The Baby-Friendly Initiative:
Evidence-Informed Key Messages and Resources

Baby-Friendly Initiative Ontario
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Citation

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Baby-Friendly Initiative Standards
This resource supports the Baby-Friendly Initiative standards and was developed to promote Baby-Friendly Initiative implementation and maintenance.

Funding
This document has been prepared with funds provided by the Government of Ontario. The information herein reflects the views of the authors and is not officially endorsed by the Government of Ontario. The resources and programs cited throughout this resource are not necessarily endorsed by the Best Start Resource Centre, the Baby-Friendly Initiative Ontario or the Government of Ontario.
The purpose of this manual is to provide service providers with simple messages to support the Baby-Friendly Initiative.

The World Health Organization (WHO)/UNICEF’s Baby-Friendly Initiative (BFI) is a globally recognized, evidence-based standard of care shown to increase breastfeeding rates by promoting, protecting and supporting breastfeeding (Health Canada, 2012; Kramer et al., 2001; Public Health Agency of Canada, 2012). Consistent with this, a Toronto study showed that hospital practices based on the BFI Ten Steps to Successful Breastfeeding were significantly associated with up to 4.3 times higher rates of exclusive breastfeeding (Toronto Public Health, 2010).

The initiative consists of the 10 Steps to Successful Breastfeeding (WHO, 1989) and the WHO International Code of Marketing of Breastmilk Substitutes (WHO, 1981) and subsequent World Health Assembly (WHA) resolutions. In Canada, the initiative is overseen by the Breastfeeding Committee for Canada (BCC). It reflects the continuum of care by including hospitals and community health services. The BCC’s BFI Integrated Practice Outcome Indicators describe the international standards for the WHO/UNICEF Global Criteria within the Canadian context. For information on BFI designated facilities in Canada visit the BCC website at: www.breastfeedingcanada.ca.

As more organizations consider implementing the BFI, there is a need for support through evidence-informed resources. In 2009 and revised in 2011, the Regional Municipality of Halton’s Public Health Department developed a resource for the purpose of providing health care providers with a comprehensive list of key common messages supporting the BFI: Common Messages Supporting the Baby-Friendly Initiative: Working Document, Revision 2 (May 2011). BFI Ontario and the Best Start Resource Centre adapted this resource, with permission from the Regional Municipality of Halton, into this Ontario-wide, user-friendly resource. This resource provides evidence-informed, consistent messages, broken down into smaller pieces of information. The resources mentioned in this report support BFI implementation and maintenance. Specifically, this resource will:
1. Increase health care providers’ confidence as they implement or maintain BFI by providing key messages using evidence-informed language.

2. Assist facilities in using common language and messages regarding BFI that are consistent throughout programming and education within their own organizations.

3. Provide facilities with evidence-informed practical resources to assist with BFI implementation and maintenance.

This resource includes:

- A breakdown of each message with supporting rational and evidence.
- Evidence-informed resources that can be used to support the implementation and maintenance of BFI.
- References for each step, listed according to type (for example, Randomised Controlled Trial (RTC) – see below for codes used).

The four columns in each section provide the following information:

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<th>Step and message number</th>
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In each section, the Breastfeeding Committee for Canada’s – BFI Practice Outcome Indicators for Hospitals and Community Health Services are listed as the first resource for each key message and linked to the relevant outcome indicator and appendices. All other resources are also hyperlinked.

BFI Ontario and the Best Start Resource Centre hope you will enjoy and benefit from this resource as you navigate your BFI journey. This resource is available online to assist with updating both resources and references periodically. If you are aware of any resources or references that would benefit this resource, contact beststart@healthnexus.ca. If you have any questions about BFI implementation, contact your provincial/territorial representative for BCC. A list of representatives can be found on the BCC website.

Type of Evidence

CRev/IRev – Critical and integrative reviews

OBSERV – Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies.

OPINION – Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

QUALI – Qualitative research

QUASI – Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.

RCT – Evidence obtained from at least one randomized controlled trial.

SRev/META – Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
Development

This resource was adapted by the Best Start Resource Centre and the Baby-Friendly Initiative Ontario (formerly Ontario Breastfeeding Committee) with assistance from an advisory committee of academic and field experts representing key stakeholder organizations. It was reviewed by key topic and content experts, and tested by organizations at various stages of BFI implementation and maintenance.

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Members of the OSNPPH FHNAG BFI workgroup

Field Testing

BFI Ontario and the Best Start Resource Centre would like to thank the following organizations for field-testing this resource:
Middlesex-London Health Unit
Ottawa Public Health
St. Joseph’s Healthcare, Hamilton
Thunder Bay District Health Unit
Trillium Health Partners, Mississauga
York Region Community and Health Services
Summary of Key Messages

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

1.1  Well communicated policies are key to providing best practice in organizations ........................................ 8
1.2  Policies need to protect all mother-baby dyads regardless of feeding method ........................................ 9
1.3  Policies need to be modeled at the organizational level ........................................................................... 10

STEP 2  Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy.

2.1  Knowledge and understanding of organizational policies impacts attitudes and practice of health care providers ................................................................................................ 11
2.2  Acquiring and maintaining skills through education allows health care providers to fulfil their role ...................................................................................................................... 12

STEP 3  Inform pregnant women and their families about the importance and process of breastfeeding.

3.1  To make an informed decision on infant and toddler feeding, mothers and families need current and factual information ......................................................................................... 14
3.2  The principles of BFI support all mother-infant dyads and promote responsive parenting ..................... 19
3.3  Infant and toddler nutrition is a public health issue and not merely a lifestyle choice ............................. 19
3.4  Women are more likely to decide to breastfeed and maintain their decision when health care providers’ words and actions demonstrate that they value breastfeeding and breastmilk .......... 25

STEP 4  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.

4.1  Skin-to-skin contact matters for all babies and mothers regardless of feeding method ......................... 26
4.2  Assisting mothers to initiate breastfeeding when baby shows feeding readiness is a key to early breastfeeding success .............................................................................................................. 28

STEP 5  Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

5.1  Providing customized information and support to each mother increases mothers’ confidence ............................ 30
5.2  Client-centred, evidence-informed education is the right of all mothers and has the potential to affect parenting and infant feeding ................................................................................................. 31
5.3  When mothers face challenges with initiating and establishing breastfeeding they need additional interventions ....................................................................................................................... 32
5.4  When mothers and babies are separated, steps need to be taken to establish and maintain milk supply and get the milk to the baby ......................................................................................... 33
5.5  Mothers who choose or need to supplement their babies need factual information to do so in a safe and nurturing manner with support from their health care providers .............................. 34
STEP 6  Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.

6.1 Exclusive breastfeeding is recommended for the first six months of life for healthy term infants, as human milk provides optimal nutrition for infant’s growth and development .......................... 35

6.2 The use of breastmilk substitute (formula) is a medical treatment that should be used only after careful consideration and with mothers’ informed consent .......................... 36

6.3 Vitamin D drops are the only supplement routinely recommended for exclusively breastfed infants .................................................................38

6.4 There are some acceptable reasons for the use of breastmilk substitutes .......................... 39

STEP 7  Facilitate 24 hour rooming-in for all mother-infant dyads: Mothers and infants remain together.

