

Breastfeeding Committee for Canada (BCC)

The National Authority for the WHO/UNICEF Baby-Friendly™ Initiative (BFI)



Guidelines for WHO/UNICEF Baby-Friendly™ Initiative (BFI) in Canada

The Seven Point Plan and Practice Outcome Indicators For The Protection¹, Promotion and Support of Breastfeeding in Community Health Services (CHS)

March 24,2004

Community Health Services

- include Public/Community Health Departments, Community Health Centres and Ontario Family Health Networks
- apply Population Health Principles
- are publicly funded

The services

- include direct care
- are provided by health professionals

The client base includes

- pre- and/or postnatal women
 - families with children from birth to 2 years and beyond
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¹ Protecting breastfeeding refers to compliance with the provisions of the WHO International Code of Marketing of Breast-Milk Substitutes, and subsequent, relevant WHA Resolutions.

Point 1. Have a written breastfeeding policy that is routinely communicated to all staff and volunteers.

The Community Health Service (CHS) has a written breastfeeding policy that addresses all of *The Seven Point Plan For The Protection, Promotion and Support of Breastfeeding in Community Health Services* and protects¹ breastfeeding.

The senior manager for the community health service is able to locate a copy of the policy and describe how the other staff members and volunteers are made aware of it.

The policy is available so that all staff members caring for mothers and babies can refer to it. The full policy is available for review by women and their families if requested.

The public policy statement (a summary of the policy) is visibly posted in all areas of the community health facility that serve mothers, infants and/or children. The public policy statement is displayed in the language(s) most commonly understood by clients and staff.²

The policy

- ❑ addresses all of the 7 Points by describing practice that
 - ❑ is measurable in terms of the criteria for each of Points 1 - 7, as laid out in these Canadian guidelines
 - ❑ protects, promotes and supports breastfeeding
- ❑ clearly indicates which CHS staff member will act as the point of first referral for mothers experiencing common breastfeeding challenges upon hospital discharge
- ❑ prohibits
 - ❑ promotion of formula or breast milk substitutes
 - ❑ prenatal group instruction on breastmilk substitute use
 - ❑ postnatal group instruction on breastmilk substitute use³
- ❑ indicates that infant feeding education sessions, food, gifts (including pens, writing pads, measuring tapes, etc.) and literature from companies whose products fall within the scope of *The Code* are not permitted
- ❑ provides that educational materials should be impartial and do not endorse company brand names (e.g., by recommending only one brand of breast pump)
- ❑ has been developed in consultation with those using the service and is available to consumers.
- ❑ includes provisions/scope for CHS staff members fostering collaboration with others such as health care providers (including physicians), community groups, local businesses (e.g., provision of a parent room at malls), schools and the media (e.g., World Breastfeeding Week events) in working toward a breastfeeding culture in the community

¹ Protecting breastfeeding refers to compliance with the provisions of the WHO International Code of Marketing of Breast-Milk Substitutes, and subsequent, relevant WHA Resolutions.

² Subject to QC language laws. Not all CLSCs will have policies displayed in French and English.

³ In a mother-infant group context, general questions and answers on infant feeding (such as infant feeding cues, weight gain, burping etc) are anticipated and welcomed. Questions pertaining to the selection or properties of individual breastmilk substitutes or the preparation and use thereof are addressed one-to-one, outside of a group context.

- ❑ is reviewed on a regular basis and includes a mechanism for auditing employee compliance with the policy.

The policy outlines the minimum standards of care. Each CHS is encouraged to strive for best practice through evidenced-based care. Protocols, where they exist, are accurate and evidence-based.

The manager responsible for client programs or services (or alternate) provides the following to the assessment team:

- ❑ a copy of the **written policy**, and a copy of the posted and, if applicable, translated policy.
- ❑ documentation reflecting all staff and volunteers who provide direct care to mothers (pre-and postnatal) and their children have been oriented to the policy . Senior administrative staff (e.g. purchasing department), if applicable, are aware of the provisions of *The Code*,⁴ and how to comply with them. New staff members should receive a copy of the policy during orientation.

The manager responsible for client programs or services (or alternate)

- ❑ shows the assessors where the policy is kept so all staff may easily refer to it in their specific work area
- ❑ points out to assessors during the orientation tour all areas and sites of the CHS where the policy is posted (including all areas where pregnant or breastfeeding mothers might receive care or services)
- ❑ indicates where translations of the policy, if any, are posted
- ❑ describes methods used to audit employee compliance with the policy e.g., annual employee competencies assessment (e.g., by a self-evaluation such as is required by some provincial Nursing Associations, by mentoring or by other means)
- ❑ indicates which group or individual is responsible for monitoring breastfeeding initiation and duration rates
- ❑ indicates which group or individual is responsible for developing initiatives to enhance breastfeeding and disseminate research findings
- ❑ describes the process of policy review
- ❑ outlines how breastfeeding employees are supported (e.g., provision for employees to have the space and time to take a lactation break or use a breast pump)
- ❑ shows evidence of a collaborative policy development process (e.g., committee membership list). Policy development should be multidisciplinary involving consumers, representatives of local breastfeeding support programs (mother-to-mother or peer breastfeeding counsellors), physicians, staff nurses and management personnel.

Staff and volunteers (of a random sample at least 80%) can

- ❑ identify at least 2 items referred to in the CHS policy
- ❑ identify one way to protect breastfeeding.

⁴ “The Code” refers to the International Code of Marketing of Breast-Milk Substitutes. World Health Organization. Geneva, 1981, and all relevant subsequent WHA resolutions.

Point 2. Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy.

Educate health care staff in skills necessary to implement the policy.

