
- Encouraging women to consider the use of non-drug methods of pain relief unless analgesic or anaesthetic drugs are necessary because of complications, respecting the personal preferences of the women.
- Encouraging women to walk and move about during labour, if desired, and assume positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother.
- Care that does not involve invasive procedures such as rupture of the membranes, episiotomies, acceleration or induction of labour, instrumental deliveries, or caesarean sections unless specifically required for a complication and the reason is explained to the mother.

Out of the randomly selected clinical staff members:

- At least 80% are able to describe at least two recommended practices and procedures that can help a mother be more comfortable and in control during labour and birth.
- At least 80% are able to list at least three labour or birth procedures that should not be used routinely, but only if required due to complications.
- At least 80% are able to describe at least two labour and birthing practices and procedures that make it more likely that breastfeeding will get off to a good start.

Out of the randomly selected pregnant women:

- At least 70% report that the staff has told them women can have companions of their choice with them throughout labour and birth and at least one reason it could be helpful.
- At least 70% report that they were told at least one thing by the staff about ways to deal with pain and be more comfortable during labour, and what is better for mothers, babies and breastfeeding.

HIV and infant feeding (optional)

Note: The national BFHI coordination group and/or other appropriate national decision-makers will determine whether or not maternity services should be assessed on whether they provide support related to HIV and infant feeding. See BFHI Section 1.2 for suggested guidelines for making this decision.

	YES	**NO**
HIV.1 Does the breastfeeding/infant feeding policy require support for HIV positive women to assist them in making informed choices about feeding their infants?	☐	☐
HIV.2 Are pregnant women told about the ways a woman who is HIV positive can pass the HIV infection to her baby, including during breastfeeding?	☐	☐
HIV.3 Are pregnant women informed about the importance of testing and counselling for HIV?	☐	☐
HIV.4 Does staff receive training on: ▪ the risks of HIV transmission during pregnancy, labour and delivery and breastfeeding and its prevention, ▪ the importance of testing and counselling for HIV, and ▪ how to provide support to women who are HIV- positive to make fully informed feeding choices and implement them safely?	☐	☐
HIV.5 Does the staff take care to maintain confidentiality and privacy of pregnant women and mothers who are HIV-positive?	☐	☐
HIV.6 Are printed materials available that are free from marketing content on how to implement various feeding options and distributed to mothers, depending on their feeding choices, before discharge?	☐	☐
HIV.7 Are mothers who are HIV-positive or concerned that they are at risk informed about and/or referred to community support services for HIV testing and infant feeding counselling?	☐	☐

Global Criteria – HIV and infant feeding (optional)

The head/director of maternity services reports that:

- The hospital has policies and procedures th at seem adequate concerning p roviding or referring pregnant women for testing a nd counselling for HIV, counselling wo men concerning P MTCT of HIV, providin g indi vidual, private counselling for pregnant women and mothers who are HIV positive on inf ant feeding options, and insuring confidentiality.
- Mothers who are HIV positive or concerned that they are at ris k are referred to c ommunity support services for HIV testing and infant feeding counselling, if they exist.

A review of the infant feeding polic y indicates that it requires t hat HIV-posi tive mothers receive counselling, including i nformation abou t the risks and benefits of various infant feeding options and specific guidance in selecting the options for their situations, supporting them in their choices.

continued on next page

Global Criteria – HIV and infant feeding

(continued from previous page)

A review of the curriculum on HIV and infant feeding and training records indicates that training is provided for appropriate staff and is sufficient, given the percentage of HIV positive women and the staff needed to provide support for pregnant women and mothers related to HIV and infant feeding. The training covers basic facts on:

- The risks of HIV transmission during pregnancy, labour and delivery and breastfeeding and its prevention.
- The importance of testing and counselling for HIV.
- Local availability of feeding options.
- The dangers of mixed feeding for HIV transmission.
- Facilities/provision for counselling HIV positive women on advantages and disadvantages of different feeding options; assisting them in exclusive breastfeeding or formula feeding (note: may involve referrals to infant feeding counsellors).
- How to assist HIV positive mothers who have decided to breastfeed; including how to transition to replacement feeds at the appropriate time.
- How to minimize the likelihood that a mother whose status is unknown or HIV negative will be influenced to replacement feed.