7.1 Rooming-in benefits babies and mothers regardless of feeding method .......................... 42

7.2 Mother-infant contact benefits premature and sick infants and their mothers .......................... 44

STEP 8  Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

8.1 Baby-led or cue-based breastfeeding benefits babies .......................................................... 45

8.2 Mothers, babies, families and society benefit from sustained breastfeeding with the introduction of complementary foods ............................................. 46

8.3 Mothers and babies are supported to wean at their own pace ............................................. 48

STEP 9  Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

9.1 Breastfeeding is best established without the use of artificial nipples or the use of pacifiers .......... 49

9.2 The use of artificial nipples and pacifiers necessitates informed-decision making .......................... 51

STEP 10 Provide a seamless transition between the services provided by the hospital, community health services and peer support programs.

10.1 Strategies which promote family, peer and professional support matter for breastfeeding success ................................................................. 52

10.2 A culture supporting the Baby-Friendly Initiative protects, promotes and supports breastfeeding and responsive parenting ............................................. 54

10.3 The determinants of health should be considered when counselling mothers regarding breastfeeding ................................................................. 55

STEP 11  World Health Organization (WHO) International Code of Marketing of Breastmilk Substitutes

11.1 Compliance with the WHO International Code of Marketing of Breastmilk Substitutes and its subsequent resolutions is essential and ethical ............................................. 56
**Step 1** Have a written breastfeeding policy that is routinely communicated to all health care providers and volunteers.

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<tr>
<td>1.1</td>
<td>Well communicated policies are key to providing best practice in organizations.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 1 and related appendices</td>
</tr>
<tr>
<td>1.1.1</td>
<td>Policies, protocols and clinical guidelines in maternal child settings should reflect the 10 Steps to Successful Breastfeeding and the WHO International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.</td>
<td>Organizations have clear, evidence-informed guidelines and practices, when policies, protocols and clinical guidelines follow the recommendations of the 10 Steps and the Code.</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendix 1 – Policy Checklist</td>
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<td>1.1.2</td>
<td>Policies must be developed with input from key stakeholders, reviewed and evaluated regularly to ensure ongoing relevance and evidence-informed practice.</td>
<td>Organizational policies are reviewed regularly in collaboration with multiple stakeholders and evaluated for effectiveness (BCC, 2011)</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendix 1 – Policy Checklist</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Policies, protocols and clinical guidelines that reflect the 10 Steps and the Code have a positive impact on breastfeeding.</td>
<td>Policies, protocols and clinical guidelines reflecting the 10 Steps and the Code have a positive impact on breastfeeding success (DeClercq et al., 2009; DiGirolamo et al., 2008; Kramer et al., 2001; Ingram et al., 2011; Renfrew et al., 2012).</td>
<td>Provincial Council for Maternal and Child Health – Policy Template – Community Organizations Provincial Council for Maternal and Child Health – Policy Template – Hospitals</td>
</tr>
<tr>
<td>1.2</td>
<td>Policies need to protect all mother-baby dyads regardless of feeding method.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 1 and related appendices</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Policies need to identify how to support all mother-baby dyads.</td>
<td>According to the BCC, policies supporting BFI must identify and support policies and practices that support non-breastfeeding mothers</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendix 1 – Policy Checklist</td>
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<td>1.3</td>
<td><strong>Policies need to be modeled at the organizational level.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 1 and related appendices</td>
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<td>1.3.1</td>
<td>The values of an organization are reflected in the organizational culture.</td>
<td>Policies need to be approved as well as practiced by all levels of staff from CEO/ED to front-line staff.</td>
<td>Provincial Council for Maternal and Child Health – Breastfeeding Placemat Template for CEOs and Administrators of Hospitals, CEOs of Local Health Integration Networks, Executive Directors of Community Health Centres and Executive Directors of Aboriginal Health Access Centres</td>
</tr>
<tr>
<td>1.3.2</td>
<td>The values of an organization are reflected in both the practices and treatment of staff and volunteers.</td>
<td>When employees breastfeed, organizations benefit with less absenteeism, greater job satisfaction, decreased employee turn-over and greater productivity (Mills, 2009; Stewart-Glenn, 2008; Witters-Green, 2003).</td>
<td>Best Start Resource Centre – How to Be a Family-Friendly Workplace Ontario Public Health Association – Creating a Breastfeeding Friendly Workplace</td>
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Step 2 Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy.

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<td>2.1</td>
<td>Knowledge and understanding of organizational policies impacts attitudes and practice of health care providers.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 2 and related appendices</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Knowledge affects attitude and practices of health care providers.</td>
<td>Increased knowledge of policies and their rationale positively affects attitudes and practices of health care providers (Lutter et al., 1997; Merewood et al., 2005).</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendix 2.1</td>
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<tr>
<td>2.1.2</td>
<td>All staff and stakeholders’ practices are affected by the education they received.</td>
<td>According to BCC, education should include all staff, volunteers and community stakeholders for maximum effectiveness.</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendices 2.1 and 2.2</td>
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<tr>
<td>2.2</td>
<td>Acquiring and maintaining skills through education allows health care providers to fulfil their role.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 2 and related appendices</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Increased skill of health care providers increases their confidence in practice.</td>
<td>When health care providers acquire and maintain skills they are more likely to practice with confidence and satisfaction (Cattaneo &amp; Buzzetti, 2001; Ingram et al., 2011; Kramer et al., 2001). By practicing with confidence, nurses and other health care providers can support mothers’ efforts to breastfeed successfully (Noel-Weiss et al., 2006).</td>
<td>Education supporting BFI: Best Start Resource Centre – Healthy Mothers, Healthy Babies breastfeeding web course Ontario Public Health Association – Breastfeeding Curriculum for Undergraduate Health Professionals Quintessence Foundation – Course for policy makers (awareness), level 1 (direct contact) and level 2 (direct contact and specialist)</td>
</tr>
<tr>
<td>2.2.2</td>
<td>According to the Baby-Friendly Initiative, education for staff and volunteers should include:</td>
<td>• The principles of the Baby-Friendly Initiative. • The WHO International Code of Marketing of Breastmilk Substitutes and subsequent resolutions. • How to support informed decision-making. • How to provide individual, culturally appropriate, supportive, and empowering breastfeeding education. • How to support non-breastfeeding mothers (see step 6). • The principles of population-based breastfeeding promotion related to the population served by the organization (BCC, 2011).</td>
<td>Registered Nurses Association of Ontario – Best Practice Guidelines for Breastfeeding Registered Nurses Association of Ontario – Breastfeeding: Fundamental Concepts – A Self-Learning Package Registered Nurses Association of Ontario – Breastfeeding e-learning University of Manitoba’s free online course Multidisciplinary Breast Feeding Education WHO Baby-Friendly Initiative includes a course for decision makers and a 20 hour course for maternity staff (awareness, direct contact)</td>
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| 2.2.3                   | According to the Provincial Council for Maternal and Child Health, three levels of education are recognized. | • Awareness  
• Direct contact  
• Specialist  
(PCMCH, 2009)  
For information about this classification, check the resource on the right. | Provincial Council for Maternal and Child Health – Breastfeeding Curriculum Outline and Educational Resources |
| 2.2.4                   | Continuing education is best practice. | Breastfeeding education for staff and volunteers should be ongoing. Tracking education offered and attendance promotes accountability and continuing education. |
**Step 3** Inform pregnant women and their families about the importance and process of breastfeeding.