The manager responsible for client programs or services (or alternate) reports that

- ❑ **all health care staff having any contact with mothers, infants and/or children** receive education on the implementation of the breastfeeding policy and describes how this instruction is given.
- ❑ **all staff members caring for women and infants** have participated in breastfeeding and lactation management education or, if new, have been oriented on arrival and scheduled for education within six months.

Education of staff is appropriate to their function. For those directly involved with breastfeeding assessment, support and intervention, all of the 7 Points are addressed. For this staff group, at least 18 hours (reflecting the core content as outlined in the UNICEF/WHO “18 hour course”) including 3 hours of supervised clinical instruction is strongly recommended.

A copy of the **curricula or course outline** for education on breastfeeding and lactation management for various disciplines of staff is available for review. A **schedule** for education of new employees exists.

CHS staff members providing direct care (of a random sample, at least 80%)

- ❑ confirm they have received the described education or, if they have been employed in the CHS less than six months, have at least been oriented to the policy
- ❑ are able to correctly answer 4 out of 5 questions on evidence-based breastfeeding care (see: *The Baby-Friendly™ Initiative* Checklist: Breastfeeding Education for Hospital and Community Health Service (CHS) Employees, Physicians and Midwives, Appendices 3, 4, 5).

ORIENTATION:

Note that Point 1 requires orientation to the breastfeeding policy.

Point 2 requires orientation to the basics of breastfeeding (i.e., the skills necessary to implement the policy).

The manager responsible for client programs or services (or alternate) provides

- ❑ an outline of the **orientation program** information for **all** health care professionals in direct contact with mothers and children (including physicians on staff, if any) which includes
 - ❑ the Baby Friendly™ Initiative (The 10 Steps and The 7 Point Plan in action)
 - ❑ the WHO Code and subsequent WHA resolutions
 - ❑ resources available for staff and parents
 - ❑ staff roles in protecting, promoting and supporting breastfeeding
- ❑ documentation of attendance of new staff members at Baby-Friendly™ orientation programs
- ❑ a description of the process for collaboration should mothers voice concerns about receiving conflicting information from health professionals; such a process could be initiated by the CHS staff, community physicians/midwives or others, and facilitates dialogue and the sharing of consistent, current information.

EDUCATION:

Staff should be educated and kept up-to-date, appropriate to their role, in skills needed to care for the breastfeeding dyad. The greatest focus is on those charged with the responsibility of *front line* support. Education will vary depending on the role of the health professional.

Health care professionals providing direct breastfeeding care for women must be able to teach correct position and latch of newborns and hand expression. Nurses, lactation consultants and nutritionists (as appropriate), will have the primary responsibility for supporting breastfeeding women and for helping them to overcome related problems. **Peer supporters, outreach workers or volunteers** providing direct help with breastfeeding must be able to teach correct position and latch of newborns as well as hand expression. Most of this type of teaching should be done in a *hands off* manner. Only in exceptional circumstances should the staff or volunteers latch the baby for the new mother.

Health care professionals who do not offer direct breastfeeding care should have relevant education at the minimum required, similar to the requirements for physicians who do not offer direct breastfeeding care stated below. They should

- ❑ know that *The Code* protects families against commercial pressure
- ❑ know that the BFI protects, promotes and supports breastfeeding families
- ❑ be able to list at least 2 items in the CHS breastfeeding policy
- ❑ be able to identify the professionals to whom mothers experiencing breastfeeding difficulties can be referred for direct breastfeeding care.

Other staff and volunteers who have contact with women and babies, including clerical staff, cleaning and maintenance staff, should be well oriented to the breastfeeding policy.

The manager responsible for client programs or services (or alternate) provides

- ❑ documentation of staff attendance at **breastfeeding education programs**, such as in-service programs, clinical mentorship, conferences, on-line programs, and grand rounds
- ❑ documentation of the schedule for educational programs offered on breastfeeding that are provided for new staff in the first six months of their employment
- ❑ a description of how the education is provided
- ❑ a description of how staff competencies are assessed (this may be by a self-evaluation, as required by some provincial Nursing Associations, by mentoring or by other means)
- ❑ a copy of the **curricula or course outlines** on breastfeeding and lactation management for staff providing direct breastfeeding care that
 - ❑ covers *The Ten Steps and the Seven Point Plan (and BCC BFI Outcomes Indicators)*
 - ❑ reflects the core content as outlined in the UNICEF/WHO “18 hour course”
 - ❑ a program of at least 18 hours is strongly recommended
 - ❑ at least 3 hours of **supervised clinical practice**, including a checklist of the practices covered in Points 3-7 and an assessment of competencies in these practices is also strongly recommended
 - ❑ includes discussion on attitudes and barriers to breastfeeding
 - ❑ includes primary references
- ❑ evidence that **physicians** working in the CHS who care for mothers and children receive

information on the physician's role in protecting, promoting and supporting breastfeeding (and evidence of outreach to independent practitioners, perhaps through the Medical Health Officer Newsletter or Perinatal Care Committee, Grand Rounds, etc. on the physician's role); the role includes

- ❑ discussing breastfeeding during prenatal visits (see Point 3; Step 3)
- ❑ discussing with mothers the benefits of breastfeeding and human milk (including banked donor milk, if available)⁵, and the risks of artificial feeding (see Point 4; Step 6)
- ❑ practising in a manner that ensures mothers and babies remain together throughout the hospital stay, unless separation is medically indicated (thus being in support of early initiation of breastfeeding and skin-to-skin contact, photo therapy at the bedside and physical exam of the baby at the bedside) (see Point 3; Steps 4 & 7)
- ❑ referring mothers experiencing difficulties to those providing direct breastfeeding care (see Point 4; Steps 5 & 10)
- ❑ understanding the medical indications for supplementation (including current information on medications and breastfeeding women) (see Point 4; Step 6) and management of common situations (e.g., a reluctant or sleepy baby, jaundice or hypoglycaemia) (see Point 4; Step 5)
- ❑ applying the WHO International Code and subsequent WHA resolutions to Physician practice (e.g., not distributing breastmilk substitute company literature or samples of breastmilk substitutes to breast or artificial feeding mothers) (see Points 4 & 5; Steps 6 & 9)
- ❑ incorporating ways to promote and support breastfeeding in hospital and in their offices (Point 7; Step 10).

