



The National Authority for the Baby-Friendly Initiative

## The BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services

### Introduction

The **Baby-Friendly Hospital Initiative** (BFHI) was initiated by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991. The BFHI has a "simultaneous focus on the role of health services in protecting, promoting, and supporting breastfeeding and on the use of breastfeeding as a means of strengthening the contribution of health services to safe motherhood, child survival and primary health care in general" (45<sup>th</sup> World Health Assembly-WHA-1992). The BFHI is embodied in the *Ten Steps to Successful Breastfeeding*, also called the *Global Criteria*, and the *International Code of Marketing of Breast-milk Substitutes* describing the minimum standard of care for newborn infants (including information supporting infants in the special care nursery as appropriate). The BFHI was revised, updated and expanded by WHO/ UNICEF in 2009, based on current research and experience in many countries.

The **Innocenti Declaration 2005** called on all governments to "revitalize the BFHI, maintaining the Global Criteria as the minimum requirement for all facilities, expanding the Initiative's application to include maternity, neonatal and child health services and community-based support for lactating women and caregivers of young children."

In Canada, the BFHI is called the **Baby-Friendly Initiative (BFI)**, reflecting the continuum of care. The **Breastfeeding Committee for Canada (BCC) BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services** describe the international standards for the WHO/UNICEF Global Criteria within the Canadian context.

**The following key applies to each of the 10 Steps in this document:**

WHO/ UNICEF statement of the Step.
Statement of the Step reflecting the Canadian context.
Global criteria/ outcome indicators are outlined regarding facility policy, mothers, staff, health care providers (hcp) (including nurses, physicians/midwives), volunteers and documentation, with additional information available in the relevant appendices.

For BFI assessment purposes, the facility's documentation and curricula are reviewed during the pre-assessment phase. For the final external assessment, random samples of mothers<sup>1</sup>, staff, health care providers (hcp's) and volunteers are interviewed and observations are made to confirm the outcomes have been achieved at least 80% of the time. More information about the BFI and the assessment process may be found on the BCC website ([www.breastfeedingcanada.ca](http://www.breastfeedingcanada.ca)).

As the BFI is a continuous quality improvement strategy, this document will be reviewed regularly.

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<sup>1</sup> A note on gender Inclusion and the language of this document: Although we use terms such as mother, father, and family in this document, a person-centred approach should be given to all individuals in our care.

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**Step 1**

**WHO** Have a written breastfeeding policy that is routinely communicated to all health care staff.

**Canada** Have a written infant feeding policy that is routinely communicated to all staff, health care providers and volunteers.

**Mothers** and clients of the facility are aware of the policies and practices supporting breastfeeding.

**The manager** identifies the infant feeding policy, or areas within the facility's policy statements, which specifically delineates adherence to *The 10 Steps to Successful Breastfeeding (The Ten Steps)* and protects breastfeeding by adhering to the *WHO International Code of Marketing of Breast-Milk Substitutes (The WHO Code)* and subsequent, relevant *WHA Resolutions*. The manager also identifies practices that support mothers who are not breastfeeding. The manager describes how health care providers (hcp), staff and volunteers are oriented to the policies and practices. The manager describes the process for policy implementation, review and auditing compliance with the policy. The manager describes how staff members who are breastfeeding are supported to sustain breastfeeding.

**Staff, health care providers, students on placements in the facility and volunteers** are oriented to the policy, and new staff members receive a copy of the policy and all are able to access the policy.

**Documents**, including the facility's written infant feeding policy and other existing policies, protocols and clinical guidelines, indicate that the facility provides care to mothers and babies consistent with *The 10 Steps* and protects breastfeeding by adhering to *The WHO Code* and subsequent, relevant *WHA Resolutions*. Documents show evidence that the policy development process is multidisciplinary with representation by all stakeholders. Documents show evidence of support for staff members who are breastfeeding.

**Written information for clients** includes easily understood summaries of the policies and practices (or *The 10 Steps* and *The WHO Code*), in the languages most commonly understood. The summary of the policy is visible in areas of the facility that serve pregnant women, mothers, infants and/or children and is posted on the facility's website.

See Appendix 1: Policy Checklist

<b>Step 2</b>	
<b>WHO</b>	<b>Train all health care staff in the skills necessary to implement the policy.</b>
<b>Canada</b>	<b>Ensure all staff, health care providers and volunteers have the knowledge and skills necessary to implement the infant feeding policy.</b>
<p><b>The manager</b> shows records of orientation of all staff, hcps, volunteers, and students to the breastfeeding policy and attendance at breastfeeding education programs, either during their employment, prior to being hired and as continuing education. If new and without prior relevant breastfeeding education, individuals must be scheduled for education within six months.</p> <p>The manager is aware that, for staff and hcps providing direct breastfeeding care<sup>2</sup>, at least 20 hours of education, including three hours of supervised clinical instruction, is strongly recommended. Staff and hcps also receive education on how to assist mothers to make informed decisions regarding infant feeding and to provide support for mothers not breastfeeding to choose what is acceptable, feasible, affordable, sustainable, and safe (AFASS) in her circumstances. The manager describes how staff and hcps can attain necessary education and skills and how competencies are assessed.</p> <p><b>Staff and hcps</b> confirm that they have received education appropriate to their role, or if new, have been oriented to the infant feeding policy and practices. All staff and hcps identify that <i>The 10 Steps</i> and <i>The WHO Code</i> protect, promote and support breastfeeding and can correctly answer questions on breastfeeding protection, promotion, and support appropriate to their role.</p> <p><b>Documents:</b> The written curricula or course outlines for orientation and education adequately address <i>The 10 Steps</i> and <i>The WHO Code</i>, appropriate to the role of the staff and hcps.</p> <p>The following records are available:</p> <ul style="list-style-type: none"> <li>• record of orientation of staff and hcps to breastfeeding policy and practices</li> <li>• record of attendance of staff and hcps at education programs</li> <li>• schedule for education of new staff</li> <li>• evidence of ongoing competency validation.</li> </ul> <p>See Appendix 2.1: Education and Orientation Checklist  Appendix 2.2: Breastfeeding Education for Hospital and Community Health Service Staff and HCPs  Appendix 2.3: Support for Mothers using Human Milk Substitutes Checklist</p>	

<sup>2</sup> Direct breastfeeding care includes any of the following: breastfeeding education, assessment, support, intervention and follow-up. Peer support counsellors benefit from breastfeeding education to facilitate the mother-to-mother peer relationship.

**Step 3**

**WHO Inform pregnant women and their families about the benefits and management of breastfeeding.**

**Canada Inform pregnant women and their families about the importance and process of breastfeeding.**

**Pregnant women** (at 32 weeks or more gestation) who use a prenatal service and who have had two or more prenatal visits or classes, confirm that they are given sufficient opportunity to discuss their infant feeding decisions with knowledgeable staff. They also confirm that the importance of exclusive breastfeeding has been discussed with them. These women can describe the importance of breastfeeding (at least two items) and the importance of skin-to-skin contact, in addition to two of the following: exclusivity of breastfeeding, risks of non-medically indicated supplementation, responsive/cue-based feeding, position/latch, rooming-in, and sustained breastfeeding. These women confirm they have received no group education on the use of human milk substitutes. Hospitalized pregnant women confirm they have received information appropriate to their needs.

**In a community health service, the manager** describes health promotion and community outreach strategies to increase public awareness and support of breastfeeding, and the creation of a breastfeeding culture in the community. The manager shows liaison with the local hospital(s) and collaboration regarding the development of the prenatal curriculum. If the facility refers families to other agencies for prenatal classes, the content should be consistent with the principles of the Baby-Friendly Initiative.

**In a hospital or birthing centre, the manager** shows that breastfeeding information is provided to at least 80% of pregnant women using the facility's perinatal services. The manager shows liaison with the community prenatal programs and collaboration regarding the development of the prenatal curriculum.

**Staff and hcps** providing prenatal education confirm that they have received breastfeeding education as outlined in Step 2.

**Documents: A written curriculum for prenatal education** used by the hospital and/or the community health service and **written information for prenatal clients** (such as booklets, leaflets, handbooks, social media, websites (including videos and YouTube channels) and text books with general information on pregnancy, parenting, infant feeding, and child care) provide accurate, evidence-based information. They are free of information on the feeding of human milk substitutes. Women who have made an informed decision not to breastfeed receive written materials on the feeding of human milk substitutes that is current, appropriate, and separate from breastfeeding information. All written information is free of promotional material for products or companies that fall within the scope of *The WHO Code* and subsequent, relevant WHA Resolutions.

