

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 Ten Steps and Practice Outcome Indicators For Baby-Friendly™ Hospitals

March 24, 2004

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

The health care facility has a written breastfeeding policy that addresses all of *The Ten Steps to Successful Breastfeeding* and protects¹ breastfeeding.

The senior manager for the institution and/or senior manager in the maternity area is able to locate a copy of the policy and describe how the other staff members 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 hospital that serve mothers, infants and/or children, particularly in the maternity unit, infant care areas, infant special care unit and prenatal care services. The public policy statement is displayed in the language(s) most commonly understood by patients and staff.²

The policy

- ❑ addresses all of the 10 Steps by describing practice that
 - ❑ is measurable in terms of the criteria for each of Steps 1 - 10, as laid out in these Canadian guidelines
 - ❑ protects, promotes and supports breastfeeding
- ❑ clearly indicates which Community Health Service (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 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)

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.

- events) in working toward a breastfeeding culture in the community
- 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 facility 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 hospital 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 hospital 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.

Step 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 is able to describe 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 10 Steps 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.

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 facility 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 Step 1 requires orientation to the breastfeeding policy.

Step 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

hospital or 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, midwives 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 hospital 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, 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 care of the breastfeeding dyad 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 Steps 3-10 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** (including independent practitioners with privileges as well as those on staff, residents and interns) 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.

All physicians in the above sample who do not teach effective position, latch or hand expression

- ❑ 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

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.

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

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 hospital 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.*

Step 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 pregnant women using the facility. If no prenatal clinic or service exists, links with the community prenatal programs should be documented. Prenatal women hospitalized longer than 48 hours should be provided with breastfeeding information.

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 breast milk
 - 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 hospital, including those areas used by pregnant women and their families confirm that there is not any promotional material that does not comply with *The Code*.

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

Babies are placed **skin-to-skin** with their mothers.⁶ An unhurried environment and unlimited skin contact facilitate a successful first feeding. Mothers are supported to breastfeed in response to their babies' cues.

Mothers on the maternity unit (from a random sample, at least 80%) should confirm that within a half-hour of birth (or in the first hour after a caesarean birth) they were given their babies to hold with skin contact, for at least 30 minutes, and offered help by a staff member to initiate breastfeeding.

Observations in the delivery/birthing room of up to ten deliveries confirm this practice.

Mothers are given their babies to hold immediately after birth, with skin-to-skin contact, for at least 30 minutes:

Mothers (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) **indicate they were given their babies to hold immediately after birth** (a medical emergency, as defined by the attending physician, delays this step)

- ❑ Placing the newly born infant on the mother's abdomen is the first opportunity for skin-to-skin contact. Staff can support this practice by using positive language (e.g. telling parents we need to "clean baby up" suggests that baby is dirty)
- ❑ For caesarean births, epidural anaesthesia facilitates early skin-to-skin contact between mother and infant to establish breastfeeding. The placing of baby skin-to-skin and assistance with initiating breastfeeding is the same as described above for the vaginally delivered baby
- ❑ If procedures such as resuscitation are required, the baby is returned and placed skin-to-skin as soon as baby is stable
- ❑ Other procedures, such as weighing, are delayed until completion of the first feeding
- ❑ The environment should be unhurried, allowing mothers to terminate skin-to-skin contact when and if they wish. It is the staff's responsibility to support and encourage mothers to hold their babies skin-to-skin for prolonged periods.
- ❑ If the mother terminates skin-to-skin contact before 30 minutes the hospital is not penalized. The assessor will assess whether the mother was fully informed regarding this choice.
- ❑ If the mother must be transferred to a different area before the baby has completed this first feeding or the mother has not indicated she wishes to terminate skin-to-skin contact, transfer should be done by stretcher or wheel chair with skin-to-skin contact maintained.

Mothers report that they were offered help within the first hour to latch their babies.

- ❑ initiating breastfeeding does not mean forcing baby to breast.
- ❑ the first breastfeed may not necessarily take place within the first half-hour, but usually does within the first two hours. This highlights the goal of avoiding separation of mother and baby after birth, in order that breastfeeding may be baby-led.

During observations in the birthing suite, the above practices are seen.

⁶Skin-to-skin means the naked baby is dried after birth and placed on his/her mother's naked chest. A warm blanket can be placed over both mother and baby.

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

Postpartum mothers (from a random sample of all mothers including those with caesarean deliveries, at least 80%) report

- nursing staff offered further assistance with breastfeeding within six hours of delivery.