Staff members and health professionals who offer direct breastfeeding care (of a random sample, at least 80%)

- ❑ confirm that they have received the described education or, if they have been on staff less than six months, have been oriented to the breastfeeding policy and lactation management
- ❑ are able to correctly answer 4 out of 5 questions on breastfeeding care and medical indications for supplementation
- ❑ are able to demonstrate effective teaching of position and latch
- ❑ are able to describe effective hand expression of breastmilk.

Staff members who do not offer direct breastfeeding care (of a random sample, at least 80%)

- ❑ know that *The Code* protects families against commercial pressure
- ❑ know that the BFI protects, promotes and supports breastfeeding families
- ❑ can list at least 2 items in the CHS breastfeeding policy
- ❑ can identify to whom mothers experiencing breastfeeding difficulties may be referred for direct breastfeeding care.

Refer to the appendices for the Baby-Friendly™ Initiative Checklists

- ❑ *Breastfeeding Education for Hospital and Community Health Services (CHS) Employees, Physicians and Midwives.*
- ❑ *Documenting Staff Education: Commitment to Education.*

⁵ At this time there is only one Human Milk Bank in Canada. With education, and a demand for more donor human milk, it is anticipated that more human milk banks will be established.

Point 3. Inform pregnant women and their families about the benefits and management of breastfeeding.

The manager responsible for client programs or services (or alternate) reports that breastfeeding counseling is given to at least 80% of women using the CHS. If no prenatal clinic or service exists, links with the community prenatal programs should be documented.

A **written description** of the minimum requirement for prenatal education should be available. Prenatal discussions should cover the importance of exclusive breastfeeding for 6 months, the benefits of breastfeeding, the hazards of not breastfeeding, the risks of artificial feeding, infant feeding cues, and basic breastfeeding management, including the value of 24 hour rooming in, early skin-to-skin contact and cue-based feeding.

Pregnant women at 32 weeks or more gestation who are using the prenatal service (of a random sample, at least 80%):

- confirm that the benefits of breastfeeding have been discussed with them
- can list at least 2 benefits of breastfeeding and 3 breastfeeding management topics
- confirm they have received no group education on the use of breastmilk substitutes.

The manager responsible for client programs or services (or alternate) provides

- written curriculum for the prenatal education including
 - the importance of exclusive breastfeeding during the first 6 months from birth, and continued breastfeeding beyond 6 months
 - the benefits of breastfeeding and human milk as well as information about donor milk banking
 - the risks associated with the use of breastmilk substitutes
 - basic breastfeeding management (see Point 4; Steps 4-10)
 - the benefits of skin-to-skin care (including skin-to-skin care for premature infants).
- a record showing that both group instruction and opportunities for one-to-one discussion on the above curriculum are provided to pregnant women and families using these services (an individual checklist of topics is helpful)
- samples of all written educational materials made available to women on breastfeeding which are current, accurate and separate from information on the feeding of breastmilk substitutes.

Educational materials for pregnant women and families provide accurate information and specifically address

- the basics of breastfeeding
 - position and latch (see appendix - teaching sheet)
 - hand expression of breastmilk
 - infant feeding cues
 - expected normal feeding behaviors (frequency of feeds, output)
 - the benefits of skin-to-skin care, especially for premature infants
 - exclusive breastfeeding, recommended for the first 6 months from birth
- breastfeeding support

- community professional follow-up
- mother-to-mother support groups
- employment rights of pregnant and breastfeeding women (the accommodation of breastfeeding women in the workplace).

These educational materials

- are available in the languages spoken by clients
- are reviewed on a regular basis
- have clear graphics or pictures
- acknowledge original authors.

These educational materials

- do not promote the use of breastmilk substitutes or any products covered under *The Code*
- are not produced by companies whose products are covered under *The Code*.

Written materials (such as booklets, leaflets, handbooks and text books with general information of pregnancy, parenting, infant feeding and child care) should not be given to women prenatally if they contain information on the feeding of breastmilk substitutes. This information should be provided in a separate document only to those specific women who have made an informed decision not to breastfeed.

Women and their families who have made an informed decision not to breastfeed will have available to them written materials on the feeding of breastmilk substitutes that are

- current, appropriate and separate from breastfeeding information
- free of promotional material that does not comply with *The Code*.

Note: Information required to make an informed decision includes

- benefits of breastfeeding for baby, mother, family and community
- health consequences for baby and mother of not breastfeeding
- risks and costs of breastmilk substitutes
- contraception compatible with breastfeeding, including the Lactation Amenorrhea Method
- *The 10 Steps* and *The 7 Point Plan*
- the right of women to be accommodated in the workplace during pregnancy and breastfeeding
- difficulty of reversing the decision once breastfeeding is stopped (see The BFI in CHS Implementation Guide p.19 for more information).

Pregnant women who have achieved 32 weeks or more gestation and who are using the prenatal service (of a random sample, at least 80%) confirm that

- they are given sufficient opportunity to discuss their infant feeding decision with knowledgeable staff
- the benefits of breastfeeding have been discussed with them and are able to list at least 2 benefits from the following:
 - infant nutrition
 - mother infant bond
 - protection - including the role of colostrum as the only food needed initially

- health of the mother
- they have received no group education on the use of infant formula.