See Appendix 3: Prenatal Education Checklist

<b>Step 4</b>	
<b>WHO</b>	<b>Help mothers initiate breastfeeding within a half-hour of birth. WHO 2009: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.</b>
<b>Canada</b>	<b>Place babies in uninterrupted skin-to-skin<sup>3</sup> contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes. Encourage mothers to recognize when their babies are ready to feed, offering help as needed.</b>
<p><b>In the hospital or birthing centre:</b></p> <p><b>Postpartum mothers</b> report that, unless there were medical indications for delayed contact, their baby was placed skin-to-skin immediately after birth (vaginal or caesarean birth without general anaesthesia) or as soon as the mother was responsive or alert (after caesarean birth with general anaesthesia). This occurred for an uninterrupted period of at least 60 minutes, or until the completion of the first feed, or for as long as the mother wished. These mothers confirm that they were encouraged to look for signs that their baby was ready to feed and that they were offered assistance as needed.</p> <p>Mothers with babies in special care report that they were able to hold their baby skin-to-skin as soon as mother and baby were stable unless there were medical indications for delayed contact.</p> <p>All mothers report that they had been informed prenatally of the importance of skin-to-skin contact and were encouraged to discuss this with staff and hcps.</p> <p>Mothers transferred to a different area (e.g. by stretcher or wheelchair) confirm that skin-to-skin contact was maintained as long as mothers wished even after completion of the first feeding. When the baby was well but the mother was ill or unavailable, mothers confirm that skin-to-skin contact with another support person of her choice (commonly her partner) was encouraged. Families receive information on how to provide skin-to-skin care safely.</p> <p><b>The manager</b> confirms that skin-to-skin care is initiated immediately after birth unless separation is medically indicated, and describes how this practice is monitored.</p> <p><b>Staff and hcps</b> confirm that routine observations and monitoring of the mother and baby (temperature, breathing, colour and tone) continue throughout the period of skin-to-skin care. The baby is removed only if medically indicated or requested by the mother, and this is recorded in the baby's chart.</p> <p><b>Documents</b> show that skin-to-skin care remains unhurried and uninterrupted for at least one hour or until the completion of the first breastfeed, unless there is a recorded medical indication for separation.</p> <p>Routine procedures, monitoring and measurements are delayed until after the first breastfeed. Medications required by baby are given while the baby is on mother's chest, preferably near the end of the first breastfeed to decrease pain.</p> <p><b>Written information for clients</b> outlines information consistent with the issues cited above.</p>	

<sup>3</sup> The term "skin-to-skin care" is used for full term infants while the phrase "kangaroo care" is preferred when addressing skin-to-skin care with preterm babies.

**In the community health service:**

**Mothers** report that they had been given information during pregnancy about the importance of skin-to-skin contact and were encouraged to discuss this with staff and hcps. Families report that they have been shown how to safely position their babies for skin-to-skin care.

**Managers, staff, and hcps** participate in educational and social marketing activities to promote immediate and uninterrupted skin-to-skin care whether the infant is breastfed or not and include information for partner.

**Written information for clients** outlines information consistent with the issues cited above.

See Appendix 4: Birth and Skin-to-Skin Care Checklist

<b>Step 5</b>	
<b>WHO</b>	<b>Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.</b>
<b>Canada</b>	<b>Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.</b>
<p><b>This step encompasses three circumstances:</b></p> <ol style="list-style-type: none"> <li>I. Initiation and establishment of breastfeeding of infants rooming-in with their mothers</li> <li>II. Initiation and maintenance of lactation if mother and baby are separated</li> <li>III. Anticipatory guidance for mothers in the hospital and community</li> </ol> <p><b>In the hospital or birthing centre:</b>  <b>Postpartum mothers</b> report that they were offered further assistance with breastfeeding within six hours of birth and at appropriate subsequent intervals.  Observations of feedings are completed as needed and at least once per shift.</p> <p><b>In the community health service:</b>  <b>Mothers discharged from hospital or birthing centre</b> confirm that assistance with breastfeeding concerns is available within 24 hours. Routine follow up is accessible within 48 hours after discharge for all mothers (care may be provided by the hospital, CHS, a breastfeeding clinic and/or midwife, etc.).  Mothers report that they were offered timely help with positioning and latch and that feeding was assessed. Ongoing information and assistance is available as needed throughout the breastfeeding experience.</p> <p><b>In hospitals and community health services:</b>  <b>Mothers</b> describe hand expression of their milk and have written information on expression and/or were advised where they could get help, should they need it.  Mothers explain responsive, cue-based feeding<sup>4</sup>.  Mothers are aware of the signs that their infant is breastfeeding effectively, and they know when to seek help should they need it.  Mothers have written information on available, knowledgeable support persons (health professional and peer support).</p> <p><b>In addition, mothers:</b></p> <ul style="list-style-type: none"> <li>• <b>who are breastfeeding</b> demonstrate effective positioning and latch. They relate they have been given age-appropriate anticipatory guidance about possible breastfeeding concerns, their solutions and available resources that will assist with breastfeeding</li> </ul>	

<sup>4</sup> Responsive feeding recognizes that successful breastfeeding is a sensitive, reciprocal relationship between a mother and her child. Breastfeeding can be used to feed, comfort and calm babies. Feeds can be initiated when babies show feeding cues, when they are distressed, when they are lonely, when the mother's breasts feel full or when she would just like to sit down and rest. Breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding. UKBFI (<https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/responsive-feeding-infosheet/>)

- **who have made the decision not to breastfeed, or who elected to supplement their babies** with human milk substitutes **for non-medically indicated reasons** report that
  - they received information to support an informed decision<sup>5</sup>
  - were assisted to choose what is acceptable, feasible, affordable, sustainable, and safe (AFASS)
  - were instructed about correct preparation, storage and feeding of human milk substitutes. Principles of responsive, cue-based feeding<sup>6</sup> are also included.
- **with babies in special care, or mother with babies who are unable to breastfeed, or who are separated from their babies during illness, or while at work or school,** confirm that they received instruction on the maintenance of lactation by frequent expression of milk (beginning within the first hour of birth and at least eight times in 24 hours to establish and maintain lactation), how to store and handle milk, how to feed their milk to their baby, where to obtain equipment and how to clean it.

**In hospitals and community health services:**

**The manager** describes a reliable and formal system in place to ensure the continuity of care, and for communication between hospital and CHS staff and hcps regarding a mother's prenatal breastfeeding concerns, and her breastfeeding progress postpartum.

The manager confirms that mothers who have never breastfed, or who have previously encountered challenges with breastfeeding, receive additional attention and support both in the prenatal and postpartum periods.

**Staff and hcps** demonstrate teaching of effective positioning/latch, cup feeding and hand expression with mothers at the facility and report that they frequently assess and report on the effectiveness of breastfeeding and indicators of the baby's milk intake.

Staff and hcps describe what they tell mothers regarding feeding cues, signs of effective breastfeeding and offer anticipatory guidance about possible breastfeeding concerns and their solutions, as well as available resources that will assist with breastfeeding.

Staff and hcps ensure continuity of care through effective liaison and information sharing between the hospital and CHS.

Staff and hcps describe the information needed to support mothers who are giving human milk substitutes to make informed decisions and safely prepare, store and use appropriate commercial human milk substitutes.

**Staff and hcps providing care in community health services** can answer breastfeeding care questions concerning challenges that occur beyond the first few weeks (e.g., breast refusal, slow growth rates, growth spurts, biting, the timely introduction of complementary foods and sustained breastfeeding).

<sup>5</sup> **Note: Supporting informed decision making includes the provision of:**

- the opportunity for a woman to discuss her concerns
- importance of breastfeeding for baby, mother, family and community
- health consequences for baby and mother of not breastfeeding
- risks and costs of human milk substitutes
- difficulty of reversing the decision once breastfeeding is stopped.

<sup>6</sup> For families who are bottle-feeding, responsive feeding is recognized as prompt, emotionally supportive, and developmentally appropriate responses to children's hunger and satiety cues (DiSantis, Hodges, Johnson, & Fisher, 2011).

**Documents** show an effective liaison and communication between hospital(s) and CHS(s) to ensure the continuum of care.

**Written information for clients** outlines information consistent with the criteria cited above.

See Appendix 5.1: Breastfeeding Care Checklist

Appendix 5.2: Breastfeeding Education Materials for Families Checklist

<b>Step 6</b>	
<b>WHO</b>	<b>Give newborns no food or drink other than breastmilk, unless medically indicated.</b>
<b>Canada</b>	<b>Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.</b>
<p><b>Mothers of babies younger than six months</b> confirm that their baby is exclusively breastfed, or that they made an informed decision to supplement for a medical or personal reason. Mothers report that they have received anticipatory guidance and an opportunity to discuss sustained breastfeeding with staff and hcps, exclusively for the first six months, then for two years and beyond, along with the introduction of appropriate complementary foods.</p> <p><b>Mothers</b>, including those mothers with babies in special care <b>who have made an informed decision not to breastfeed</b>, report that the staff and hcps discussed feeding options with them and supported their informed selection of an appropriate human milk substitute (commercial infant formula).</p> <p><b>In hospitals and birthing centres, the manager:</b></p> <ul style="list-style-type: none"> <li>• provides annual data for the facility showing: <ul style="list-style-type: none"> <li>○ breastfeeding initiation rates</li> <li>○ exclusive breastfeeding rates of babies from birth to discharge (minimum 75%)</li> <li>○ supplementation rates (medically-indicated and non-medically indicated)</li> </ul> </li> <li>• describes a reliable system of data collection</li> </ul> <p><b>In community health services, the manager:</b></p> <ul style="list-style-type: none"> <li>• provides annual data showing: <ul style="list-style-type: none"> <li>○ exclusive breastfeeding rates of babies on entry to the community service, which coincides with hospital discharge (goal is 75%). If the <i>exclusive breastfeeding rate</i> on entry to service is less than 75%, <ul style="list-style-type: none"> <li>▪ demonstrates the “<i>any breastfeeding rate</i>”<sup>7</sup> is at least 75%, <u>and</u></li> <li>▪ provides data for at least three years, showing improvements in breastfeeding rates</li> </ul> </li> <li>○ exclusive and any breastfeeding duration rates (see appendix 6.4)</li> </ul> </li> <li>• describes a reliable system of data collection of breastfeeding rates. It is expected that breastfeeding duration rates are monitored to reflect the current WHO/UNICEF and Health Canada recommendations of exclusive breastfeeding to six months and continued breastfeeding to two years and beyond.</li> <li>• describes collaboration with others (e.g., community members, academia) to assess and understand the cultural norms and conditions within the community affecting breastfeeding rates and disparities.</li> </ul>	

<sup>7</sup> “Any Breastfeeding” includes all babies who receive human milk either exclusively or non-exclusively.