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<td>3.1</td>
<td>To make an informed decision on infant and toddler feeding, mothers and families need current and factual information.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 3 and related appendices</td>
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<tr>
<td>3.1.1 to 3.1.6</td>
<td>According to the Breastfeeding Committee for Canada, as a minimum this information should include the following points:</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – step 3</td>
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<td>3.1.1</td>
<td>The importance of exclusive breastfeeding during the first six months from birth, and sustained breastfeeding for two years or beyond.</td>
<td>The benefits of breastfeeding are dose related. For example, a baby breastfed for longer than 4 months has a lower risk of developing diabetes than a baby breastfed for 2 months (Ip, 2009). Breastfeeding provides total nutrition for the first 6 months (Dewey, 2001; Kramer &amp; Kakuma, 2009) and provides an ongoing nutritional component throughout infancy and toddlerhood. Breastfeeding is cost-effective and reduces inequalities. For example, a breastfeeding family has more available income for nutrition for the entire family. Breastfeeding decreased baby’s response to painful stimuli (Shah, 2009).</td>
<td>Health Canada – Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada See step 6 for information about Vitamin D Ontario Public Health Association – Position Paper: Breastfeeding Position Paper Ontario Public Health Association – Position Paper: Informed Decision-Making and Infant Feeding</td>
</tr>
<tr>
<td>3.1.2</td>
<td>The importance of breastfeeding for both mother and baby.</td>
<td>Colostrum has high immunologic properties that are well suited to the newborn. Continued exclusive breastfeeding contributes to the development of an effective immune system (Forchielli &amp; Walker, 2005). Breastmilk is a living fluid that changes to meet the needs of a growing baby. Breastfeeding is a brain and relationship building activity for both mother and baby (Clinton, 2012) There is strong evidence that prolonged and exclusive breastfeeding has many benefits to baby, mother and society (Meyers, 2009). Even short-term breastfeeding confers some of these benefits.</td>
<td>Health Canada – Ten Valuable Tips for Successful Breastfeeding and 10 Great Reasons to Breastfeed your Baby Best Start Resource Centre – Breastfeeding Matters: An important guide to breastfeeding for women and their families. – Chapter 1 World Health Organization – Long-term effects of breastfeeding: A Systematic Review Evergreen Perinatal Education and La Leche League – Outcomes of Breastfeeding versus Formula Feeding</td>
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| **3.1.3** | Information about donor milk banking. | According to WHO and other experts, if the mother’s own expressed breastmilk is not available to supplement her baby, the next choice is pasteurized, banked human milk particularly for sick or premature infants in hospital. | Roger Hixon Ontario Human Milk Bank  
Human Milk Banks of North America |
| **3.1.4** | The risks and costs associated with the use of breastmilk substitutes: For baby | NOT breastfeeding increases the risk of:  
Sudden Infant Death Syndrome (SIDS) (Ip et al., 2009; Venneman, 2009) and post neonatal death (Chen, 2004).  
Infections (Duijts et al., 2010) such as:  
• ear (Ip et al., 2009);  
• lower respiratory tract (Ip et al., 2009; Kramer et al., 2009);  
• urinary tract (Marild, 2004); and  
• bacterial meningitis (Hanson, 2007).  
Inflammation of the gut leading to:  
• diarrhea (Kramer et al., 2001; Quigley, 2007; Talayero, 2006);  
• gastrointestinal infections (Kramer et al., 2009);  
• inflammation of the stomach and intestines that can lead to necrotizing enterocolitis in preterm babies (McGuire & Anthony, 2003); | Stuebe, A. (2009). The Risks of Not Breastfeeding for Mothers and Infants  
Evergreen Perinatal Education and La Leche League – Outcomes of Breastfeeding |
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<td><strong>3.1.4</strong></td>
<td>The risks and costs associated with the use of breastmilk substitutes (continued): For baby (continued)</td>
<td>• crohn’s disease, ulcerative colitis, and other digestive diseases (Barclay et al., 2009; Klement et al., 2004). The association is expected to increase with better quality studies. Chronic diseases such as: • obesity (Horta, 2013; Ip, 2009); • type II diabetes (Horta, 2013; Ip, 2009); • high blood pressure and heart disease in adulthood (Horta, 2013; Singhal et al., 2001), though others say the latter are less conclusive (Fall et al., 2011; Ip, 2009); • higher cholesterol levels as adults (Horta, 2013); and • some childhood cancers such as acute lymphoblastic leukemia, Hodgkin’s disease and neuroblastoma (Ip, 2009; Martin et al., 2005). Decreased IQ (Horta, 2013).</td>
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<tr>
<td></td>
<td>For mother</td>
<td>Not breastfeeding increases a mother’s risk of: Breast (Ip, 2009) and ovarian cancer (Ip, 2009) Chronic diseases such as cardiovascular disease, (Schwarz et al., 2009), and type 2 diabetes and the metabolic syndrome (Schnatz et al., 2010; Wiklund, et al., 2011).</td>
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<td><strong>3.1.4</strong></td>
<td>The risks and costs associated with the use of breastmilk substitutes (continued):</td>
<td>Breastmilk substitutes increase the cost of health for families and society (Ball &amp; Bennett, 2001; Bartick &amp; Reinhold, 2010; Cattaneo et al., 2006).</td>
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<td></td>
<td>For health care/society</td>
<td>• There have been many recorded incidences where infants became sick from breastmilk substitutes. Some were due to manufacturer’s errors, others from errors in reconstitution. Powdered infant formula poses an independent risk of infection as it is not sterile (Reich et al., 2010).</td>
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<td>• Money for breastmilk substitutes and feeding accessories can use a substantial part of a family’s budget.</td>
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<td>Reversing a decision to stop breastfeeding can be difficult and sometimes impossible.</td>
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<td><strong>3.1.5</strong></td>
<td>Care supportive of establishing and sustaining breastfeeding.</td>
<td>See key messages and resources for steps 5 – 10.</td>
<td>See Step 5</td>
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<tr>
<td><strong>3.1.6</strong></td>
<td>The importance of immediate and prolonged skin-to-skin care for all infants (including kangaroo care for premature infants).</td>
<td>See key messages and resources for step 4.</td>
<td>See Step 4</td>
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<td>3.2</td>
<td><strong>The principles of BFI support all mother-infant dyads and promote responsive parenting.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 3, related appendices and components from Steps 4 to 9</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Families need to receive the message that BFI principles and practices support all mother-baby dyads regardless of feeding choice.</td>
<td>Informed-decision making, skin-to-skin holding, cue-based feeding, continuity of care and post-partum support are some of the principles and practices that support all mother-baby dyads. These practices promote responsive parenting.</td>
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<td>3.2.2</td>
<td>All families need to be welcomed and supported.</td>
<td>The practices of family-centered or client-centered care have been established as best practices in supporting openness, respect and empowerment.</td>
<td>Public Health Agency of Canada – Family-Centered Maternity and Newborn Care: National Guidelines – Chapter 1 Introduction and Philosophy (This resource is currently not available online.)</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Mothers need to know their rights regarding breastfeeding</td>
<td>The Ontario Human Rights Commission supports the rights of breastfeeding mothers including breastfeeding in public.</td>
<td>Ontario Human Rights Commission – Pregnancy and Breastfeeding</td>
</tr>
<tr>
<td>3.3</td>
<td><strong>Infant and toddler nutrition is a public health issue and not merely a lifestyle choice.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 3 and related appendices</td>
</tr>
<tr>
<td>3.3.1 to 3.3.10</td>
<td>Pregnant women benefit from open discussions around the following topics and additional support, particularly, if they are at risk of not breastfeeding or early cessation of breastfeeding.</td>
<td></td>
<td>Public Health Agency of Canada – Family-Centered Maternity and Newborn Care: National Guidelines – Chapter 4 Care During Pregnancy (This resource is currently not available online.)</td>
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<tr>
<td><strong>3.3.1</strong> Alcohol</td>
<td>Alcohol consumed by the mother passes into her bloodstream and her breastmilk (Giglia et al., 2008). Alcohol in breastmilk can negatively affect infant sleep and intake of breastmilk (Menella &amp; Garcia-Gomez, 2001). Health care providers can assist mothers who choose to drink alcohol and breastfeed to avoid or minimize the baby's exposure to alcohol (Chien et al., 2005; Health Canada, 2012; Koren, 2002).</td>
<td>Best Start Resource Centre – Breastfeeding and Alcohol Use: Parent Knowledge and Behaviour in Ontario</td>
<td>Best Start Resource Centre – Resources on Alcohol</td>
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</table>
| **3.3.2** Birth control | Breastfeeding can provide a natural period of protection from future pregnancy. The Lactational Amenorrhea Method (LAM) can be used to prevent a pregnancy during the first six months postpartum if the following conditions are met (Peterson et al., 2000):  
  • Breastfeeding is exclusive (no supplemental feedings except for medications or vitamins; feedings occur at least every four hours during the day and no longer than one six hour stretch at night; there is no use of soothers, or expressed milk feedings).  
  • No vaginal bleeding or spotting after lochia ends (all bleeding, spotting, or bloody vaginal discharge before postpartum day 56 can be ignored).  
  • The baby is less than six months old.  
Non hormonal methods are the first choice in family planning options for breastfeeding mothers according to WHO (Academy of Breastfeeding Medicine, 2006; WHO, 2008), but trials are still insufficient to establish effect of hormonal contraception (Truitt et al., 2003, Espey et al., 2012). | Halton Region – Breastfeeding and Birth Control – What are my options?  
Society of Obstetricians and Gynecologists of Canada – Canadian Contraception Consensus  
World Alliance for Breastfeeding Action – LAM – The Lactational Amenorrhea Method  
World Health Organization. Progesterone-only contraceptive use during lactation and its effects on the neonate. |
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<tr>
<td>3.3.3</td>
<td>Family relationships</td>
<td>The support of partners, in particular, but also mothers, other family members and friends can both positively and negatively affect women’s breastfeeding experience and success (Arora et al., 2000; Clifford &amp; McIntyre, 2008).</td>
<td>Dadcentral.ca – 24hr Cribside Assistance: A site for Dads, by Dads.</td>
</tr>
<tr>
<td>3.3.4</td>
<td>History of maltreatment and sexual abuse</td>
<td>Memories from assaults and abuse can be triggered during pregnancy, birth and breastfeeding. Mothers need the support of health care providers who can listen, inform and support women towards healing. Women who have experienced sexual or physical abuse can find breastfeeding a vulnerable time and may find the experience traumatizing. Care needs to be individualized and the decision not to breastfeed needs to be respected (Wood &amp; Van Estrick, 2010).</td>
<td>A Safe Passage – Supporting Women Survivors of Abuse through the Childbearing Years</td>
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| 3.3.5                   | Nutrition                                                     | Milk composition relies on the mother’s nutrient stores. Her nutritional needs can be met with a balanced diet and by following the advice for breastfeeding women in Eating Well with Canada’s Food Guide. Breastfeeding women need an extra two to three Food Guide Servings each day. These extra food guide servings can either be included as an additional snack, or can be added to their usual meals. Breastfeeding women should drink enough fluids to satisfy their thirst and keep urine non-concentrated.  
• Mothers with very restricted diets, such as vegans, will likely need additional vitamin and mineral supplements.  
• Women can continue to take 0.4 mg folic acid supplement while breastfeeding and as part of their intra-conception health (Health Canada, 2009).  
Caffeine use is not contraindicated, but there may be a cumulative effect on infants causing irritability due to the long half-life particularly in the neonatal period (Hale 2010). Health Canada recommends breastfeeding women consume no more than 300mg of caffeine per day. |                                                  | Health Canada – Eating Well with Canada’s Food Guide  
Health Canada – Food and Nutrition – Pregnancy and Breastfeeding  
Health Canada – Food and Nutrition – Caffeine in Food |
<p>| 3.3.6                   | Obesity                                                      | Breastfeeding rates are lower amongst women with higher BMIs (Donath &amp; Amir, 2008). Breastfeeding challenges are more common in women with higher BMIs. |                                                  |</p>
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<td>3.3.7</td>
<td>Postpartum depression and anxiety</td>
<td>Dennis &amp; McQueen, (2007) and Ip et al., (2009) state that not breastfeeding or early cessation of breastfeeding is associated with an increased rate of postpartum depression. Those with depressive symptomatology in the perinatal period are at risk of early cessation of breastfeeding (Dennis &amp; McQueen, 2009).</td>
<td>Best Start Resource Centre – Resources on Postpartum Mood Disorders</td>
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| 3.3.9                   | Smoking                                                       | Breastfeeding rates are lower amongst women who smoke. Women who smoke are less inclined to intend to breastfeed (Donath & Amir, 2004; Horta, Kramer & Platt, 2001). Mothers who smoke are encouraged to breastfeed. Health care providers can offer the following strategies.  
• Mothers should limit their babies’ exposure to second-hand and third-hand smoke and keep their home and car smoke-free (Priest et al., 2009).  
• All mothers should be offered strategies to quit smoking or cut down on the number of cigarettes smoked (Lumley et al., 2009).  
• Mothers who are unable to smoke after breastfeeding to reduce the baby’s exposure to nicotine in the breastmilk (Dahlstrom et al., 2008; Mennella, Yourshaw & Morgan, 2007). | Best Start Resource Centre – Resources on Smoking and Tobacco |
### Step 3