The same women are able to describe

- at least 2 of the following breastfeeding management topics:
 - importance of rooming-in
 - the importance of skin-to-skin care
 - how to ensure an adequate milk supply
 - importance of feeding on demand, including feeding cues
 - correct position and latch
 - hand expression of breastmilk
 - the signs of successful breastfeeding (how to tell that their infant is doing well). *[The key points are that nipple is free of pain or trauma; nipple is not distorted at the end of a feed; elements of a good latch are evident; rhythmic suckle with nasal swallow sound are evident; baby ends feed satisfied; 8 or more breastfeeds occur per 24 hours; 6-8 wet diapers and 2 – 5 stools occur in 24 hours (age appropriate, first 6 weeks); fontanel is not sunken; skin is elastic and oral mucous membranes are moist; weight gain of 120 - 240 g/week (4 – 8 oz/week)) occurs in first 3 months].*

Observations in all areas of the CHS confirm that there is not any promotional material that does not comply with *The Code*.

Point 4. Support mothers to establish and maintain exclusive breastfeeding to 6 months.

Point 4 includes 3 phases of the continuum of care:

- I. The Initiation and Establishment of Breastfeeding
- II. Initiation and Maintenance of Lactation if Mother and Baby Are Separated
- III. Exclusive Breastfeeding to 6 Months

I. THE INITIATION AND ESTABLISHMENT OF BREASTFEEDING

Early hospital discharge (before establishment of milk production) is routine in many Canadian hospitals. In the event of early discharge

- professionals in CHSs accomplish some of the required teaching to establish breastfeeding
- a reliable and formal system is in place for communicating a mother's breastfeeding progress to community health employees as she moves from hospital to the community
- families with unresolved breastfeeding issues are discharged from hospital with written plans that support their breastfeeding goals, and they know how follow-up with an appropriate health care provider or health care service will occur.

After discharge from the hospital or birthing centre, all mothers are aware of and can access assistance with breastfeeding within 48 hours. Mothers and families are aware of the signs that their infant is breastfeeding effectively, and they know when to seek help.

CHS Staff Members

- with breastfeeding knowledge and skills are available during normal office hours (Telephone help is available outside of office hours; a service may be negotiated with the hospital, other professional service or peer support groups)
- frequently assess the effectiveness of breastfeeding, the adequacy of the baby's hydration and the baby's milk intake
- effectively teach mothers positioning and latch as well as hand expression of breastmilk.

Mothers

- receive timely assistance and anticipatory guidance with breastfeeding
- understand cue-based feeding.

As the goal is for mothers to be able to latch their babies independently, it is important to request permission to touch the mother or baby and to take a *hands off* approach as much as is possible. *Hands on* is only used after asking permission and when additional help is necessary.

CHS Staff Members who offer direct care (of a random sample, at least 80%)

- are observed demonstrating effective teaching of positioning and latching
- are observed demonstrating effective teaching of hand expression of breastmilk
- ensure that mothers are able to assess for adequate hydration and milk intake

- ❑ discuss breastfeeding progress with mothers at each contact, unless a medical or other emergency takes precedence (a quick checking-in can determine whether all is going well and can reinforce the staff member's willingness to offer information and help toward the goal of successful breastfeeding).

Mothers (from a randomly selected sample, at least 80% who are breastfeeding)

- ❑ confirm that **assistance with breastfeeding** was available within 48 hours after discharge (from the CHS, a breastfeeding clinic and/or midwife, etc.), the most common concerns being position, latch, importance of skin-to-skin and/or typical infant behaviours
- ❑ report that they were offered timely help with **positioning and latch** by CHS staff
- ❑ demonstrate correct position and latch, which is observed when
 - ❑ the baby's body is aligned close to and facing the mother, unencumbered by blankets etc
 - ❑ the baby's mouth is wide open
 - ❑ the baby's chin is touching the breast
 - ❑ more of the areola below the nipple is in the baby's mouth (requiring the mouth be off-centre with greater cover by the lower jaw such that the nipple is high in baby's mouth).
 - ❑ the baby's cheeks are full and no dimpling is evident
 - ❑ the baby begins rhythmic bursts of sucking
 - ❑ the nipples are not distorted after the feeding
 - ❑ the mother's hand supports baby's neck and shoulders (without pushing the baby's head on to the breast)
- ❑ describe effective **hand expression** of breastmilk
- ❑ confirm that **if their baby was unable to breastfeed**, they were shown how to express breastmilk and encouraged to express breastmilk at least 6 – 8 times in 24 hours, and/or have detailed written information on hand expression, use of breast pumps and storage and handling of breastmilk.
- ❑ are aware of the **signs of successful breastfeeding** (such as signs of adequate infant hydration and milk intake)
- ❑ relate that no restrictions have been placed on the frequency or length of their baby's breastfeeds (assuming the baby is breastfeeding effectively) A minimum number of feedings can be suggested (i.e., at least 8 in 24 hours) but not a maximum number.
- ❑ relate the knowledge that recommendations are to breastfeed their babies whenever they are hungry or as often as the baby wants
- ❑ relate the knowledge that they may initiate a breastfeed by awakening their babies during periods of light sleep (babies awakened from deep sleep may not feed properly) since frequent breastfeeding can enhance effective latching and minimize the likelihood of normal breast fullness becoming engorgement
- ❑ relate cue-based⁶ feeding

⁶ Cue-based feeding – frequent, unrestricted feedings based on the baby's cues. Babies nurse best “on cue” before they reach the crying state, and for as long and as often as they are interested. The infant “cues” for [initiating] feeding include: rapid eye movements, waking, stretching, stirring, hand-to-mouth activity, and oral activities such as sucking, licking, rooting.