**Staff** and hcps describe the importance of exclusive breastfeeding, the medical indications for supplementation as defined by WHO<sup>8</sup>, and information provided to mothers to support informed decision making about feeding their own expressed breastmilk, pasteurized human donor milk or human milk substitutes, without the use of bottles or artificial teats.

Staff and hcps record this important information in clients' charts.

**Documents** provide the facility data including records of client's informed decision-making and supplementation for medical indications.

**Written information for clients** outlines information consistent with the criteria cited above.

See Appendix 6.1: Data Collection of Breastfeeding Rates

Appendix 6.2: WHO/UNICEF Medical Indications for Supplementation

Appendix 6.3: Calculation of Exclusive Breastfeeding in Hospitals and Birthing Centres

Appendix 6.4: Calculation of Exclusive Breastfeeding in Community Health Facilities

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<sup>8</sup> See Appendix 6.2 for the WHO/UNICEF definitions of medical indications for supplements.

**Step 7**

**WHO Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.**

**Canada Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together.**

**Postpartum mothers** including those with caesarean births, report that from birth (or from the time that they could respond to their babies in the case of general anaesthetic) their infants have remained with them, and that a support person was welcomed to stay with them day and night.

**Mothers** relate they have received information about safe skin-to-skin, co-sleeping and bed sharing. Mothers confirm that they were not separated from their infants and were invited to hold their babies skin-to-skin and breastfeed during painful procedures.

**In hospitals and birthing centres, the manager** confirms that:

- teaching and examinations occur at the mother's bedside or with her present
- breastfeeding is welcome everywhere, including all the public areas, and that facilities for privacy are available on request

**In community health services, the manager** confirms that:

- families receive information about safe sleeping (including room-sharing, avoiding swaddling, etc.) using harm reduction messaging
- staff and hcps encourage mothers to hold their babies skin-to-skin and breastfeed if painful procedures are necessary
- staff and hcps encourage mothers who are not breastfeeding to hold their babies skin-to-skin and use other comfort measures if painful procedures are necessary
- skin-to-skin care and mother/baby togetherness are encouraged in the home environment for all mothers regardless of feeding decisions
- breastfeeding is welcome everywhere, including all the public areas, and that facilities for privacy are available on request.

**Staff and hcps** report that mothers and babies are separated only for medical reasons, and that anticipatory guidance is given to mothers to protect, promote and support breastfeeding. They report that examination, teaching and procedures occur at the mother's bedside or in her presence, and that mothers are encouraged to hold and settle their babies if painful procedures are necessary. Staff and hcps describe how mothers are welcomed to breastfeed anytime, anywhere. They confirm that routine observations and monitoring of mother and baby (temperature, breathing, colour and tone) continue throughout the period of skin-to-skin care.

**Documents** show evidence of medical indications for separation of mothers and babies, the length of separation and anticipatory guidance to protect, promote and support breastfeeding.

**Written information for clients**, including signage, outlines information consistent with the criteria cited above.

See Appendix 7: Mother Baby Togetherness Checklist

<b>Step 8</b>	
<b>WHO</b>	<b>Encourage breastfeeding on demand.</b>
<b>Canada</b>	<b>Encourage responsive<sup>9</sup>, cue-based feeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.</b>
<p><b>Mothers</b> describe age-appropriate, responsive, cue-based, effective feeding (feeding cues, unrestricted frequency and length of breastfeeds, signs of effective breastfeeding, signs of readiness for solids). Mothers confirm that they have received anticipatory guidance and an opportunity to discuss sustained breastfeeding with staff and hcps, exclusively for the first six months, then for two years and beyond, after introduction of appropriate complementary foods. Discussion of sustained breastfeeding included information about mother's rights for accommodation at school and in the workplace.</p> <p><b>In hospitals and community health services:</b> <b>The manager</b> relates that staff and hcps offer timely anticipatory guidance and problem solving to mothers regarding effective, responsive, cue-based feeding as per Canadian and International guidelines.</p> <p><b>Staff and hcps</b> describe the information mothers are taught about age-appropriate differences in infant variables (behaviour, output and feeding frequency) and how to assess their babies for signs of effective breastfeeding. Staff and hcps discuss breastfeeding as part of the relationship between mother and child – not simply as a means of providing food. They confirm that they discuss breastfeeding progress with mothers at each contact, unless a medical or other emergency takes precedence.</p> <p><b>Documents</b> show evidence that mothers receive information on responsive, cue-based feeding and continued breastfeeding.</p> <p><b>Written information for clients</b> outlines information consistent with the criteria cited above.</p> <p>See Appendix 8.1: Responsive Cue-Based Feeding Checklist Appendix 8.2: Initiation of Lactation: Anticipated Behaviours and Feeding Patterns</p>	

<sup>9</sup>Responsive feeding recognizes that successful breastfeeding is a sensitive, reciprocal relationship between a mother and her child. Breastfeeding can be used to feed, comfort and calm babies. Feeds can be initiated when babies show feeding cues, when they are distressed, when they are lonely, when the mother's breasts feel full or when she would just like to sit down and rest. Breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding. <https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/responsive-feeding-infosheet/>

**Step 9**

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

**Canada Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).**

**Mothers** report that they received information and support to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers.  
If the baby has been given a bottle or pacifier, the mother confirms that this was her informed decision or a medical indication.

**In hospitals and community health services:**

**The manager** provides records confirming that mothers of breastfeeding infants are supported to find alternative solutions or make an informed decision regarding the use of artificial teats.

**Staff and hcps** describe feeding alternatives recommended for breastfed infants requiring supplemental feedings (e.g. cups, spoons) and soothing techniques for all infants.

**Documents** show evidence of support and informed decision making.

**Written information for clients** outlines the risks associated with artificial teats and describes alternatives.

See Appendix 9: Artificial Teats Checklist

<b>Step 10</b>	
<b>WHO</b>	<b>Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.</b>
<b>Canada</b>	<b>Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health<sup>10</sup> to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.</b>
<p><b>Mothers</b> 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. Mothers confirm that they could access peer support programs. Mothers report that they live in a community that supports a positive breastfeeding culture.</p> <p><b>In hospitals and birthing centres:</b> <b>The manager</b> describes an adequate procedure for the transition from hospital to CHS and describes the liaison and collaboration between the hospital, CHS and peer support programs to protect, promote and support breastfeeding.</p> <p><b>In community health services:</b> <b>The manager</b> describes an adequate procedure for the transition from hospital to CHS and describes the liaison and collaboration between the hospital, CHS and peer support programs to protect, promote and support breastfeeding. The manager describes the strategies and approaches used to support principles of primary health care and population health to improve breastfeeding outcomes.</p> <p><b>Staff and hcps</b> describe effective transition for all mothers between hospital or birthing centre and community programs and can locate the written support materials provided to mothers.</p> <p><b>Documents</b> show evidence of liaison and collaboration across the continuum of care.</p> <p><b>Written information for clients</b> lists hospital, community health and peer support providers.</p> <p>See Appendix 10.1: Continuum of Care Checklist Appendix 10.2: Primary Health Care and Population Health Principles Checklist</p>	

<sup>10</sup> Core Competencies of Public Health in Canada, PHAC 2007 Version 1.0

## WHO International Code of Marketing of Breast-Milk Substitutes

**WHO Compliance with the International Code of Marketing of Breast-Milk Substitutes.**

**Canada Compliance with the WHO International Code of Marketing of Breast-Milk Substitutes.**

**Mothers and pregnant women** report that they have not received any marketing materials, samples, coupons, or gift packs that include human milk substitutes and infant feeding paraphernalia.

Mothers and pregnant women confirm that they have not received group instruction regarding the preparation, storage and feeding of human milk substitutes.

### **In hospitals and community health services:**

**The manager** confirms that no employees of manufacturers or distributors of human milk substitutes, bottles, teats, or pacifiers have any direct or indirect contact with pregnant women or mothers.

Scientific information regarding these products is provided to designated clinical instructors, who then provide in-service education to staff and hcps.

**Staff and hcps** report at least two reasons why it is important not to give free samples or promotional materials regarding products that fall within the scope of *The Code*.

They demonstrate that bottles or cans of human milk substitutes and bottles are stored discreetly.

**Documents** show that the facility does not receive free gifts (including but not limited to crib cards, samples, or other incentives), non-scientific literature, materials or equipment, money, or support for in-service education or events, from manufacturers or distributors of human milk substitutes, bottles, teats, or pacifiers.