These mothers (at least 80% of those breastfeeding)

- demonstrate correct positioning and latch of their own babies
- report that they were shown how to express their milk or given written information on expression and/or advised where they could get help, should they need it.

Mothers with babies in special care, where applicable, (of a random sample, at least 80%) confirm

- assistance with initiating lactation within 6 hours of birth
- instruction on the maintenance of lactation by frequent expression of breast milk

Staff on duty on maternity units (from a random sample, at least 80%)

- report that they teach mothers positioning/latch
- report that they teach mothers techniques for hand expression of breastmilk.
- demonstrate correct teaching of positioning/latch with one mother on the unit.
- describe an acceptable technique for hand expressing breastmilk that they teach to mothers.

This step encompasses two circumstances:

- I. Initiation and establishment of breastfeeding of infants rooming in with their mothers
- II. Initiation and maintenance of lactation if mother and baby are separated

I. INITIATION OF AND ESTABLISHMENT OF BREASTFEEDING

After the initial breastfeeding (or attempt), all mothers are assisted further with breastfeeding in the first six hours postpartum.

Mothers and families

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

Staff

- with breastfeeding knowledge and skills are available all the time
- 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.

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 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.

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.

Staff Members who offer direct care (from 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 **further assistance** with breastfeeding was provided by nursing staff within 6 hours postpartum, 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 staff
- ❑ are able to 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 before discharge and/or have detailed, written information on hand expression, use of breast pumps and storage and handling of breastmilk. Information should be reader friendly, correct and effective.
- ❑ confirm that **if their baby was unable to breastfeed**, that they were shown how to express milk within 6 hours of delivery and encouraged to express breastmilk at least 6-8 times in 24 hours. Hand expression is often more effective than a mechanical pump for expressing colostrum, especially in the first 24 hours
- ❑ report that if **discharged before breastfeeding is established**, they know how further help will be provided in the community.

II. INITIATION AND MAINTENANCE OF LACTATION IF MOTHER AND BABY ARE SEPARATED

The initiation and maintenance of lactation if mother and baby are separated:

- ❑ mothers who have been or are separated from their babies should be given extra support and information about establishing breastfeeding with their baby. Mothers with ill babies are under a great deal of stress and require support in hospital and the community.
- ❑ mothers whose babies are in **special care** should be shown how to initiate and maintain breastmilk supply through frequent expression – at least 6-8 times in 24 hours. They also need to know how to store breast milk, where to obtain equipment and how to clean it.

Breastfeeding Mothers know

- ❑ how to hand express and store breastmilk
- ❑ how to maintain lactation during separation, during illness or while at work or school.

Staff

- ❑ teach effective hand expression of breastmilk
- ❑ describe appropriate storage and handling of expressed breastmilk
- ❑ describe maintenance of lactation during separation of mother and baby.

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

- ❑ confirm that **if their baby was unable to breastfeed**, they were shown how to express colostrum within 6 hours of delivery and encouraged to express breastmilk at least 6-8 times in 24 hours. Hand expression is often more effective than a mechanical pump for expressing colostrum, especially in the first 24 hours
- ❑ describe effective **hand expression** of breastmilk before discharge and/or have written information on hand expression, use of breast pumps and storage and handling of breastmilk. Information should be reader friendly, correct and effective.
- ❑ report they have been 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 expressing breastmilk
- ❑ can describe appropriate storage and handling of expressed breastmilk
- ❑ can identify effective and appropriate pumps
- ❑ facilitate access to effective pumps for use at home
- ❑ relate the information given to mothers about maintaining lactation during separation, during illness or while at work or school.

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

Postpartum mothers (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) confirm that their babies have received no food or drink other than breast milk in the hospital.

During **observations**, 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.

No promotion for infant foods or drinks other than breastmilk should be displayed or distributed to mothers, staff or others within the facility.

Purchase arrangements for formula, specialty formulas and fortifiers used in hospital, including those for use in Paediatric and Special Care Units are reviewed.

Postpartum mothers (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) confirm

- ❑ their babies have not received food or drink other than breast milk in the hospital
- ❑ they have been advised not to feed foods or drinks other than breastmilk for about 6 months, unless medically indicated
- ❑ 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
- ❑ breastfeeding is recommended for 2 years and beyond, with exclusive breastfeeding during the first 6 months from birth.