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<td>3.3.10</td>
<td>Substance use</td>
<td>Substance use should not be an automatic exclusion to breastfeed. Pregnancy and breastfeeding may provide an opportunity for support and treatment. Pregnant women are often receptive to counselling to reduce or eliminate substance use. Caution must be taken as after maternal ingestion, small amounts of drugs of abuse may transfer to the infant over the next few days, and they may reside in the neonate for long periods. Therefore, the infant may test positive for weeks to months after maternal exposure. Mothers who abuse drugs should be forewarned that their infants will test drug screen positive for 2-4 weeks or more depending on the type of drug ingested and counselled regarding the negative effects on their infant (American Academy of Pediatrics, 2001).</td>
<td>Motherisk – <em>Pregnancy and Breastfeeding</em></td>
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<td><strong>3.4</strong></td>
<td>Women are more likely to decide to breastfeed and maintain their decision when health care providers’ words and actions demonstrate that they value breastfeeding and breastmilk.</td>
<td></td>
<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services</em> – Step 3 and related appendices</td>
</tr>
<tr>
<td><strong>3.4.1</strong></td>
<td>Women, especially those who are not sure about breastfeeding, want breastfeeding information during pregnancy (Aurora et al., 2000).</td>
<td>Prenatal classes, specifically designed to teach breastfeeding can increase self-efficacy (Noel-Weiss, Bassett, &amp; Cragg, 2006). Women are more likely to initiate breastfeeding and breastfeed longer on the recommendation of their health care provider (Clifford &amp; McIntyre, 2008). Midwives, nurses and other health care providers positively influence breastfeeding duration when providing skill-based teaching, accurate information, with sensitivity to mother’s needs and a positive attitude to breastfeeding, (Clifford &amp; McIntyre, 2008).</td>
<td>Health Canada – <em>Ten Valuable Tips for Successful Breastfeeding and 10 Great Reasons to Breastfeed your Baby</em></td>
</tr>
</tbody>
</table>
Step 4 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.