Research grants require disclosure.

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

**Written information for clients** including posters is consistent with the criteria cited above.

See Appendix 11: WHO International Code of Marketing of Breast-milk Substitutes  
Compliance Checklist

## Appendices

For BFI assessment purposes, the facility's documentation and curricula are reviewed during the pre-assessment phase. For the final external assessment, random samples of mothers, staff, hcps, and volunteers are interviewed and observations are made to confirm the outcomes have been achieved at least 80% of the time. The checklists in the Appendix can be used by facilities to ensure that practice meets this standard. More information about the BFI and the assessment process may be found on the BCC website ([www.breastfeedingcanada.ca](http://www.breastfeedingcanada.ca)).

### Appendix 1: Policy Checklist

#### The policy:

(Y = Yes; N = No; IP = In Progress)

Y N IP

- is created in collaboration with multiple stakeholders including community members and addresses all *10 Steps*
- protects all families through compliance with the provisions of the *WHO Code*, and subsequent, relevant WHA Resolutions prohibiting:
  - promotion of human milk substitutes and feeding bottles or teats
  - pre-and postnatal group instruction on human milk substitute use<sup>11</sup>
  - use or distribution of non-human milk gift packs with samples and supplies or other promotional materials to pregnant women or mothers
  - free gifts from manufacturers of human milk substitutes to staff and the facility (including food, gifts, pens, writing pads, measuring tapes, support for continuing education, etc.)
  - infant feeding education sessions and literature from companies whose products fall within the scope of *The WHO Code*
- indicates that educational materials should be impartial and do not endorse company brand names or products (e.g., by recommending only one brand of breast pump)
- is reviewed on a regular basis in collaboration with multiple stakeholders, including community members, and includes a mechanism for evaluating the effectiveness of policy implementation
- is visible in areas open to families and is posted on the website in summary form in the language(s) most commonly understood by families. The summary form clearly indicates how the policy is reflected in practice
- is available to anyone who wishes a copy
- is based on current evidence-based standards
- identifies policies and practices that support mothers using human milk substitutes.

<sup>11</sup> In a group setting, general questions on infant feeding (such as infant feeding cues, weight gain etc.) are anticipated and welcomed. Questions pertaining to the selection or properties of individual human milk substitutes (formula and/or bottle feeding) or the preparation and use thereof are addressed one-to-one, outside of a group context.

## Appendix 2.1: Education and Orientation Checklist

**Education of staff and health care providers (hcps) is appropriate to their role and setting.** For those providing direct breastfeeding care<sup>12</sup> all of *The 10 Steps* are addressed. For this group, at least 20 hours (reflecting the core content as outlined in the UNICEF/WHO “20-hour course”) including three hours of supervised clinical instruction is strongly recommended.

### All staff, hcps and volunteers:

(Y = Yes; N = No; IP = In Progress)

Y N IP

- know that the BFI protects, promotes, and supports
  - breastfeeding families
  - families using human milk substitutes by providing individual information on infant feeding free from commercial influences
- know that *The WHO Code* protects
  - families against commercial pressure
  - staff and hcps from conflicts of interest
- confirm that they have been oriented to the infant feeding policy.

### In addition, staff and hcps providing direct breastfeeding care:

Y N IP

- confirm they have received the described education or, if they have been in the facility less than six months, know when education will be provided
- can correctly answer four out of five questions on basic evidence-based breastfeeding care
- can identify two issues that should be discussed with a pregnant woman if she indicates that she is considering giving her baby something other than human milk
- can describe information given individually to mothers who have made an informed decision not to breastfeed including cost implications, safe and hygienic preparation, feeding and storage of human milk substitutes
- can demonstrate teaching of effective position and latch
- can describe and demonstrate effective hand expression of milk.

### In addition, physicians, and midwives:

Y N IP

- confirm that they have been oriented to the infant feeding policy
- can identify to whom mothers experiencing breastfeeding difficulties may be referred for direct breastfeeding care
- can identify medical indications for supplementation
- if they provide clinical breastfeeding support to mothers, they can
  - correctly answer four out of five questions on breastfeeding care
  - demonstrate effective teaching of position and latch.

<sup>12</sup> Direct breastfeeding care includes any of the following: breastfeeding education, assessment, support intervention and follow-up.

**In addition, non-clinical staff members:****Y N IP**

- can describe at least one reason why breastfeeding is important
- describe how a mother may be supported to feel comfortable to feed her baby anywhere in the facility, including a private space if she should request one
- can identify to whom mothers experiencing breastfeeding difficulties may be referred for direct breastfeeding care.

**Education Materials****Y N IP**

- a copy of the curriculum or course outline for education on breastfeeding and lactation for various disciplines is provided
- a copy of information provided to non-breastfeeding mothers is provided
- a schedule for education of new staff and hcps exists.

## Appendix 2.2: Breastfeeding Education for Hospital and Community Health Service Staff and Health Care Providers

*The 10 Steps* represent minimum practice guidelines for hospitals and community health services. Therefore, in striving for optimal care based on best practice, the BFI provides an evidence-based beginning in the ongoing journey of providing excellent care to childbearing families. The focus of the Baby-Friendly Initiative external assessment is on breastfeeding outcomes.

- Education is important to ensure successful outcomes in the assessment process.
- Education needs of individual institutions will vary to achieve expected outcomes.

The education should be appropriate to the role of staff and hcps. For those providing direct breastfeeding care, WHO/UNICEF recommends a minimum of 20 hours of education, including three hours of supervised clinical practice.

- Staff and hcps offering direct breastfeeding care must be able to demonstrate certain skills and effectively teach mothers basic breastfeeding skills. As well as speaking to mothers, the assessment process involves asking specific questions to staff and hcps who offer direct breastfeeding care, observing their actions and examining breastfeeding outcomes.
- Staff and hcps must be prepared to answer questions regarding protecting, promoting, and supporting breastfeeding.

Education can be provided to staff and hcps in a variety of ways, including computer modules, readings, supervised clinical practice, discussion groups, focused education sessions, self-paced learning modules, etc. Effective implementation of policies relies not only on knowledge but also on the attitudes of staff and hcps. Changing attitudes, though difficult and slower than acquiring knowledge, most likely occurs when a variety of strategies are employed.

### **To meet educational indicators, educational materials (written, visual and video) for use in staff and hcps education must:**

- comply with the provisions to *The WHO Code* and subsequent relevant World Health Assembly (WHA) Resolutions<sup>13</sup>
  - not include materials from companies whose products fall within the scope of *The WHO Code*
  - not be provided by companies whose products fall within the scope of *The WHO Code*
- be referenced with up-to-date and, preferably, primary references
- promote evidence-based care and best practice
- be accurate and current.

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<sup>13</sup> See Appendix 11: WHO International Code of Marketing of Breast-milk Substitutes

## **Documenting Staff and Hcps Education: Commitment to Education**

The commitment to breastfeeding education within a hospital or community health service may be shown in many ways (e.g., in some provinces, nurses are required to provide evidence of self-assessment of their practice as a condition of maintaining registration). Modules on breastfeeding may be part of compulsory education requirements like Cardio-pulmonary Resuscitation and Neonatal Resuscitation. Administration may elect to keep records of the education of staff and hcps or may require individuals to provide documentation as part of annual performance appraisals. The review board granting privileges may require breastfeeding education hours as a pre-condition. Obtaining continuing education recognition credits may be an incentive.

Documentation of staff and hcps education involves at least two processes.

### **1. Audits of breastfeeding outcomes**

- ❑ Does the hospital or community health service meet the Baby-Friendly Outcome Indicators?
- ❑ Are new staff and hcps given appropriate orientation/education to provide the standard of care required?

### **2. Documenting education provided to staff and hcps (can be done in many ways):**

- ❑ provide a schedule for orientation of new staff and hcps and document attendance
- ❑ provide schedules of in-service programs provided and document attendance
- ❑ record education support provided (e.g., funding provided for attending conferences or courses)
- ❑ provide a schedule for mentoring and education for individual staff and hcp by breastfeeding care clinicians and document attendance
- ❑ outline the process established to educate, and follow up with staff and hcps who are not able to meet standards of care as outlined in the hospital or community health service policy
- ❑ complete performance appraisals and encourage staff and hcps to contribute their record of breastfeeding education as part of the performance appraisal or professional competence requirements for registration/licensure/privileges
- ❑ provide up-to-date educational resources and research articles for use by hospital and community health services staff and hcps.

### Appendix 2.3: Support for Mothers Using Human Milk Substitutes Checklist

#### The manager provides:

(Y = Yes; N = No; IP = In Progress)

**Y N IP**

- written infant feeding policy or practices describing support for mothers using human milk substitutes
- written curriculum outlining education to support the mothers using substitutes.