A review of the antenatal information indicates that it covers the important topics on this issue (these include the routes by which HIV-infected women can pass the infection to their infants, the approximate proportion of infants that will (and will not) be infected by breastfeeding; the importance of counselling and testing for HIV and where to get it; and the importance of HIV positive women making informed infant feeding choices and where they can get the needed counselling).

A review of documents indicates that printed material is available, if appropriate, on how to implement various feeding options and is distributed to or discussed with HIV positive mothers before discharge. It includes information on how to exclusively replacement feed, how to exclusively breastfeed, how to stop breastfeeding when appropriate, and the dangers of mixed feeding.

Out of the randomly selected clinical staff members:

- At least 80% can describe at least one measure that can be taken to maintain confidentiality and privacy of HIV positive pregnant women and mothers.
- At least 80% are able to mention at least two policies or procedures that help prevent transmission of HIV from an HIV positive mother to her infant during feeding within the first six months.
- At least 80% are able to describe two issues that should be discussed when counselling an HIV positive mother who is deciding how to feed her baby.

Out of the randomly selected pregnant women who are in their third trimester and have had at least two antenatal visits or are in the antenatal in-patient unit:

- At least 70 % report that a staff member has talked with them or given a talk about HIV/AIDS and pregnancy.
- At least 70% report that the staff has told them that a woman who is HIV-positive can pass the HIV infection to her baby.
- At least 70% can describe at least one thing the staff told them about why testing and counselling for HIV is important for pregnant women..
- At least 70% can describe at least one thing the staff told them about what women who do not know their HIV status should consider when deciding how to feed their babies.

Summary

	YES	NO
Does your hospital fully implement all **10 STEPS** for protecting, promoting, and supporting breastfeeding? (if "No") List questions for each of the 10 Steps where answers were "No":	☐	☐
Does your hospital fully comply with the **Code of Marketing of Breast-milk Substitutes**? (if "No") List questions concerning the Code where answers were "No":	☐	☐
Does your hospital provide **mother-friendly care**? (if "No") List questions concerning mother-friendly care where answers were "No"	☐	☐
Does your hospital provide adequate support related to **HIV-and infant feeding** (if required)? (if "No") List questions concerning HIV and infant feeding where answers were "No":	☐	☐
If the answers to any of these questions in the "Self Appraisal" are "no", what improvements are needed? If improvements are needed, would you like some help? If yes, please describe:		

This form is provided to facilitate the process of hospital self-appraisal. The hospital or health facility is encouraged to study the Global Criteria as well. If it believes it is ready and wishes to request a pre-assessment visit or an external assessment to determine whether it meets the global criteria for Baby-friendly designation, the completed form may be submitted in support of the application to the relevant national health authority for BFHI.

If this form indicates a need for substantial improvements in practice, hospitals are encouraged to spend several months in readjusting routines, retraining staff, and establishing new patterns of care. The self-appraisal process may then be repeated. Experience shows that major changes can be made in three to four months with adequate training. In-facility or in-country training is easier to arrange than external training, reaches more people, and is therefore encouraged.

Note: List the contact information and address to which the form and request for pre-assessment visit or external assessment should be sent.

Appendix C

- **Assessing Policies and Practices in Childcare Centers: A Survey for Childcare Directors**

Rutgers Center for State Health Policy
Assessing Policies and Practices in Childcare Centers
A Survey for Childcare Directors

1. What age groups does your child care center serve?

_____

If the center only serves children 6 years and older, end the interview by thanking the respondent and explaining that we are only studying centers that serve younger children.