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<tr>
<td>4.1</td>
<td>Skin-to-skin contact matters for all babies and mothers regardless of feeding method.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 4 and related appendices</td>
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<tr>
<td><strong>4.1.1</strong></td>
<td>Immediate skin-to-skin contact following birth promotes an easier transition to extra-uterine life as evidenced by decreased crying, increased interaction with mother, and successful breastfeeding.</td>
<td>Skin-to-skin contact stabilizes the physiologic parameters: heart rate, respiratory rate, oxygen saturation and consumption, apnea and bradycardia episodes. Babies who are kept skin-to-skin have better thermoregulation than babies swaddled in blankets (Mori et al., 2010). Babies who are kept skin-to-skin have higher blood glucose level at two hours post birth (Moore et al., 2009). Skin-to-skin contact with their mothers allows babies to initiate pre-feeding and feeding behaviours that allow the baby to move towards the breast and nipple and self-latch (Widstrom et al., 2011). Babies breastfeed more successfully, if they are kept skin-to-skin following birth as opposed to being swaddled in blankets (Moore et al., 2012).</td>
<td>Provincial Council for Maternal Child Health – Mother-Baby Dyad Care: Implementation Tool Kit Best Start Resource Centre – Breastfeeding Matters: An important guide to women and their families. Section 2 – Getting started.</td>
</tr>
<tr>
<td><strong>4.1.2</strong></td>
<td>Immediate skin-to-skin contact is most beneficial, when it is uninterrupted for the first 2 hours post birth.</td>
<td>Any observations, data collection and procedures should be completed without interruption of skin-to-skin contact. Immediate and uninterrupted skin-to-skin contact at birth and rooming-in postpartum positively affects early mother-infant interaction (Dumas et al., 2013). Skin-to-skin contact is encouraged immediately following caesarean section.</td>
<td>Breast-Crawl – a video that shows how babies instinctively crawl to the breast and latch</td>
</tr>
<tr>
<td><strong>4.1.3</strong></td>
<td>Skin-to-skin contact beyond the immediate postpartum period, continues to benefit all babies and mothers.</td>
<td>Skin-to-skin contact continued beyond the immediate postpartum period has been shown to improve mother’s mood during the first 2 months and to increase breastfeeding rates at 3 months.</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – step 4 and related appendices</td>
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<td></td>
<td></td>
<td></td>
<td>St. Francis Xavier University – Enhancing Baby’s First Relationship: Results from a Study on Mother-Infant Skin-to-Skin Contact. A video for parents and one for health care providers present the findings from a study.</td>
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<tr>
<td>4.1.4</td>
<td>Partners or another support person can provide skin-to-skin contact when mothers are unable.</td>
<td>Babies, placed skin-to-skin with fathers when the mother was not available after birth, cry less, show more pre-feeding behaviours and may breastfeed earlier (Erlandsson, Dsilna, Fagerberg, &amp; Christensson, 2007).</td>
<td>Baby-Friendly UK – Skin-to-Skin in Theatre or Recovery – explains how mothers can be skin-to-skin with their babies following c-section.</td>
</tr>
<tr>
<td>4.2</td>
<td><strong>Assisting mothers to initiate breastfeeding when baby shows feeding readiness is a key to early breastfeeding success.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 4 and related appendices</td>
</tr>
<tr>
<td>4.2.1</td>
<td>There are post-birth practices that promote early breastfeeding initiation and success.</td>
<td>Most babies in skin-to-skin contact with their mothers will show feeding readiness within 60 minutes from birth (Widstrom et al., 2011) and often much sooner. Interruptions to the mother/baby dyad disrupt the transition for baby and can lead to poor feeding behaviour in the first few days (Righard &amp; Alade, 1990). Babies show earlier feeding cues, root and latch better, when they are not swaddled or tied, and do not have their hands covered (Widstrom et al., 2011). When babies are allowed a lot of time at and near the breast, they lose less weight, have transitional stools faster, feed better and more often (Yamauchi &amp; Yamanouchi, 1990).</td>
<td>Peel Region – Breastfeeding in the First Hours and Skin to Skin. These videos from the Region of Peel teach about breastfeeding initiation, cue based feeding and skin-to-skin contact.</td>
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<tr>
<td>4.2.2</td>
<td>Health care providers should be aware that birth practices can affect breastfeeding.</td>
<td>Caesarean births are linked to less successful breastfeeding initiation and may require additional breastfeeding support (Sakalidis et al., 2012). Several types of analgesia given to the mother during labour may interfere with the newborn’s spontaneous breast-seeking and breastfeeding behaviours (Ransjo-Arvidson et al., 2001). A small association between epidural anesthesia and less successful breastfeeding has been noted in some studies (Baumgarder et al., 2003; Emery, 2009). Women receiving epidural anesthesia during labour may require added breastfeeding support.</td>
<td>Public Health Agency of Canada – <em>Family-Centered Maternity and Newborn Care: National Guidelines – Chapter 5: Care During Labour and Birth</em> (This resource is currently not available online.)</td>
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**Step 5** Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