#### Staff and hcps providing direct care:

**Y N IP**

- can describe how to help mothers make informed decisions including the provision of
  - the opportunity for a woman to discuss her concerns
  - importance of breastfeeding for baby, mother, family, and community
  - health consequences of not breastfeeding for baby and mother
  - risks and costs of human milk substitutes
  - difficulty of reversing the decision once breastfeeding is stopped.
- can correctly answer four out of five questions regarding the feeding of human milk substitutes, including:
  - the risks and benefits of feeding human milk substitutes<sup>14</sup>
  - how to help a mother choose what is acceptable, feasible, affordable, sustainable, and safe (AFASS) in her circumstances
  - the safe and hygienic preparation, feeding, and storage of human milk substitutes<sup>15</sup>
    - boiling and cooling water before mixing feeds
    - correct proportions for mixing human milk substitutes
    - importance of clean technique
    - feeding baby safely
  - how to teach preparation of feeding options chosen by the mother
  - responsive, cue-based feeding.<sup>16</sup>

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<sup>14</sup> “Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system since they constitute a risk group.” WHO/UNICEF Global Strategy for Infant and Young Child Feeding, p10.

<sup>15</sup> **WHO Guidelines for the safe preparation, storage and handling of powdered infant formula**

English: [http://www.who.int/foodsafety/publications/micro/PIF\\_Care\\_en.pdf](http://www.who.int/foodsafety/publications/micro/PIF_Care_en.pdf)

French: [http://www.who.int/foodsafety/publications/micro/PIF\\_Care\\_fr.pdf](http://www.who.int/foodsafety/publications/micro/PIF_Care_fr.pdf)

<sup>16</sup> “Although true responsive feeding is not possible when bottle feeding, as this risks overfeeding, the mother-baby relationship will be helped if mothers are supported to tune in to feeding cues and to hold their babies close during feeds. Offering the bottle in response to feeding cues, gently inviting the baby to take the teat, pacing the feeds and avoiding forcing the baby to finish the feed can all help to make the experience as acceptable and stress-free for the baby as possible, as well as reducing the risk of overfeeding.” <https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/responsive-feeding-infosheet/>

**Mothers who have made an informed decision not to breastfeed confirm they have received sufficient information and support:**

**Y N IP**

- to make informed decisions about feeding their babies
- to safely prepare, store and feed human milk substitutes in appropriate volumes
- to feed their babies with cup or bottle
- on responsive, cue-based feeding.

### Appendix 3: Prenatal Education Checklist

#### The written minimum curriculum for prenatal education includes:

(Y = Yes; N = No; IP = In Progress)

Y N IP

- the importance of exclusive breastfeeding during the first six months from birth, and sustained breastfeeding for two years and beyond
- the importance of breastfeeding and human milk for both mother and baby
- information about donor milk banking
- the risks and costs associated with the use of human milk substitutes
- care supportive of establishing and sustaining breastfeeding (see below and Steps 4-10)
- the importance of immediate and prolonged skin-to-skin care for all infants (including kangaroo care for premature infants).

#### Prenatal Education aimed at reducing inequities in breastfeeding rates among populations:

Y N IP

- based on surveillance data and community assessment, populations within the applicable geographic area with lower rates of breastfeeding than the entire population, will have prenatal education services and strategies designed to reduce breastfeeding inequities between populations
- describes health promotion and community outreach strategies to reach diverse populations.

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

Y N IP

- expected health care practices supportive of establishing effective breastfeeding (e.g., immediate and prolonged skin-to-skin care, early and frequent skin-to-skin breastfeeds, 24-hour rooming-in, 24-hour support from partner or support person)
- the basics of breastfeeding
  - position and latch
  - hand expression of milk
  - infant feeding cues and responsive, cue-based feeding
  - expected normal feeding behaviours (frequency of feeds, output)
  - the benefits of skin-to-skin care for all infants (including those who will not be breastfed), and especially for premature infants
  - national guidelines for breastfeeding: exclusive breastfeeding for the first six months, addition of appropriate complementary foods at six months, and sustained breastfeeding for two years and beyond
- breastfeeding support
  - community professional follow-up
  - mother-to-mother (peer) support groups
- rights of pregnant and breastfeeding women (the accommodation of breastfeeding women in the community, at school and in the workplace).
- these educational materials:
  - are available in the languages commonly used by clients
  - are current
  - have clear graphics or pictures
  - acknowledge original authors

- do not promote the use of human milk substitutes or any products covered under *The WHO 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 human milk substitutes. This information should be provided in a separate document to those specific women who have made an informed decision not to breastfeed.

**Hospitalized women and women using the prenatal services:**

**Y N IP**

- receive appropriate breastfeeding information as specified above (provision of this information is documented in their chart).

**Women and their families who have made an informed decision not to breastfeed** will have available to them written materials on the preparation, storage and feeding of human milk substitutes that are:

**Y N IP**

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

See appendix 2.3 for more information regarding support for women who are not breastfeeding.

**Note:** A woman who is not sure about breastfeeding or who states prenatally that she does not wish to breastfeed is supported in her decision making by staff and hcps through discussion of the following:

**Y N IP**

- her ideas and concerns about infant feeding
- importance of breastfeeding for baby, mother, family, and community
- if she is at risk for preterm labour she is encouraged to provide her early milk even if she does not choose to breastfeed
- health consequences for baby and mother of not breastfeeding
- risks and costs of human milk substitutes. Ask parents to consider whether it is acceptable, feasible, affordable, sustainable, and safe (AFASS) in their circumstances.
- difficulty of reversing the decision once breastfeeding is stopped.

## Appendix 4: Birth and Skin-to-Skin Care Checklist

### Prenatal Care

(Y = Yes; N = No; IP = In Progress)

Y N IP

- hospitals and community health services collaborate to provide information for families about skin-to-skin care and uninterrupted contact until completion of the first feeding.

### Pregnant mothers

Y N IP

- receive information about skin-to-skin care until completion of the first feeding
- are encouraged to discuss skin-to-skin care with their hcps
- have been shown how to safely position their babies for skin-to-skin care.

### In the hospital

Y N IP

- at birth, babies are placed skin-to-skin with their mothers.<sup>17</sup> An unhurried environment and unlimited skin contact facilitate safe transition of the newborn and a successful first feeding
- mothers are supported to breastfeed in response to their babies' cues
- skin-to-skin care remains uninterrupted for at least one hour, until completion of the first breastfeed or along as the mother wishes, unless there is a medical indication, which should be documented in the baby's chart
- staff can describe what to teach families to ensure skin-to-skin care is provided safely
- routine measurements are delayed until completion of the first feeding (where required by statute, eye ointment may be applied within the first hour)
- required medications are given while the baby is on the mother's chest
- routine observations of the baby (temperature, breathing, colour and tone) and mother continue throughout the period of skin-to-skin care (if the health of either gives rise to concern, separation may be medically indicated; however, skin-to-skin care will begin as soon as medical status permits)
- 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 by stretcher or wheel chair with skin-to-skin contact maintained
- mothers and babies born by caesarean are treated in the same way as mothers and babies born vaginally, with respect to skin-to-skin care (if the caesarean was under general anaesthetic, babies are placed skin-to-skin with their mother as soon as the mother is responsive and alert, with the same procedure followed)
- the mother's designate holds the baby skin-to-skin if mother is ill or unavailable
- mothers are encouraged to look for signs that their babies are ready to feed during this first period of contact and if needed, help is offered
- babies are skin-to-skin or clothed but not swaddled or bundled.

<sup>17</sup>Skin-to-skin means the naked baby is placed on his/her mother's naked chest immediately at birth then dried and covered with a warm, dry blanket.

**If babies are cared for in a special care nursery**

**Y N IP**

- mothers are given the opportunity to hold their babies skin-to-skin unless there are medically justifiable reasons why they could not (these reasons are clearly explained in the baby's chart).

## Appendix 5.1: Breastfeeding Care Checklist for Hospitals and Community Health Services

As the goal is for mothers to be able to latch their babies independently, it is important for staff and hcps 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.

### Mothers, staff and hcps can describe and demonstrate

(Y = Yes; N = No; IP = In Progress)

Y N IP

- position and latch:**
  - the baby's body is aligned close to and facing the mother, unencumbered by blankets or the like
  - 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 onto the breast).
- hand expression of milk:** all mothers are taught how to hand express their milk as this is often more effective than a mechanical pump for expressing colostrum, especially in the first 24 hours.
- cup feeding**, as appropriate.

### Continuum of Care

Y N IP

- a reliable and formal system is in place for communicating a mother's breastfeeding progress to community health staff and hcps as she moves from hospital to the community
- families with unresolved breastfeeding issues are discharged from hospital or birthing centre with written plans that
  - support their breastfeeding goals
  - provide information regarding follow-up with an appropriate hcp or community service
- mothers and families are aware of and can access assistance with breastfeeding within 48 hours of discharge
- routine follow up is accessible within 48 hours after discharge for all mothers (care may be provided by the hospital, CHS, a breastfeeding clinic and/or midwife, etc.).
- mothers and families are aware of the signs that their infant is breastfeeding effectively, and they know when to seek help.

**Initiation and maintenance of lactation if babies are unable to breastfeed or are separated from their mothers:****Mothers**

Y N IP

- are shown how to hand express milk as soon as possible – at least within the first hour of birth and encouraged to express milk at least six times in the first 24 hours and at least eight times in each 24-hour period thereafter
- know how to store milk, where to obtain equipment and how to clean it
- are given extra support
- report they have been given appropriate information on how to maintain lactation during separation, during illness or while at work or school.

**Staff and hcps describe**

Y N IP

- appropriate storage and handling of expressed breastmilk
- maintenance of lactation during separation or illness of mother or baby.