2. Does your child care center provide any meals, snacks, or beverages to children attending the facility?

☐ YES
☐ NO

If yes to question 2 ask:

What types of meals do you offer? (Check all that apply)

☐ Breakfast
☐ Lunch
☐ Snack
☐ Dinner / Supper
☐ Beverages
☐ Other _____

If no to question 2, probe

Do you offer any snacks or beverages or any other type of food?

☐ YES
☐ NO

2(i). Do parents provide meals, snacks, and beverages for their children?

☐ YES
☐ NO

If no to all parts of question 2 then ask ONLY questions 4, 7, 8, and 9

3. Does you child care center have a policy to apply nutrition standards that are consistent with the Dietary Guidelines for Americans to all food offered to children at your facility?

☐ YES
☐ NO

If "yes" to question 3 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

☐ YES

☐ NO

c. Please describe the nutrition standards in the policy.

3(i). *If there is a written or informal policy in place ask:* Does this policy apply to meals, snacks, and beverages that parents send with their children?

☐ YES

☐ NO

☐ Parents do not send food with children

4. Does your child care center have a policy that makes water available to children at all times?

☐ YES

☐ NO

If "yes" to question 4 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

□ YES

□ NO

5. Does your child care center ban or limit sugar-sweetened beverages (such as soda, lemonade, and other beverages that are not 100% fruit juice), including flavored/sweetened milk?

□ YES

□ NO

If "yes" to question 5 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

□ YES

□ NO

c. Please describe the policy. (Probe if it is to ban or limit)

5(i) Does you child care center limit the portion size of 100% juice served to children in your facility?

□ YES

□ NO

If "yes" to question 5(i) ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

☐ YES
☐ NO

6. Does your child care center have a policy that limits or prohibits serving less healthy foods or food of minimal nutritional value to children in your facility?

☐ YES

☐ NO

If "yes" to question 6 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

☐ YES

☐ NO

c. Please describe the policy. (Probe limit or prohibit)

7. Does your child care center have a policy in place that states food not be used as a reward for children attending your facility?

☐ YES

☐ NO

If "yes" to question 7ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

☐ YES

□ NO

c. Please describe the policy.

8. Does your child care center have a policy in place that provides support for breastfeeding mothers whose children attend your facility? (eg., accept and provide storage for breast milk; provide private space for expressing breast milk)

□ YES

□ NO

If "yes" to question 8 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

□ YES

□ NO

c. Please describe the policy.

9. Does your child care center have a policy to limit screen time for children 2 years of age or older to no more than 2 hours per day?

□ YES

□ NO

If "yes" to question 9 ask:

a. Is that a federal, state, or local policy or requirement? Probe which one (federal, state, or local)?

b. Is it a written policy?

□ YES

□ NO

c. Please describe the policy.

Appendix D

- **School Wellness Policy Telephone Questionnaire**

The Center for State Health Policy

School Wellness Policy Telephone Questionnaire

1.. Does your school district have a policy to apply nutrition standards that are consistent with the Dietary Guidelines for Americans to all food sold on school campuses during the school day? By all food sold we mean including foods sold a-la-carte in cafeterias, food stores, snack bars, and vending machines

☐ YES
☐ NO

If yes to question 1 ask:

1a. Please describe the nutrition standards.

1b. Are these nutrition standards part of a State policy or requirement that applies to your school district?

1c. Is this part of your school district's wellness policy?

1d. May we have a copy of the written policy (or the school wellness policy, if the nutrition standards are a part of the school wellness policy) [if these are two separate policies, try to obtain a copy of both]?

1e. Do you have any additional policies for food sold in cafeteria, vending machines, school programs and also for food sent by parents?

☐ YES

☐ NO

If yes, please describe the policy.

If no to question 1 ask:

2. Is there any informal policy in place to apply nutrition standards to all food sold (e.g., foods sold in cafeterias and vending machines) on public school campuses during the school day?

☐ YES

☐ NO

If yes to question 2 ask:

2a. Please describe the informal policy

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