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<tr>
<td><strong>5.1</strong></td>
<td>Providing customized information and support to each mother increases mothers’ confidence.</td>
<td>Peer and professional support can lead to higher self-confidence (Larsen et al., 2008; Grassley et al., 2008).</td>
<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services</em> – Step 5 and related appendices</td>
</tr>
<tr>
<td><strong>5.1.1</strong></td>
<td>Peer and professional support improves mother’s confidence.</td>
<td>Higher self-efficacy is linked to better breastfeeding outcomes (Blyth et al., 2002; Chezem, 2003; Dennis, 2006; Nichols, 2009).</td>
<td>See also Step 10.</td>
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**5.1** Peer and professional support improves mother’s confidence. Higher self-efficacy is linked to better breastfeeding outcomes (Blyth et al., 2002; Chezem, 2003; Dennis, 2006; Nichols, 2009).
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<td>5.2</td>
<td><strong>Client-centred, evidence-informed education is the right of all mothers and has the potential to affect parenting and infant feeding</strong></td>
<td>As mothers recover from labour and birth they go through three distinct postpartum stages resulting in different information needs (Ingram, 2002). Information is more likely to be retained when it responds to the requests of each mother, and when it is based on principles of adult education, involving her auditory, visual and kinesthetic learning needs. Mother’s experience of breastfeeding is shaped in part by the information she receives from those she considers to be breastfeeding experts (Larsen et al., 2008).</td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 5 and related appendices</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Health care providers should keep in mind the following when providing information to new mothers:</td>
<td>Public Health Agency of Canada – Family-Centred Maternity and Newborn Care: National Guidelines – Appendix 2: The Three Phases of the Postpartum Period (This resource is currently not available online.) See Step 2 Public Health Agency of Canada and Quebec Breastfeeding Support Group Committee – Bring Baby to the Breast available from <a href="mailto:info@videoallattement.org">info@videoallattement.org</a> (418) 666-7000.</td>
<td></td>
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<tr>
<td>5.2.2</td>
<td>According to the Breastfeeding Committee for Canada, there are key skills that should be taught to help mothers learn to breastfeed. Skin-to-skin contact and cue-based feeding also promote responsive parenting in all mothers.</td>
<td>• Maintaining skin-to-skin contact. • Recognizing feeding cues. • Knowing about positioning and latching baby. • Learning hand expressing colostrum/breastmilk. • Understanding signs of effective milk transfer.</td>
<td>Queensld Government – Baby Feeding Cues (signs) Best Start Resource Centre – Breastfeeding Matters: An important guide to breastfeeding for women and their families. Section 3, 4 and 5. Best Start Resource Centre – Breastfeeding Your Baby resources Stanford School of Medicine – Newborn Nursery at LPCH – Hand Expression of Breastmilk Video</td>
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<td>5.2.3</td>
<td>Establishing a plentiful milk supply is key to maintaining lactation for as long as mother and baby wish.</td>
<td>Lactation adequacy is related to early milk volume (Hill et al., 2005). Frequent feeds from both breasts encourage plentiful milk supply and successful breastfeeding (Walshaw, 2010) and should respect baby’s cues.</td>
<td>Public Health Agency of Canada – <em>Family-Centred Maternity and Newborn Care: National Guidelines</em> – Chapter 7: Breastfeeding (This resource is currently not available online.) Region of Peel – Breastfeeding Resources – <em>Breastfeeding Instructional Videos</em></td>
</tr>
<tr>
<td>5.3</td>
<td><strong>When mothers face challenges with initiating and establishing breastfeeding they need additional interventions.</strong></td>
<td>If early breastfeeding challenges are not resolved by skin-to-skin contact, helpful positioning and deep latching, cue-based feeding and offering small amounts of colostrum to lick or take by spoon or cup, it is important to involve a breastfeeding expert to assist mother and baby.</td>
<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services</em> – Step 5 and related appendices</td>
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| 5.3.1                   | Common early challenges include:  
  • Baby not latching  
  • Baby latching poorly  
  • Mother experiences nipple pain which can be caused by a variety of reasons. | Proper advice and management is required to ensure that problems do not lead to a discontinuation of breastfeeding (Colin & Scott, 2002). Perceived insufficient milk supply is a frequent concern and reason for early weaning that can be addressed with maternal education (Gatti, 2008). Following an assessment of the mother-infant dyad, unrestricted feeding, using both breasts, improving latch and position, using breast compression are strategies to improve milk intake. Expressing breastmilk by hand or with a breastpump after feeds can increase milk supply. Galactogogues can be used in cases where there is no treatable cause of reduced milk production (Zuppa et al., 2010). | International Breastfeeding Centre – *Video Online and Information Sheets* |
<p>| 5.3.2                   | The most common causes for breastfeeding discontinuation are: perceived low milk supply, previous breastfeeding problems, and perceived ease of bottle-feeding. | | International Breastfeeding Centre – <em>Video Online and Information Sheets</em> |</p>
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<td>5.3.3</td>
<td>Timely interventions are critical to the success of breastfeeding.</td>
<td>Timely access to breastfeeding support, including professional support after discharge from hospital provides an assessment of infant well-being and can increase breastfeeding success.</td>
<td>See Step 10</td>
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<tr>
<td>5.4</td>
<td><strong>When mothers and babies are separated, steps need to be taken to establish and maintain milk supply and get the milk to the baby.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 5 and related appendices</td>
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<tr>
<td>5.4.1</td>
<td>When a mother and baby have to be separated, all efforts should be made to unite them as soon as possible and to support them during the separation.</td>
<td>Both infant and mother should be provided with tangible evidence of the other’s presence (e.g., picture of baby for mother, pad with breastmilk close to baby). This will stimulate let-down and increase prolactin levels in the mother and pre-feeding behaviour in the baby.</td>
<td>Best Start Resource Centre – Breastfeeding Matters Fact Sheet: Expression and Storage of Breastmilk</td>
</tr>
<tr>
<td>5.4.2</td>
<td>Frequent removal of milk/colostrum is needed to establish and maintain an adequate milk supply</td>
<td>The mother’s milk supply can be established and maintained by frequent, regular milk removal if, for any reason, the baby is not able to effectively stimulate milk supply or has to be separated from the mother (Hill et al., 2005). Hand expression yields more colostrum in the first 48 hours after birth than using a breast pump (Ohyama et al., 2010). Breast pumps should be used with discretion and require adequate follow up by a lactation consultant. Lactation adequacy is related to early milk volume (Hill et al., 2005).</td>
<td>Best Start Resource Centre – Breastfeeding Matters Fact Sheet: Expression and Storage of Breastmilk</td>
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<tr>
<td>5.5</td>
<td>Mothers who decide to or need to supplement their babies need factual information to do so in a safe and nurturing manner with support from their health care providers.</td>
<td>Teaching safe preparation, storage and feeding of breastmilk substitutes is part of the Baby-Friendly Initiative. This should always be taught on an individual basis. Brand names should not be used. Instructions should be based on the WHO guidelines.</td>
<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services</em> – Step 5 and related appendices</td>
</tr>
<tr>
<td>5.5.1</td>
<td>When parents need to or have decided to feed their infant breastmilk substitutes, teaching how to prepare, store and feed breastmilk substitutes (infant formula) in a safe and nurturing manner is key to infant health and well-being.</td>
<td></td>
<td>WHO – <em>Food Safety – Guidelines for the safe preparation, storage and handling of infant formula</em></td>
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<tr>
<td>5.5.2</td>
<td>Health care providers must ensure parents are aware of the AFASS principles when feeding breastmilk substitutes. When feeding breastmilk substitutes to their infants, parents needs to be sure their feeding decision is • acceptable • feasible • affordable • sustainable • safe (AFASS) These principles were established by WHO within the context of HIV transmission, but are applicable to any infant feeding decision.</td>
<td></td>
<td>WHO – <em>Guidelines on HIV and Infant Feeding</em></td>
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Step 6 Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.