## Appendix 5.2: Breastfeeding Education Materials for Families Checklist

### Breastfeeding Education Materials for Families

The Baby-Friendly Initiative encourages facilities and services to provide information to parents consistent with *The 10 Steps and The WHO Code*. Facilities and services have varying abilities to produce materials suitable for family education. It is not necessary that all materials across Canada are the same; however, the following guidelines will assist staff and hcps in the selection and/or production of suitable materials.

### Materials

(Y = Yes; N = No; IP = In Progress)

**Y N IP**

- include accurate information to parents with particular attention to information on:
  - position and latch (see Appendix 5.1)
  - hand expression of milk
  - infant feeding cues
  - expected normal feeding behaviours (see Appendix 8.2)
  - community professional follow-up
  - mother-to-mother support groups
- comply with the provisions of *The WHO Code* and subsequent relevant World Health Assembly (WHA) Resolutions
- encourage breastfeeding: exclusively during the first six months from birth and continued after the introduction of complementary foods for two years and beyond
- are reviewed on a regular basis
- contain clear graphics or pictures
- acknowledge original authors
- use innovative health promotion communication strategies such as social media and social marketing aimed at the entire population as well as targeted toward populations with lower breastfeeding rates within the community.

### Suggestions

Materials<sup>18</sup>

- are written at a grade 6-8 level
- have adequate white space
- use type size 12 or greater
- present basic information
- do not present breastfeeding as difficult, rule-laden, or medicalized
- reflect the cultural diversity of the community (including pictures and drawings)
- describe user-friendly dietary information that reflects the cultural diversity of the community
- employ a style of writing that is empowering to mothers
- are generic (using company materials gives the impression of endorsement).

<sup>18</sup> Adapted from the Jones, F. & Green, M. *The Baby Friendly Initiative*, 2006. HA

## Appendix 6.1: Data Collection of Breastfeeding Rates

The facility documents data collection on breastfeeding rates.  
See Appendix 6.3: Hospital Data and Appendix 6.4: CHS Data

### Hospitals breastfeeding rates

(Y = Yes; N = No; IP = In Progress)

Y N IP

- initiation of breastfeeding (any<sup>19</sup> breastfeeding)
- exclusive breastfeeding from birth to discharge (minimum 75%)
- supplementation rate, both medically and non-medically indicated.

### Community health services breastfeeding rates

Y N IP

**On entry to service** (which coincides with hospital discharge)

- exclusive breastfeeding rate (goal is minimum 75%)
- If the exclusive breastfeeding rate on entry to service is less than 75%, the facility demonstrates,***
  - the “any breastfeeding rate”<sup>20</sup> is at least 75%
  - provides data for at least three years, showing increases in breastfeeding rates.

### Breastfeeding duration rates

- exclusive and non-exclusive breastfeeding rates at a minimum of two other time points including around six months to reflect current breastfeeding recommendations
- mechanisms to monitor breastfeeding duration twelve months or beyond.

### Population Health Principles and Breastfeeding Rates Surveillance

- systematically monitors breastfeeding rates and trends within communities and monitors shifts in overall population breastfeeding rates, as well as disparities between populations based on ethnicity, social economic status, education, geography, age, etc.
- collaborates with others (e.g., community members, academia) to assess and understand the cultural norms and conditions within the community affecting breastfeeding rates and disparities.

**All facilities are expected to show an increase in breastfeeding rates over their previous assessment data at the time of re-assessment.**

<sup>19</sup> ‘Any breastfeeding’ includes all babies who receive human milk either exclusively or non-exclusively

<sup>20</sup> ‘Any breastfeeding’ includes all babies who receive human milk either exclusively or non-exclusively

**Mothers confirm that:**

(Y = Yes; N = No; IP = In Progress)

Y N IP

- breastfeeding is recommended for two years and beyond:
  - exclusive breastfeeding during the first six months from birth
  - continued breastfeeding after the introduction of complementary foods
- babies younger than six months receive human milk exclusively, (or there are acceptable medical indications for supplementation)
- they received information to help them make informed decisions regarding:
  - the use of human milk substitutes
  - the use of pacifiers or artificial nipples
  - the difficulty of reversing the decision not to breastfeed.

**Mothers using human milk substitutes (see Appendix 2.3) confirm they have received sufficient information and support:**

Y N IP

- to make informed decisions<sup>21</sup> about feeding their babies
- to safely prepare, store and feed human milk substitutes responsive to infant cues and in appropriate volumes
- if they are using human milk substitutes as a supplement to breastfeeding,** on preserving and improving the breastfeeding relationship.

**Staff and hcps members providing direct breastfeeding care:**

Y N IP

- know the medical indications for supplements (see *WHO Acceptable Medical Reasons for Supplementation Appendix 6.2*)
- when feeding at the breast is insufficient, recommend using mothers' own expressed milk, or pasteurized donor milk wherever possible
- document the rationale when supplements have been recommended, including medical reason and evidence of parental consent
- effectively help breastfeeding mothers of fussing babies by encouraging more frequent, effective breastfeeding, skin-to-skin cuddling, rocking, and carrying
- articulate the importance of exclusive breastfeeding during the first six months from birth, of sustained breastfeeding for two years and beyond
- inform mothers of the information above and potential risks, with emphasis on ensuring that families make informed decisions
- do not recommend bottles and artificial nipples for breastfeeding babies
- describe information given to mothers using supplements, including maintenance of breastfeeding, preparation and storage of human milk substitutes, responsive, cue-based feeding, and age-appropriate amounts.

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<sup>21</sup> **Note: Supporting informed decision making includes the provision of:**

the opportunity for a woman to discuss her concerns and information regarding:

- importance of breastfeeding for baby, mother, family, and community
- health consequences for baby and mother of not breastfeeding
- risks and costs of human milk substitutes
- difficulty of reversing the decision once breastfeeding is stopped.

## Appendix 6.2: WHO/UNICEF Medical Indications for Supplementation

Whenever interruption or cessation of breastfeeding is considered, the importance of breastfeeding should be weighed against the risks posed by the use of human milk substitutes and the need to intervene because of the presenting medical condition.

### INFANT CONDITIONS

Infants who should not receive human milk or any other milk except specialized human milk substitute include (replacement feeding):

- those with classic galactosemia - special galactose-free human milk substitute is needed
- those with maple syrup urine disease - a special milk substitute, free of leucine, isoleucine and valine is needed
- those with phenylketonuria - a special phenylalanine-free human milk substitute is needed (some breastfeeding is possible, under careful monitoring)
- those whose mother is HIV positive.

Infants for who human milk remains the best feeding option but who may need other food, in addition to human milk for a limited period, include those infants:

- born weighing less than 1500 g (very low birth weight)
- born at less than 32 weeks of gestation (very preterm)
- who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischemic stress, those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or human milk feeding)
- with a significant weight loss in the presence of clinical indications (mother's milk production not established).

### MATERNAL CONDITIONS

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines. Maternal conditions that may justify permanent avoidance of breastfeeding (replacement feeding) include:

- HIV positive test results
- severe illness that prevents a mother from caring for her infant (e.g., sepsis or untreated tuberculosis)
- maternal medication, including:
  - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available
  - radioactive iodine-131 is better avoided given that safer alternatives are available - a mother may be able resume breastfeeding later and should consult her health care provider
  - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided
  - cytotoxic chemotherapy requires that a mother stop breastfeeding during therapy.

Maternal conditions during which breastfeeding can continue, although health problems may be of concern:

- breast abscess - breastfeeding should continue on the unaffected breast; feeding on the affected breast can resume once treatment has started
- hepatitis B - infants should be given hepatitis B vaccine within the first 48 hours
- hepatitis C (health concerns may exist if the mother's nipples are bleeding)
- mastitis - if breastfeeding is very painful, remove milk by expression to prevent progression of the condition
- herpes simplex virus type 1 (HSV-1) - direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved
- substance use, including:
  - maternal use of nicotine, excessive alcohol, ecstasy, amphetamines, cocaine, and related stimulants has been demonstrated to have harmful effects on breastfed babies
  - alcohol, opioids, benzodiazepines, and cannabis can cause sedation in both the mother and the baby
  - mothers should be encouraged not to use these substances and given opportunities and support to abstain and apply harm reduction principles.

From: WHO/UNICEF (2009). Baby-Friendly Hospital Initiative: Revised, expanded and updated for integrated care. Geneva; WHO and UNICEF.

**Appendix 6.3: Calculation of Breastfeeding Rates – Hospitals**

Statistics on births in the last year		Number	% of T
<b>T</b>	<b>Total live births in the last year</b>		100
	Births by C-section <u>without</u> general anaesthesia		
	Births by C-section <u>with</u> general anaesthesia		
	Infants admitted to NICU or similar units		

Statistics on Infant Feeding		Number	% of T
<b>A</b>	Infants exclusively breastfed (or fed human milk) from birth to discharge		
<b>B</b>	Infants who received at least one feed other than human milk (human milk substitute, water, or other fluids) in the hospital because of documented medical reason		
<b>C</b>	Infants who received at least one feed other than human milk without any documented medical reason		
<b>D</b>	Non-breastfed infants		
	The hospital data above indicates that at least 75% of the babies born in the past year were exclusively breastfed or fed human milk from birth to discharge (A)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>[[If "No"]</i> The hospital data above indicates that at least 75% of the babies born in the past year were exclusively breastfed or fed human milk from birth to discharge, or if they received any feeds other than human milk, this was because of documented medical reasons (A + B)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Data Sources**

Please describe the sources for the above data.