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

- ❑ describes acceptable medical reasons when breastfeeding babies receive other food or drink
- ❑ confirms that nurses assess breastfeeding and the charts of any breastfed infants receiving supplements must include documentation of acceptable medical reasons
- ❑ confirms that rates of supplementation for breastfed babies are audited regularly for amounts given and reason for supplementation
- ❑ confirms that 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
- ❑ confirms breastfeeding is recommended for 2 years and beyond, with exclusive breastfeeding during the first 6 months from birth
- ❑ confirms that none of the staff or volunteers distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

Staff members providing direct breastfeeding care (from a random sample of at least 80%)

- ❑ have a clear understanding of the medical reasons where supplements are required (see *Acceptable Medical Reasons for Supplementation on page 19*)
- ❑ 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
- ❑ are able to articulate the benefits of exclusive breastfeeding⁷ during the first 6 months from birth, the benefits of continued breastfeeding for 2 years and beyond 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 to use supplements)
- ❑ do not distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

Staff or volunteers who do not offer direct breastfeeding care

- ❑ do not distribute breastmilk substitutes, products or promotional items that fall within the scope of *The Code*.

OBSERVATIONS by BFI assessors on the maternity units occur for at least two hours.

Assessors will constantly observe their surroundings e.g. during interviews with mothers, in the nurseries (where applicable) and in the common areas of the facility, including gift shops and storage areas.

- ❑ **Healthy, term babies being fed food or drink other than breast milk** (supplements)
 - ❑ mothers and babies who are breastfeeding are identified
 - ❑ mothers and staff are asked to indicate why breastfed babies are being supplemented
 - ❑ the mother has made an informed decision to use a supplement
 - ❑ an acceptable medical reason is charted in at least 80% of the cases where supplements for breastfed babies have been recommended by staff.
- ❑ **Separation of mothers and babies**
 - ❑ to facilitate babies receiving only breast milk, babies should stay with their mothers. Assessors will pay careful attention to any baby not with his/her mother
 - ❑ if separated for medical reasons, the separation is of the shortest possible duration. Where possible, the separated baby who is cuing to feed is returned to his or her mother.

⁷ See page ... for exclusive breastfeeding definition

- ❑ **During observations** BFI assessors observe
 - ❑ 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
 - ❑ breastfeeding is welcomed in all public areas.

Purchase of formula, specialty formulas and fortifiers used in hospital:

The BFI assessors review purchase arrangements for formula, specialty formulas and fortifiers used in hospital, including those for use in Paediatric and Special Care Units to confirm that the hospital

- ❑ does not promote products covered by *The Code*
- ❑ does not profit in a way that could influence care from a contract with a company whose products are covered by *The Code*

A review of invoices and interviews with the purchase agent should confirm that

- ❑ breastmilk substitutes and bottle feeding supplies are purchased in the same manner as other pharmaceuticals (no less than standard discount or 80% of cost)
- ❑ volumes purchased are realistic and in line with the small amount of formula consumption anticipated
- ❑ no free or low cost supply arrangement is attached to the formula contract, and no refunds on competitor contracts.

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).

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

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

Step 7. Practice rooming in - mothers and infants remain together - 24 hours a day.

Postpartum mothers should be observed to have their babies bed-sharing or in cots by their bedside unless separation is clinically indicated. A family member or friend is encouraged and welcomed to stay and support the mother throughout her hospital stay (including overnight).

Mothers with babies not in special care nurseries (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) report that from birth, or from the time they were able to respond to their babies in the case of general anesthetic, their infants have stayed with them in the same room day and night.

- ❑ Mothers and babies should remain together throughout the hospital stay with all teaching and examinations occurring at the mother's bedside or with her present.
- ❑ Parents are invited to hold and settle their babies when and if painful procedures (such as blood tests) are necessary.
- ❑ Helping mothers settle distressed or fussy babies empowers their role and helps prepare families to cope with babies at home.

Mothers with babies not in special care nurseries (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding)

- ❑ report that from birth (or from the time they were able to respond to their babies in the case of general anesthetic), their infants have stayed with them in the same room day and night
- ❑ report they were encouraged to have a support person stay with them, including overnight
- ❑ 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).

Staff members (from a random sample, at least 80%) report

- ❑ 24 hour rooming-in and family support are actively facilitated.

Step 8. Encourage breastfeeding on demand.

Encourage baby-led or cue-based⁹ feeding.

Mothers of healthy, term babies (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) report

- ❑ no restrictions have been placed on the frequency or length of their babies' breastfeeds (assuming the baby is breastfeeding effectively)
- ❑ they have been advised to breastfeed their babies whenever they are hungry or as often as the baby wants and that they should wake their babies for breastfeeding if the babies sleep too long¹⁰ or the mother's breasts are overfull
- ❑ a staff member has described infants feeding cues.