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<tbody>
<tr>
<td>6.1</td>
<td>Exclusive breastfeeding is recommended for the first six months of life for healthy term infants, as human milk provides optimal nutrition for infant’s growth and development.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 6 and related appendices</td>
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<tr>
<td><strong>6.1.1</strong></td>
<td>Healthy term infants need only breastmilk until 6 months of age.</td>
<td>Breastmilk provides all the nutrition required for healthy term infants until 6 months of age (Health Canada, 2012). When mothers are well supported and follow the WHO recommendations on breastfeeding, their infants receive milk volumes that result in adequate energy intake and normal infant growth (Nielsen et al., 2011).</td>
<td>Health Canada – Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada</td>
</tr>
<tr>
<td><strong>6.1.2</strong></td>
<td>If supplementation is needed, mothers need information about hand expressing or pumping.</td>
<td>Expressing milk at least 7 times per 24 hour period will ensure that most mothers establish a plentiful milk supply without breastfeeding directly.</td>
<td>Best Start Resource Centre – Breastfeeding Matters Fact Sheets – Expressing and Storing Breastmilk</td>
</tr>
<tr>
<td><strong>6.2</strong></td>
<td><strong>The use of breastmilk substitute (formula) is a medical treatment that should be used only after careful consideration and with mothers’ informed consent.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 6 and related appendices</td>
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</table>
| **6.2.1**               | Current, factual information during pregnancy and after the birth supports informed-decision making. | Prenatal and postpartum information should include the information presented in step 3:  
- Medical reason for supplementation  
- Hazards of breastmilk substitutes  
- Preferred options of feeding:  
  - Expressed breastmilk (mother’s own)  
  - Banked donor milk  
  - Commercial breastmilk substitutes  
Mothers who receive prenatal education have lower rates of in hospital supplementation (Tender et al, 2009). | See step 3  
Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Appendix 6  
World Health Organization/UNICEF – Acceptable reasons for use of breast-milk substitutes |
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<tr>
<td>6.2.2</td>
<td>Health care providers should inform parents of safe and alternative feeding methods when a baby needs to be supplemented or when an informed decision to use breastmilk substitutes has been made.</td>
<td>If breastmilk substitutes are used, it must be done with attention to safety. If breastmilk substitutes are needed, health care providers should recommend the use of a concentrated liquid or ready-to-serve formula if the infant is premature, ill or has a compromised immune system. There is a risk of ingesting enterobacter sakazakii with powdered formula, which is not a sterilized substance (WHO, 2004). They should ensure safe and optimal reconstitution and storage for any baby. Parents should be taught to observe the infant for stress cues, signs of fullness and tolerance of the feeding. Parents need to learn how to feed in a responsive manner. The baby’s elimination patterns and weight gain patterns should be monitored to determine if the baby is getting enough. Parents need to be somewhat less concerned about the frequency of the feedings and the exact volume consumed during the feedings. The primary focus should be on the infant and the infant’s cues and responses. Families need to be aware of formula recalls and how to find the information. Families need to be aware of water contamination or the contents of their well water. Refer to the WHO/UNICEF document for more complete information regarding infant supplementation, temporary avoidance of breastfeeding, and maternal health conditions that may be a concern. Information should be provided individually, not in a group teaching situation.</td>
<td>See Step 5 World Health Organization/UNICEF – Guidelines for the safe preparation, storage and handling of powdered infant formula. Health Canada – Recommendations for the Preparation and Handling of Powdered Infant Formula World Health Organization/UNICEF – Question and answers on Enterobacter sakazakii in powdered infant formula. Health Canada – Advisories, Warnings and Recalls World Health Organization. Global Strategy for Infant and Young Child Feeding</td>
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### Step 6

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<tr>
<td>6.3</td>
<td><strong>Vitamin D drops are the only supplement routinely recommended for exclusively breastfed infants.</strong></td>
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<tr>
<td>6.3.1</td>
<td>Sunlight is the principle source of vitamin D for all humans.</td>
<td>Direct sun exposure is not recommended for infants (Casey 2010).</td>
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<tr>
<td>6.3.2</td>
<td>Vitamin D deficiency can lead to serious medical concerns.</td>
<td>Vitamin D deficiency can lead to children with low bone mass, poor bone growth, and mineralization. Inadequate levels can cause rickets, higher risk of osteoporosis, multiple sclerosis and some forms of cancer (Health Canada, 2004). The strongest evidence for the health benefits of vitamin D is for bone diseases, many types of cancer, cardio-vascular disease, metabolic diseases such as diabetes mellitus, multiple sclerosis, cognitive impairment, and some infections such as influenza, pneumonia, and septicemia (Grant, 2011). Vitamin D synthesis is influenced by skin pigmentation, amount of exposed skin, latitude (Casey, 2010) and use of sunblock (CPS, 2007). In one study the highest incidence of rickets was amongst children living in the north, and children with darker skin. 94% were breastfed, and none received the recommended dose of vitamin D supplement (Ward, 2007). After allowing for BMI, vitamin D levels are also influenced by the season (Ostergard, 2011).</td>
<td>Health Canada – <em>Vitamin D supplementation of breastfed infants in Canada: Key statistics and graphics (2007-2008)</em></td>
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<td><strong>6.3.3</strong></td>
<td>A Vitamin D supplement of 400 IU/day is recommended in Canada for all full-term healthy infants.</td>
<td>Evidence is mounting that recommended daily levels may have to be increased (CPS, 2007; Grant, 2011). No adverse effects have been shown at the currently recommended dose of 400 IU per day (Casey, 2010). In 2007-2008, the percent of mothers who gave a vitamin D supplement to their breastfed infant in Ontario was significantly lower than the national average of 67% (Health Canada, 2008).</td>
<td>Health Canada – <em>Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada</em></td>
</tr>
<tr>
<td><strong>6.3.4</strong></td>
<td>Vitamin D supplementation is recommended to begin at birth and continue until the child’s diet includes at least 400 IU/day of vitamin D from other dietary sources or until the infant reaches the age of two.</td>
<td>Health care providers should discuss vitamin D supplementation with parents including the mother’s Vitamin D levels, with recommendations as required for supplementation (Taylor, 2010; Linger-Gould, 2011). As a preventative measure, it is reasonable to offer vitamin D to the age of two years (Lerch, 2009).</td>
<td>Alberta Health Service – <em>Nutrition Guidelines for Healthy Infants and Young Children</em></td>
</tr>
<tr>
<td><strong>6.4</strong></td>
<td>There are some acceptable reasons for the use of breastmilk substitutes.</td>
<td></td>
<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 6 and related appendices</em></td>
</tr>
<tr>
<td><strong>6.4.1</strong></td>
<td>Some infants should not receive breastmilk or any other milk except specialized formula.</td>
<td>Infants with classic Galactosemia Infants with Maple Syrup Urine Disease Infants with Phenylketonurea (some breastfeeding is possible with careful monitoring)</td>
<td><em>Ontario Newborn Screening Program</em></td>
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### Step 6.4.3