## Appendix 6.4: Calculation of Breastfeeding Rates: Community Health Services

Statistics on births in the last year		Number	% of T
<b>T</b>	Total births in the service area in the last year		100
<b>M</b>	A representative sample of mothers surveyed in the past year		

Statistics on infant feeding		Number	% of M																																																
<b>A</b>	Babies exclusively breastfeeding or receiving only human milk on entry to service (exclusive breastfeeding rate)																																																		
<b>S</b>	Babies breastfeeding with supplementation on entry to service (non-exclusive breastfeeding)																																																		
The data above demonstrates that the <u>exclusive</u> breastfeeding rate for babies entering into service in the past year was at least 75%		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
<p><b>[If “No”]</b> The data above indicates that the “any breastfeeding” rate (exclusive + non-exclusive) for babies entering into service in the past year was at least 75%</p> <p><b><u>AND</u></b> The CHS provides data for at least 3 years, showing improvement in breastfeeding rates</p> <table border="1"> <thead> <tr> <th rowspan="2">Bf rates (% of M)</th> <th colspan="2">Year</th> <th colspan="2">Year</th> <th colspan="2">Year</th> </tr> <tr> <th>Exc.</th> <th>Any</th> <th>Exc.</th> <th>Any</th> <th>Exc.</th> <th>Any</th> </tr> </thead> <tbody> <tr> <td>Entry to service</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Duration rates Examples of time points - at least 2 needed</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>~ 2m</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>~ 6m</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other Example ~ 12m</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Bf rates (% of M)	Year		Year		Year		Exc.	Any	Exc.	Any	Exc.	Any	Entry to service							Duration rates Examples of time points - at least 2 needed							~ 2m							~ 6m							Other Example ~ 12m							<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bf rates (% of M)	Year		Year		Year																																														
	Exc.	Any	Exc.	Any	Exc.	Any																																													
Entry to service																																																			
Duration rates Examples of time points - at least 2 needed																																																			
~ 2m																																																			
~ 6m																																																			
Other Example ~ 12m																																																			
There is a mechanism to monitor exclusive and non-exclusive breastfeeding rates at a minimum of two <i>other</i> time points including around six months to reflect current breastfeeding recommendations.		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
Mechanism to monitor breastfeeding duration twelve months or beyond.		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
Breastfeeding rates and trends within communities are systematically monitored.		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
Shifts in overall population breastfeeding rates as well as disparities between populations based on ethnicity, socioeconomic status, education, geography, age, etc.) are monitored.		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
There is collaboration with others (e.g. community members, academia) to assess and understand the cultural norms and conditions within the community affecting breastfeeding rates and disparities.		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																
<b>Data Sources</b>																																																			
Please describe the sources for the above data.																																																			

## Appendix 7: Mother-Baby Togetherness Checklist

### Staff, hcps and mothers confirm the following:

(Y = Yes; N = No; IP = In Progress)

Y N IP

- mothers and babies remain together throughout the hospital stay or community health service visit with all teaching and examinations occurring at the mother's bedside or with her present
- if separated from their babies for medical reasons, mothers are separated for the shortest possible duration (where possible, the separated baby who is cuing to feed is reunited with his or her mother)
- mothers are invited to breastfeed, hold baby skin-to-skin, and settle their babies when and if painful procedures (such as blood tests or immunizations) are necessary
- mothers are encouraged to have a support person stay with them, including overnight
- mothers are aware of the importance of keeping their babies near, including at night
- mothers are encouraged to share their bedroom at home with their infant for at least the first few months
- mothers and their families receive accurate information about safe infant sleeping for every sleep.

### In the facility:

Y N IP

- breastfeeding is welcome everywhere
- appropriate facilities for comfortable breastfeeding exist in both public and private areas
- signs welcoming breastfeeding are displayed in all public areas.

## Appendix 8.1: Responsive, Cue-Based Feeding Checklist

### Staff, hcps and mothers confirm that:

(Y = Yes; N = No; IP = In Progress)

Y N IP

- feeding according to the Global Guidelines (six months exclusive, sustained breastfeeding for two years and beyond) is promoted and supported
- breastfeeding progress is observed and discussed with mother at appropriate intervals
- mothers are encouraged to feed responsively according to their baby's cues, whenever they are hungry or as often as the baby wants<sup>22</sup>
- no upper restrictions are placed on the frequency or length of breastfeeds. A minimum number of feedings can be suggested (i.e., at least 8 in 24 hours) but not a maximum number.

### Timely Anticipatory Guidance is given about:

- age-appropriate normal feeding behaviours, frequency of feeds, output and infant states and their implications for feeding (see appendix 8.2)
- possible breastfeeding problems, their solutions and available resources that will assist with breastfeeding
- all contraception methods compatible with breastfeeding, including the Lactation Amenorrhea Method (LAM).

### Complementary feeding with continued breastfeeding

- the introduction of safe, appropriate, complementary foods in a responsive manner at six months to enable mother to
  - maintain responsive breastfeeding
  - safely prepare and use nutrient-dense complementary foods
  - ensure age-appropriate consistency of foods
  - increase amounts and frequency of food gradually while supporting breastfeeding
  - adapt feeding during and after a child's illness
- overcoming breastfeeding challenges that may occur with the growing child
- women's rights to accommodations in the community, school and workplace that support and sustain breastfeeding.

<sup>22</sup> Responsive feeding recognizes that successful breastfeeding is a sensitive, reciprocal relationship between a mother and her child. Breastfeeding can be used to feed, comfort and calm babies. Feeds can be initiated when babies show feeding cues, when they are distressed, when they are lonely, when the mother's breasts feel full or when she would just like to sit down and rest. Breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding. "Although true responsive feeding is not possible when bottle feeding, as this risks overfeeding, the mother-baby relationship will be helped if mothers are supported to tune in to feeding cues and to hold their babies close during feeds. Offering the bottle in response to feeding cues, gently inviting the baby to take the teat, pacing the feeds and avoiding forcing the baby to finish the feed can all help to make the experience as acceptable and stress-free for the baby as possible, as well as reducing the risk of overfeeding" (<https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/responsive-feeding-infosheet/>)

## Appendix 8.2: INITIATION OF LACTATION: ANTICIPATED BEHAVIOURS AND FEEDING PATTERNS\*

	Birth – 2 hours	2 - 20 hours	20 - 24 hours	24 - 48 hours	48 - 72 hours	> 72 hours
<b>INFANT</b> <i>State</i>	Alert, eager to suckle	Periods of light and deep sleep	Increasing wakefulness followed by long, deep sleep after cluster feeds	Similar to 20 - 24 hours. Periods of deep and light sleep	Periods of light and deep sleep	Periods of deep and light sleep
<i>Feeding patterns</i>	Breastfeed within 1 - 2 hrs after birth but may feed minimally	Sporadic, variable and frequent feeds (offer skin-to-skin to maximize feeding opportunities)	Frequent or cluster feedings, which may occur during the night.	Feeds frequently (at least 8 times per day)	Feeds frequently (at least 8 times per day)	Feeds frequently (8 or more times a day)
<i>Voids</i>	Not usual	Increase as feedings increase. May void 0 – 1 times	Gradually increases, may void 0 – 1 times. (uric acid crystals can be normal)	Increasingly wet diapers, urine pale in colour (may have 2 – 3 wet diapers in a day)	Increasingly wet diapers, urine pale (may have 3 or more wet diapers in a day)	Increasing numbers of wet diapers per day. Urine pale.
<i>Stools</i>	Not usual	Meconium	Meconium	Meconium and transition stool	Transition stools several times in the day	Transition – to lighter or yellowish stools
<i>Weight</i>		Decreases	Decreases	Decreases	Decreases	Decreases up to 10% and then begins to increase by day 4 or 5
<b>MOTHER</b>	Produces colostrum	Colostrum - as colostrum removed, alveoli cells secrete milk or colostrum	Colostrum - transition milk may start but this usually occurs earlier in multips than primips	Transition milk - breast fullness may appear as milk starts to increase	Breast fullness	Engorgement if feedings have not been frequent

\* Variances occur. Factors that slow initiation of the lactation process are: cesarean birth, analgesics and anaesthetics (epidurals included) during supplementation, lack of breast stimulation, sleepy infant, and any additional conditions that interfere with frequent and unlimited feedings.

Roberta J. Hewat, PhD, RN, IBCLC May be copied in its entirety, not to be adapted without permission and not to be used for commercial purposes.

## Appendix 9: Artificial Teats Checklist

(Y = Yes; N = No; IP = In Progress)

**Y N IP**

- Pacifiers/soothers/dummies are not routinely offered to breastfeeding babies
- Parents are taught calming techniques for babies as alternatives to soothers/pacifiers/dummies
- Artificial teats (bottle nipples) are not routinely offered to breastfed babies
- When supplemental feedings are required (or provided), alternatives to bottles and teats (e.g., cup or spoon) are recommended and provided especially in the early postpartum period
- Nipple shields are not routinely provided - if they are used, breastfeeding assessment is documented and the mother receives support, information, and follow-up.