- ❑ has been described to them by a CHS staff member, including expected normal feeding behaviors,⁷ frequency of feeds, output and infant states and their implications for feeding
- ❑ is well enough understood that they can identify two feeding cues such as waking, mouthing and rooting (crying being a last resort and not a first cue of hunger, see behaviors described in footnote 8)
- ❑ relate they are aware of the benefits of keeping their babies near, including at night
- ❑ relate they have received accurate information about the benefits of and the contraindications to co-sleeping, including bed-sharing (refer to the BFI in CHS Implementation Guide Appendix 12 for more information)
- ❑ relate they have been given anticipatory guidance about possible breastfeeding problems, their solutions and the available resources that will assist with breastfeeding
- ❑ relate that staff have discussed breastfeeding progress at most contacts with them.

The manager responsible for client programs or services (or alternate)

- ❑ confirms that no restrictions are placed on the frequency or length of breastfeeds
- ❑ describes the infant feeding cues taught by staff
- ❑ identifies that skin-to-skin contact is encouraged
- ❑ confirms parents are invited to hold and settle their babies when and if painful procedures (such as blood tests, or immunizations) are necessary for the infant (since helping mothers to settle distressed or fussy babies empowers their role and assists families to cope with babies).

II. MAINTENANCE OF LACTATION IF MOTHER AND BABY ARE SEPARATED

Breastfeeding mothers know how to hand express and store breastmilk, and how to maintain lactation during separation from their babies.

Staff can teach effective hand expression, appropriate storage and handling of breastmilk and maintenance of lactation during separation of mother and baby.

Mothers (of a random sample of mothers, at least 80% of those breastfeeding)

- ❑ know how to hand express and store breast milk and/or are provided with detailed, written information on hand expression, use of breast pumps and storage and handling of breastmilk
- ❑ are given appropriate information on how to maintain lactation during separation, during illness or while at work or school.

Staff (of a random sample, at least 80%)

- ❑ report that they teach mothers how to hand express breastmilk
- ❑ are able to describe an acceptable technique for hand expression of breastmilk
- ❑ can identify effective and appropriate pumps
- ❑ facilitate access to effective pumps for use at home

⁷ See appendix 5: Initiation of Lactation: Anticipated Behaviors and Feeding Patterns

- ❑ can describe appropriate storage and handling of expressed breastmilk
- ❑ can relate the information given to mothers about maintaining lactation during separation, during illness or while at work or school.

III. EXCLUSIVE BREASTFEEDING TO 6 MONTHS

Foods or drinks other than breastmilk are not recommended until the age of 6 months. All babies are assessed on an individual basis as to the timing of the introduction of complementary foods.

Supplements to breastmilk are given to babies younger than 6 months only when

- ❑ acceptable medical reasons apply
- ❑ parents make a fully informed decision to supplement.

Mothers whose babies are younger than 6 months (from a random sample at least 80% of those in contact with the CHS) can

- ❑ confirm they have been advised not to feed foods or drinks other than breastmilk for about 6 months, unless medically indicated
- ❑ confirm breastfeeding is recommended for 2 years and beyond, with exclusive breastfeeding during the first 6 months from birth
- ❑ correctly state an appropriate age for the introduction of complementary foods and drinks
- ❑ offer an adequate explanation of why it is advisable to exclusively breastfeed for 6 months (i.e., delay the introduction of complementary foods) including knowledge of the benefits and the risks of not doing so
- ❑ confirm they have received information to help them make an informed decision regarding the use of breastmilk substitutes, the use of pacifiers or artificial nipples and the difficulty of reversing the decision not to breastfeed
- ❑ confirm they have received information on and an opportunity for discussion about all contraception methods compatible with breastfeeding, including the Lactation Amenorrhea Method (LAM)
- ❑ if they are feeding breastmilk substitutes, report they were shown (or someone checked they knew) how to prepare a bottle of breastmilk substitute
- ❑ confirm they have received current information on how to access community-based breastfeeding and parenting support.

The manager responsible for client programs or services (or alternate) confirms that

- ❑ breastfeeding is recommended for 2 years and beyond, with exclusive breastfeeding during the first 6 months from birth
- ❑ mothers receive information supporting informed decision making regarding the use of breastmilk substitutes, the use of pacifiers or artificial nipples and the difficulty of reversing the decision not to breastfeed
- ❑ nurses assess breastfeeding during postpartum visits and document rationale when supplements have been recommended for breastfeeding infants

- ❑ nurses have provided to all mothers information and discussion on contraception compatible with breastfeeding, including the Lactation Amenorrhea Method (LAM)
- ❑ mothers receive current information on how to access community-based breastfeeding and parenting support.

Staff Members providing direct breastfeeding care (from a random sample, at least 80%)

- ❑ are able to articulate the benefits of exclusive breastfeeding during the first 6 months from birth (see definition on page 17) and the risks of feeding supplements to breastmilk
- ❑ inform mothers of the above benefits and risks, with emphasis on ensuring that families make informed decisions (BFI Assessors will not penalize the hospital or community health service when families have made a truly informed decision.)
- ❑ have a clear understanding of the medical reasons where supplements are required (see *Acceptable Medical Reasons for Supplementation on page 17*)
- ❑ recommend supplementing with the mothers own breastmilk, or donor human milk (where available) wherever possible
- ❑ document the rationale when supplements have been recommended, including medical reason and evidence of parental consent
- ❑ effectively help breastfeeding mothers of fussy babies by encouraging more frequent, effective breastfeeding, skin-to-skin cuddling, rocking and carrying
- ❑ can answer breastfeeding management questions concerning challenges that occur beyond the first few weeks (e.g., biting, breast refusal, slow growth rates and growth spurts)
- ❑ can list recommended alternatives for soothing infants instead of artificial nipples and pacifiers since
 - ❑ soothers are not recommended during the time of establishing breastfeeding
 - ❑ information is available and can be provided to support alternate ways to soothe a fussy baby
- ❑ understand that nipple shields should be used only in extremely rare situations. If they are used, the rationale for their use should be documented, and the mother should be supported in weaning the baby off the shield
- ❑ relate knowledge that, when babies require any feeds in addition to breastfeeds, bottles and artificial nipples are not routinely recommended
- ❑ Do not distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