The manager on the maternity unit

- ❑ confirms no restrictions are placed on the frequency or length of breastfeeds
- ❑ describes the feeding cues taught by the staff.

Encourage baby-led or cue-based feeding. There should be no restrictions placed on the frequency or length of breastfeeds. Staff should be aware of the importance of frequent breastfeeding and encourage mothers to breastfeed according to their baby's cues.

Mothers of healthy, term babies (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding)

- ❑ 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 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 the knowledge that recommendations are to breastfeed their babies whenever they are hungry or as often as the baby wants
- ❑ relate cue-based¹¹ feeding

⁹ 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.

¹⁰ Education is provided to staff regarding normal newborn behavior and feeding patterns in order that evidence-based guidance is provided to the family (this should include the implication of infant states on ability to feed).

¹¹ 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 staff member, including expected normal feeding behaviors,¹² 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 12)
- ❑ are aware of the **signs of successful breastfeeding** (such as signs of adequate infant hydration and milk intake)
- ❑ relate that staff discuss breastfeeding progress at most contacts with them
- ❑ relate they have been given **anticipatory guidance** about possible breastfeeding problems, their solutions and available resources that will assist with breastfeeding.

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).

Staff members (from a random sample, at least 80%)

- ❑ describe differences in expected newborn variables in the first 24 hours compared to the next 24 hours in regard to the infant's
 - ❑ behavior
 - ❑ output, and
 - ❑ feeding frequency
- ❑ ensure that mothers are able to assess adequate hydration and milk intake
- ❑ discuss breastfeeding progress with mothers at each contact, unless a medical or other emergency takes precedence. (This may be a quick check-in question if all is going well, and demonstrates that staff value breastfeeding and are willing to offer information and help.)
- ❑ offer **anticipatory guidance** about possible breastfeeding problems and their solutions and available resources that will assist with breastfeeding.

¹² See appendix 5: Initiation of Lactation: Anticipated Behaviors and Feeding Patterns

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

Postpartum mothers whose babies are not in a special care nursery (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) report that, to the best of their knowledge, their infants have not been fed using bottles with artificial nipples (also called artificial teats) nor are given pacifiers by the staff.

The manager responsible for client programs or services (or alternate) reports that breastfeeding infants are not given bottles with artificial nipples or pacifiers.

During two-hour **observation periods** on the maternity unit infants are not observed using artificial nipples. If artificial nipples or soothers are observed, mothers indicate that they have made an informed decision and that the artificial nipple or soother was not given or recommended by the staff.

Postpartum mothers whose babies are not in a special care nursery (of a random sample including those with caesarean deliveries, at least 80% of those who are breastfeeding) report that, to the best of their knowledge

- their infants have not been fed using bottles with artificial nipples
- have not been given pacifiers by the staff.

Observations:

- Mothers of babies (not in special care) observed using soothers** indicate they have
 - made an informed decision and
 - have been provided with information about feeding cues and
 - alternative methods of calming babies.
- Documentation in patient's charts** should reflect that
 - breastfeeding assessment has been completed
 - information has been provided to parents regarding the use of artificial nipples.

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

- describe recommended alternatives for soothing infants, such as encouraging more frequent, effective breastfeeding, skin-to-skin cuddling, rocking and carrying, instead of the use of artificial nipples and pacifiers since
 - soothers are not provided or 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.

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

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.

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

Planning for an effective transition from hospital or birthing centre to Community Health Services (CHS) includes:

- assessment of all mothers-baby dyads prior to discharge for effectiveness of breastfeeding
- provision of written information prior to discharge on the signs of successful breastfeeding and where to seek assistance for concerns
- referral to community resources
- established community resources such as mother-to mother (peer) support groups, and other services such as baby clinics, telephone help lines, home visits from community health nurses, and breastfeeding clinics
- evidence of strong liaison and communication between hospital and community facilities.

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

- confirm that their plans for infant feeding after discharge were explored
- report that the hospital or community health service will provide follow-up support after hospital discharge
- know which CHS staff members they can contact for help with breastfeeding and know how to access those staff members
- are aware of professional and lay support services in the community
- describe one thing that has been recommended to ensure that 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 (where applicable) 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 both hospital and CHS 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 counsellors (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 hospital 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
- ❑ describes the method for assessing client satisfaction with the service.

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.

WRITTEN MATERIALS PROVIDED TO MOTHERS AND FAMILIES

- | |
|---|
| <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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