**Appendix 10.1: Continuum of Care Checklist**

(Y = Yes; N = No; IP = In Progress)

**Y N P**

- there is strong liaison and communication between hospital and community health services
- prior to hospital discharge, effectiveness of breastfeeding is assessed, variances identified and appropriate discharge feeding plans are in place
- there is a system of follow-up support for mothers after they are discharged (e.g., early postnatal or breastfeeding clinic check-up, home visit, telephone call, or referral to a mother support group)
- in the community, effectiveness of breastfeeding is assessed, variances identified and appropriate feeding plans are in place
- parents receive written information on how to tell that their baby is feeding well and where to seek assistance if needed
- referrals are routinely made to community resources:
  - mother-to-mother (peer) support groups exist and families are referred to them
  - other services are available such as baby clinics, telephone help lines, home visits from community health nurses and breastfeeding clinics
- the hospital, CHS and other community groups collaborate to promote/support breastfeeding (e.g., family physicians, pediatricians, midwives, Pregnancy Outreach Programs, Canada Prenatal Nutrition Programs, daycares, schools, employers and businesses, media, and World Breastfeeding Week)
- outreach occurs to families in the community who do not routinely or regularly use the hospital and CHS programs, to ensure that the above information is accessible to them in a timely fashion (e.g., web or printed information, including translations, liaison between community institutions, peer support groups and community health care providers to share the above information as widely as possible).

## Appendix 10.2: Primary Health Care and Population Health Principles Checklist

**Community Health Services** apply principles of Primary Health Care and Population Health to support the continuum of care and create strategies that affect the broad determinants that improve breastfeeding outcomes.

**Community Health Services** show mechanisms to engage and collaborate with multiple stakeholders to assess, understand and address breastfeeding rates, trends, and disparities in the community. This includes:

(Y = Yes; N = No; IP = In Progress)

Y N P

- collaborate and partner with others (e.g., primary health care partners, community members) to assess and understand the cultural norms and conditions within the community effecting breastfeeding rates and disparities
- apply population health promotion strategies to promote breastfeeding for the entire population as well as address disparities between populations
- create supportive environments in workplaces and the community to welcome breastfeeding mothers
- advocate for and with others for breastfeeding policies and rights in workplaces and the community
- use communication strategies including social marketing and social media to reach diverse populations
- apply a diversity and inclusion lens to breastfeeding program development and implementation
- use community development principles to engage stakeholders to determine appropriate, accessible, and affordable service delivery to support breastfeeding in the community (e.g., building capacity to create peer support programs and establishing primary health care drop-in clinics)
- evaluate program and service delivery effectiveness to improve breastfeeding rates
- advocate for accessible and affordable human donor milk in the region
- communicate and advocate for *The Code* compliance in the community and through local and national policy and legislation
- incorporate the importance of sustaining breastfeeding in emergency preparedness plans.

## Appendix 11: The WHO International Code of Marketing of Breast-milk Substitutes Compliance Checklist

(Y = Yes; N = No; IP = In Progress)

**Y N IP**

- human milk substitutes, products or promotional items that fall within the scope of *The WHO Code* are not promoted, distributed, or displayed
- free samples of human milk substitutes are not given to mothers
- company personnel do not advise mothers
- teaching materials, posters, calendars, videos, websites etc. are free of commercial endorsements including human milk substitutes, bottles, soothers, and artificial nipples
- equipment including bottles, weight graphs, office supplies, crib cards, measuring tapes etc. are free of commercial endorsements (including company name or product name)
- all independently-run businesses operating on the facility site(s) are informed of *The WHO Code* and do not display or discount products that fall within the scope of *The WHO Code*. These products may be sold to clients who request them
- staff and health care providers' education is not sponsored or provided by companies whose products fall within the scope of *The WHO Code*
- hospital or CHS foundations and other charitable funding bodies do not accept funds from companies whose products fall within the scope of *The WHO Code*
- gifts or personal samples from companies which produce products that fall under the Code are not accepted by staff or hcps
- space, equipment, or educational materials sponsored or produced by companies are not used when teaching mothers about infant feeding
- human milk substitutes are kept out of the sight of pregnant women and mothers
- staff or hcps only demonstrate the use of human milk substitutes to postnatal mothers or family members who need to use them or who have made an informed decision to use them
- gift packs with human milk substitutes or related supplies are not distributed to pregnant women or mothers
- financial or material inducements to promote products within the scope of the Code are not be accepted by staff or hcps or their families
- manufacturers and distributors of products within the scope of the Code disclose to the institution any contributions made to staff or hcps, such as fellowships, study tours, research grants, conferences, or the like. The recipient should make similar disclosures.

**Purchase arrangements for human milk substitutes, specialty milk substitutes, fortifiers and feeding equipment used in facility**, including those for use in Pediatric and Special Care Units confirm that the facility:

(Y = Yes; N = No; IP = In Progress)

**Y N IP**

- does not promote products covered by *The Code*
- does not profit in a way that could influence care from a purchase agreement with a company whose products are covered by *The Code*
- human milk substitutes and feeding equipment are purchased in the same manner as other pharmaceuticals and food
- volumes purchased are realistic and in line with the small amount of human milk substitute consumption anticipated
- no free or low cost supply arrangement is attached to the purchase agreement, and no refunds on competitor contracts.

## Summary of the WHO International Code of Marketing of Breast-milk Substitutes<sup>23</sup> and Relevant Resolutions of the World Health Assembly

*The Code* includes these 10 important provisions:

1. **No advertising** of these products to the public
2. **No free samples** to mothers
3. No promotion of products in **health care facilities**
4. **No company mothercraft nurses** to advise mothers
5. **No gifts or personal samples to health workers**
6. **No words or pictures idealizing artificial feeding**, including pictures of infants, on the labels of the products
7. **Information** to health care workers should be **scientific and factual**
8. **All information** on artificial infant feeding, including the labels, should explain the **benefits of breastfeeding, and the costs and hazards associated with artificial feeding**
9. **Unsuitable products**, such as sweetened condensed milk, should not be promoted for babies
10. All products would be of a high **quality** and take account of the climatic and storage conditions of the country where they are used

### Relevant Resolutions of the World Health Assembly

#### WHA Resolution 39.28 (1986)

- Any food or drink given before complementary feeding is nutritionally required may interfere with the duration or maintenance of breastfeeding and therefore should neither be promoted nor encouraged for use by infants during this period.

The practice being introduced in some countries of providing infants with specially formulated milks (so-called follow-up milks) is not necessary.

For further information see: Chetley, A (1985). Protecting Infant Health: A Health Workers' Guide to the International Code of Marketing of Breast Milk Substitutes. International Organization of Consumers Unions. Penang. (Available in Canada from INFACI).

#### WHA Resolution 47.5 (1994)

- Member States are urged to "foster appropriate complementary feeding from the age of about six months."

#### WHA Resolution 49.15 (1996)

- Member States are urged to "ensure that complementary foods are not marketed for or used in ways that undermine exclusive and sustained breastfeeding."

#### WHA Resolution 54.2 (2001)

- Member States are urged to strengthen national mechanisms to ensure global compliance with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions regarding labelling and all forms of advertising and commercial promotion in all types of media, and to inform the general public on progress in implementing *The Code* and subsequent relevant WHA resolutions.
- Member states are urged to strengthen activities and develop new approaches to protect, promote and support exclusive breastfeeding for six months.

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<sup>23</sup> World Health Organization, Geneva, 1981

## Breastfeeding Committee for Canada

### The BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services

<b>Step 1</b>	WHO	Have a written breastfeeding policy that is routinely communicated to all health care staff.
	Canada	Have a written infant feeding policy that is routinely communicated to all staff, health care providers and volunteers.

<b>Step 2</b>	WHO	Train all health care staff in the skills necessary to implement the policy.
	Canada	Ensure all staff, health care providers and volunteers have the knowledge and skills necessary to implement the infant feeding policy.

<b>Step 3</b>	WHO	Inform pregnant women and their families about the benefits and management of breastfeeding.
	Canada	Inform pregnant women and their families about the importance and process of breastfeeding.

<b>Step 4</b>	WHO	Help mothers initiate breastfeeding within a half-hour of birth. WHO 2009: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.
	Canada	Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes. Encourage mothers to recognize when their babies are ready to feed, offering help as needed.

<b>Step 5</b>	WHO	Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.
	Canada	Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

<b>Step 6</b>	WHO	Give newborns no food or drink other than breastmilk, unless medically indicated.
	Canada	Support mothers to exclusively breastfeed for the first six months, unless supplements are <i>medically</i> indicated.

<b>Step 7</b>	WHO	Practice rooming-in - allow mothers and infants to remain together 24 hours a day.
	Canada	Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together.

<b>Step 8</b>	WHO	Encourage breastfeeding on demand.
	Canada	Encourage responsive, cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

<b>Step 9</b>	WHO	Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
	Canada	Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

<b>Step 10</b>	WHO	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
	Canada	Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.

<b>The Code</b>	WHO	Compliance with the International Code of Marketing of Breast-milk Substitutes.
	Canada	Compliance with the International Code of Marketing of Breast-milk Substitutes.