WRITTEN MATERIALS PROVIDED TO MOTHERS AND FAMILIES

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| <ul style="list-style-type: none"> ❑ encourage breastfeeding for 2 years and beyond, with exclusive breastfeeding during the first 6 months from birth ❑ are current, accurate and appropriate (as well as compliant with <i>The Code</i>) ❑ reflect current information on how to access community-based breastfeeding and parenting support. |
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ON-SITE OBSERVATIONS BY ASSESSORS

Where services are provided at a central site, observations by BFI assessors occur for at least two hours. Assessors will constantly observe their surroundings e.g. during interviews with mothers and in the common areas of the site. They will also ask to observe other areas (including storage areas) of the CHS.

For any healthy **breastfed babies younger than 6 months** being fed food or drink other than breastmilk, mother and staff are asked to indicate why (non-breastfeeding dyads are identified). Where supplements have been recommended by staff for breastfeeding babies, an acceptable medical reason is given in at least 80% of the cases.

If babies are observed using soothers, their mothers indicate that they have

- made an informed decision and
- have been provided with information about feeding cues and
- alternative methods of calming babies.

During observations of common areas (including storage areas) there is evidence that the CHS complies with the WHO International Code of Marketing of Breast Milk Substitutes:

- breastmilk substitutes, bottles, artificial nipples and pacifiers are not promoted, displayed or distributed to mothers or staff in the facility
- patient teaching materials including posters, calendars, videos and teaching sheets should be free of commercial endorsements including breastmilk substitutes, bottles, soothers and artificial nipples
- equipment including weight graphs, office supplies and measuring tapes are free of commercial endorsements.

Acceptable Medical Reasons for Supplementation⁸

A few medical indications in a maternity facility may require that individual infants be given fluids or food in addition to, or in place of, breastmilk.

It is assumed that severely ill babies, babies in need of surgery, and very low birth weight infant will be in a special care unit. Their feeding will be individually decided, given their particular nutritional requirements and functional capabilities, though breastmilk is recommended whenever possible. These infants in special care are likely to include:

- ❑ *infants with very low birth weight (less than 1,500 grams) or who are born before 32 weeks gestational age*
- ❑ *infants with severe dysmaturity with potentially severe hypoglycaemia, or who require therapy for hypoglycaemia, and who do not improve through increased breastfeeding or by being given breastmilk.*

For babies who are well enough to be with their mothers on the maternity ward, there are very few indications for supplements. In order to assess whether a facility is inappropriately using fluids or artificial feeds, any infant receiving supplements must have been diagnosed as:

- ❑ *infants whose mothers are severely ill (for example with psychosis, eclampsia, or shock)*
- ❑ *infants with inborn errors of metabolism (e.g. galactosaemia, phenylketonuria, maple syrup urine disease)*
- ❑ *infants with acute water loss, for example during phototherapy for jaundice, if increased breastfeeding cannot provide adequate hydration.*
- ❑ *infants whose mothers are taking medication which is contraindicated when breastfeeding (e.g. cytotoxic drugs, radioactive drugs, anti-thyroid drugs other than propylthiouracil).*

When breastfeeding has to be temporarily delayed or interrupted, mothers should be helped to establish or maintain lactation, for example through manual or hand-pump expression of milk, in preparation for the moment when breastfeeding may be begun or resumed.

In addition

- ❑ **infants who have not regained birth weight at two to three weeks of age or who have insufficient weight gain, when increased breastfeeding cannot provide adequate intake.**

Exclusive Breastfeeding is defined in the Baby-Friendly™ Initiative in Community Health Services Canadian Implementation Guide 2002 as follows:

No food or liquid other than breastmilk, not even water, is given by the biological mother, health care provider or family member/ supporter, with the exception of undiluted drops or syrups consisting of vitamin and mineral supplements or medicines (adapted from WHO/ UNICEF, 2001).

⁸ from the Annex to the Global Criteria for Baby Friendly Hospitals [UNICEF, 1992]

(Breastfeeding definitions: an Appendix will be added when endorsed by the BCC).

Point 5. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

The manger responsible for client programs or services (or alternate)

- ❑ confirms that staff offer ongoing **anticipatory guidance and discussion** for parents on continued breastfeeding and on the introduction of complementary foods
- ❑ provides documentation of **ongoing data collection** on breastfeeding duration, and describes how this data is used to improve both service to community families and breastfeeding outcomes.

At the time of reassessment, assessors will look for increased duration of breastfeeding in the community.

CHS staff who provide direct care to families confirm that they offer ongoing anticipatory guidance and discussion for parents on sustaining breastfeeding.

Women with babies aged 3 months or older confirm that they have received anticipatory guidance and an opportunity to discuss sustained breastfeeding with CHS staff.

The manager responsible for client programs or services (or alternate)

- ❑ confirms that staff offer **ongoing anticipatory guidance and discussion** for parents on
 - ❑ the benefits for mother and child of continued breastfeeding for two years and beyond
 - ❑ the introduction of available and safe complementary foods from 6 months (see BFI in CHS Implementation Guide Point 5, p 27, and Appendix 13, p 74)
 - ❑ women's rights to accommodations in the workplace that support and sustain breastfeeding
 - ❑ the value of continuation of co-sleeping (including bed sharing)
 - ❑ contraception compatible with breastfeeding, including the Lactation Amenorrhea Method
 - ❑ overcoming breastfeeding challenges that may occur with the growing child
- ❑ provides copies of any **printed information** (and translations, if available) regarding the above that is made available to families, health care providers, breastfeeding support groups and other community resource providers and this printed information
 - ❑ is accurate
 - ❑ has clear graphics or pictures (where applicable)
 - ❑ provides **evidence of outreach**
 - ❑ to families in the community who do not routinely or regularly use the CHS, to ensure that the above information is accessible to them in a timely fashion e.g., printed information (including translations), liaison with community institutions or peer support groups
 - ❑ to community health care providers to share the above information as widely as possible
- ❑ provides **documentation of ongoing data collection on breastfeeding duration** (to establish breastfeeding trends over time) which may be accomplished by
 - ❑ conducting chart reviews

- ❑ reviewing telephone interviews
- ❑ reviewing interviews at immunization clinics, postpartum drop-ins, mother-infant groups
- ❑ collecting information from national, provincial or regional surveys
- ❑ provides **evidence that this data is used to improve both service to families in the community and breastfeeding outcomes.**

At the time of reassessment, assessors will look for increased duration of breastfeeding in the community.

CHS staff who provide direct care to families (of a random sample, at least 80%)

- ❑ confirm they offer ongoing **anticipatory guidance and discussion** for parents on
 - ❑ the benefits for mother and child of continued breastfeeding for two years and beyond
 - ❑ the introduction of available and safe complementary foods from 6 months and natural weaning
 - ❑ women's rights to accommodations in the workplace that support and sustain breastfeeding
 - ❑ the value of continuation of co-sleeping (including bed sharing)
 - ❑ contraception compatible with breastfeeding
- ❑ describe how and when the above mentioned anticipatory guidance is offered
- ❑ can list at least 2 benefits of continued breastfeeding for two years and beyond
- ❑ can answer 4 out of 5 questions on the introduction of complementary foods and the normal course of weaning (such as give the appropriate age for introducing complementary foods; offer an adequate explanation as to why mothers should wait until 6 months of age; explain the normal course of baby-led weaning; state the appropriate behaviours in mother-led weaning)
- ❑ can list at least 2 accommodations in the workplace which would support women to sustain breastfeeding
- ❑ can list 2 benefits of continued co-sleeping (including bed sharing)
- ❑ can list at least 2 methods of contraception which are compatible with breastfeeding
- ❑ can answer one question on LAM.

Within Canada's multi-cultural society, it is anticipated that the women and families using the CHS are a broadly representative, multi-lingual, multi-cultural sample of women, representative of the community at large. Where the CHS targets a specific population (e.g., an ethnic, religious or socio-economic group), there are strategies to reach all members of the client group.

Women with babies aged 3 months age or older (of a randomly selected sample, at least 80%) confirm that they have received anticipatory guidance and an opportunity to discuss with CHS staff

- ❑ the benefits for mother and child of continued breastfeeding for two years and beyond
- ❑ the introduction of available and safe complementary foods from 6 months
- ❑ women's rights to accommodations in the workplace that support and sustain breastfeeding
- ❑ the value of continuation of co-sleeping (including bed sharing)
- ❑ contraception compatible with breastfeeding
- ❑ the normal course of weaning.

The following are Baby-Friendly™ in CHS assessment indicators:

A community health service will be eligible for Baby-Friendly™ assessment when a minimum of 75% of mothers within the geographic boundary of that service are breastfeeding upon entry into the service.

As The Baby-Friendly™ Initiative emphasizes the continuum of care; the time of entry into the CHS is deemed to coincide with discharge from hospital.

Note that hospitals considering moving forward with assessment need “an exclusive breastfeeding rate from birth to discharge which exceeds the national average or is at least 75% (whichever is larger).” (UNICEF Guidelines, March 1992, Part II Self Appraisal; BCC, Using the BFHI Self-Appraisal Tool, 1999.) A strong collaboration between hospital and CHS underpins the BFI.

1. Percentage of babies who are breastfeeding:

<p>Babies breastfeeding upon transition from hospital to community care (i.e., upon discharge from hospital or birthing unit):</p>	<p>At least 75%. This includes breastfeeding babies who are</p> <ul style="list-style-type: none"> <input type="checkbox"/> exclusively breastfed <input type="checkbox"/> being supplemented for medical reasons <input type="checkbox"/> being supplemented due to parental informed decision.
<p>Babies breastfeeding on first contact with CHS (ideally within 48 hours of hospital discharge or as per Provincial or Territorial standards):</p>	<p>At least 73 % - no more than a 2% drop-off from hospital discharge. (A greater drop off might indicate that an earlier first contact is needed.)</p> <p>This number may be greater as it includes</p> <ul style="list-style-type: none"> <input type="checkbox"/> breastfed babies whose mothers delayed initiation in hospital and are now breastfeeding.
<p>Babies breastfeeding or breastmilk feeding at 2 weeks of age:</p>	<p>At least 70% - no more than a 5% drop off from entry into the service.</p> <p>This number may be greater as it includes.</p> <ul style="list-style-type: none"> <input type="checkbox"/> babies who have resumed breastfeeding thanks to CHS support <input type="checkbox"/> breastfed babies whose mothers delayed initiation and are now breastfeeding <input type="checkbox"/> babies whose families have moved into the service area.

2. Ongoing data collection to establish breastfeeding trends over time is documented. (Breastfeeding definitions: an Appendix will be added when endorsed by the BCC).

Point 6. Provide a welcoming atmosphere for breastfeeding families.

The manager responsible for client programs or services (or alternate)

- ❑ confirms that breastfeeding is welcome everywhere in the CHS and that facilities for privacy are available on request, where possible
- ❑ confirms that all staff and volunteers refrain from the distribution of breastmilk substitutes, products or promotional items that fall within the scope of *The Code*
- ❑ describes how the CHS assesses client access and satisfaction with the service.

CHS staff who offer direct breastfeeding care and CHS staff or volunteers who do not offer direct breastfeeding care

- ❑ describe how they make mothers feel welcome to breastfeed at all sites
- ❑ do not distribute any items that fall within the scope of *The Code*.

During on-site observations

- ❑ appropriate facilities for comfortable breastfeeding exist (in public and private areas)
- ❑ signs welcoming breastfeeding are displayed in all waiting areas
- ❑ the CHS complies with the provisions of *The Code*.

The manager responsible for client programs or services (or alternate)

- ❑ confirms that breastfeeding is welcome everywhere, including all public areas of the service and affiliated sites
- ❑ confirms that facilities for privacy are available on request, where possible
- ❑ confirms that signs addressing the above two issues are posted in all public areas of the CHS and affiliated sites
- ❑ describes how staff support mothers to feel welcome to breastfeed at all sites
- ❑ confirms that all staff and volunteers refrain from the distribution of breastmilk substitutes, products or promotional items including coupons and vouchers that fall within the scope of *The Code*
- ❑ describes the method(s) at the CHS for assessing client access and satisfaction with the service (e.g., whether clients using the service are representative of all the cultural groups that reside in the area; where certain groups are under-represented, how this is addressed; where the CHS targets a specific population (such as an ethnic, religious or at-risk group) whether strategies are in place to reach all members of that client group or community).

Staff who provide direct breastfeeding care (of a random sample, at least 80%)

- ❑ describe how they make mothers feel welcome and how they facilitate breastfeeding at all sites
- ❑ do not distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

CHS staff or volunteers who do not offer direct breastfeeding care (of a random sample, at least 80%)

- ❑ correctly explain the CHS's policy regarding welcoming breastfeeding in public places
- ❑ describe how they make mothers feel welcome and how they facilitate breastfeeding at all sites
- ❑ are aware of the private area (where possible) for breastfeeding and other mothers
- ❑ do not distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

During observations of at least 2 hours in common or any other area of any of the CHS sites, BFI assessors observe that

- ❑ breastfeeding is welcomed in all public areas
- ❑ an appropriate sign is displayed in all waiting areas encouraging breastfeeding
- ❑ waiting and other areas have comfortable seating for breastfeeding
- ❑ private areas are available for breastfeeding, if possible
- ❑ the CHS is free from professional support materials sponsored by companies which manufacture and market items covered under *The Code*
- ❑ the CHS is free from promotion of breastmilk substitutes, bottles, artificial nipples and pacifiers
- ❑ no distribution is made of breastmilk substitutes or any products which fall within the scope of *The Code*.

Point 7. Promote collaboration between health care providers, breastfeeding support groups and the local community.

Mothers confirm an effective transition from hospital, birthing centre or midwife to CHS and know at least one way to access breastfeeding support outside of office hours.

The manager responsible for client programs or services (or alternate) describes an adequate procedure for the transition from hospital to CHS and describes the liaison and collaboration between the CHS and the local community to promote/support breastfeeding.

CHS staff who provide direct breastfeeding care describe effective transition for all mothers from hospital, birthing centre or midwife to CHS and can locate the written support materials provided to mothers.

Mothers (of a random sample, at least 80% of those who are breastfeeding)

- confirm an effective transition from hospital, birthing centre or midwife to the CHS
- confirm their plans for infant feeding were explored and follow-up support after hospital discharge was provided by the CHS staff
- state they were aware of professional and lay support services in the community
- know which CHS staff members they can contact for help with breastfeeding and know how to access those staff members
- describe one thing that has been recommended to ensure they can be linked to a breastfeeding mother-to-mother support group or peer breastfeeding counsellors
- relate appropriate information about accessing breastfeeding support out of office hours.

The manager responsible for client programs or services (or alternate)

- describes an adequate procedure for the transition from hospital, birthing center or midwife to CHS staff, to ensure the continuum of care. This includes
 - evidence of strong liaison and communication between hospital(s) and CHS in discharge planning
 - an awareness of hospital policies
 - the provision of written information prior to hospital discharge on the signs of successful breastfeeding and where and from whom to seek assistance for concerns
 - a system of follow-up support for all breastfeeding mothers after they are discharged (e.g., early postnatal or lactation clinic check-up, home visit, telephone call, referral to a mother support group, etc.)
- describes at least one way in which mothers are referred to local **community breastfeeding support** groups or peer breastfeeding counselors (e.g., through written material or counseling) and can provide
 - a copy of the written information for mothers about these services
 - documentation showing routine and specific referral of mothers to the community breastfeeding support groups

- ❑ provides evidence of **liaison and collaboration between the CHS and the local community** to promote/support breastfeeding (e.g., family physicians, pediatricians, midwives, Pregnancy Outreach Programs, Canada Prenatal Nutrition Programs, schools, employers and businesses, media, World Breastfeeding Week)
- ❑ provides documentation of consultation with voluntary breastfeeding support in the development of policies and guidelines concerning breastfeeding.

Staff (of a random sample, at least 80%)

- ❑ describe effective transition for all mothers from hospital, birthing centre or midwife to CHS
- ❑ demonstrate a clear line of communication with the local hospitals and mother-to-mother support groups to provide a "seamless" continuum of breastfeeding care
- ❑ describe how women are referred to mother-to-mother support groups or peer breastfeeding counsellors
- ❑ know where the written support materials provided to mothers are kept.