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<tr>
<td>Some mothers may need to avoid breastfeeding permanently.</td>
<td>Mothers with HIV infections should avoid breastfeeding permanently if replacement feeding is acceptable, affordable, feasible, sustainable and safe (AFASS).</td>
<td>CAMH, Motherisk. Exposure to Psychotropic Medications and Other Substances during Pregnancy and Lactation. Motherisk – Breastfeeding and Drugs. Texas Tech University Health Sciences Centre – Infant Risk Centre – Recommendations for Radio-contrast Agents</td>
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### Step 6.4.4

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<tr>
<td>Some mothers may need to avoid breastfeeding temporarily. During this time mothers should be counselled how to maintain their milk supply. Some of these conditions may justify permanent avoidance of breastfeeding.</td>
<td>Mothers who are severely ill and unable to care for their infants. Mothers who have active lesions of herpes simplex virus type 1 on the breasts that may come in contact with the infant’s mouth should avoid breastfeeding until all active lesions have resolved. Mothers who are taking medications, including: Sedating psychotherapeutic drugs, anti-epileptic drugs, opioids and their combinations should be avoided and a safer alternative should be sought. It is possible to feed while on many psychotherapeutic medications, including methadone (Jansson et al., 2008). Radioactive iodine – 131 should be avoided and a safer alternative sought. Breastfeeding can resume two months after receiving this substance. Most radioactive substances used for common tests and procedures are compatible with breastfeeding or may only require a brief disruption of breastfeeding. Excessive use of topical iodine or iodophors on open wounds or mucous membranes can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided. During treatment with cytotoxic chemotherapy breastfeeding should be avoided. When mothers are taking any medications or substances it is important to seek out the latest references and reliable resources.</td>
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| 6.4.5                   | There are some health conditions that may be of concern, although breastfeeding can continue. | Breast abscess – breastfeeding should continue on the unaffected side and resume from the affected side, once treatment has started.  
Hepatitis B – Infants should be given the Hepatitis B vaccine within 48 hours or as soon as possible.  
Mastitis – Mothers should be treated by their health care provider and continue to breastfeed. If it is too painful to breastfeed, it is important for mothers to continue frequent milk removal.  
Substance use – Mothers should be encouraged not to use these substances, and given opportunities and support to abstain. | Best Start Resource Centre – Breastfeeding Matters Fact Sheet – Breast Infection (Mastitis)  
CAMH, Motherisk. Exposure to Psychotropic Medications and Other Substances during Pregnancy and Lactation. |
Step 7 Facilitate 24 hour rooming-in for all mother-infant dyads: Mothers and infants remain together.

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<tr>
<td>7.1</td>
<td>Rooming-in benefits babies and mothers regardless of feeding method.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 7 and related appendices</td>
</tr>
<tr>
<td>7.1.1</td>
<td>When mothers and babies room-in, babies transition more easily to extra-uterine life.</td>
<td>The smell, touch and sound of the mother helps babies stabilize their heart, respiratory rate and blood sugar (Moore, Anderson, Bergman, &amp; Dowswell, 2012). When mothers and babies room-in together, babies are more likely to spend less time in their cribs, and more time in quiet sleep (Keefe 1987).</td>
<td>Provincial Council for Maternal Child Health – Mother-Baby Dyad Care: Implementation Tool Kit</td>
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<td><strong>7.1.2</strong></td>
<td>When mothers and babies room-in, mothers adjust to their role more easily.</td>
<td>When mothers and babies remain together 24 hours a day, regardless of the feeding method, mothers have an easier transition to motherhood (O’Connor, Vietze, Sherrod, Sandler, &amp; Altmeier, 1980; Zuppa et al., 2009). Increased maternal Prolactin and Oxytocin levels provide the optimal environment for parental attachment (Uvnas-Moberg, 1998). Skin-to-skin holding and rooming-in postpartum positively affect early mother-infant interaction (Dumas et al., 2013). When mothers and babies room-in together, mothers are more likely to value closeness with their babies (Svensson, Matthiesson &amp; Windstrom, 2005) and have an increased attachment to their babies (Norr et al., 1989).</td>
<td>Provincial Council for Maternal Child Health – Mother-Baby Dyad Care: Implementation Tool Kit. Public Health Agency of Canada – Family-Centred Maternity and Newborn Care: National Guidelines Chapter 6 Early Postpartum Care of the Mother and Infant and Transition to the Community specifically: Combined Mother/Baby Postpartum Care (This resource is currently not available online.)</td>
</tr>
<tr>
<td><strong>7.1.3</strong></td>
<td>When mothers and babies room-in, babies are more likely to breastfeed and mothers are more likely to establish a plentiful milk supply.</td>
<td>When mothers and babies room-in together, babies breastfeed more often (Buranasin, 1991; Yamouchi &amp; Yamanouchi, 1990). Increased breastfeeding is associated with faster passage of meconium and decreased bilirubin levels (Yamouchi &amp; Yamanouchi, 1990). When mothers and babies room-in together, mothers are more likely to initiate breastfeeding (Buranasin, 1991), have an increased desire to breastfeed (Procianoy et al, 1987) and are more likely to establish a plentiful milk supply (DeCarvalho et al., 1983). Mothers are more likely to establish a plentiful milk supply if they experience frequent breast and nipple stimulation, and frequent milk removal. This happens when babies feed often and effectively (Neville &amp; Morton; 2001).</td>
<td>Kellymom.com: Parenting/Breastfeeding – How does milk production work? Public Health Agency of Canada – Family-Centred Maternity and Newborn Care: National Guidelines Chapter 6 Early Postpartum Care of the Mother and Infant and Transition to the Community specifically: Combined Mother/Baby Postpartum Care (This resource is currently not available online.)</td>
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<td>7.1.4</td>
<td>Babies are calmed during examinations or painful procedure, when they are with their mothers.</td>
<td>All procedures should be completed at mother’s bedside in hospital. Learning about her baby and how to soothe her baby is an empowering experience for new mothers. A support person can be present to assist and support the mother during her hospital stay.</td>
<td>Provincial Council for Maternal Child Health Mother-Baby Dyad Care: Implementation Tool Kit</td>
</tr>
<tr>
<td>7.2</td>
<td><strong>Mother-infant contact benefits premature and sick infants and their mothers.</strong></td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 7 and related appendices</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Premature infants benefit from Kangaroo care.</td>
<td>Premature babies held skin-to-skin according to kangaroo-care principles are less likely to have apnea attacks, breathe better, have a more stable temperature during kangaroo-care and tend to be more alert when awake (Bergman, ND).</td>
<td>Kangaroo Mother Care – About KMC</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Mothers of premature infants benefit from Kangaroo care.</td>
<td>Parents of premature babies become central to the caring team, tend to bond better and interact with their baby more. They may also experience more emotional healing and less guilt and learn more quickly about their baby (Bergman, ND).</td>
<td>Kangaroo Mother Care – About KMC</td>
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**Step 8** Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

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<tr>
<td>8.1</td>
<td>Baby-led or cue-based breastfeeding benefits babies.</td>
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<td>Breastfeeding Committee for Canada – <em>BFI Practice Outcome Indicators for Hospitals and Community Health Services</em> – Step 8 and related appendices</td>
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<td>8.1.1</td>
<td>Babies demonstrate feeding readiness by showing feeding cues.</td>
<td>Early feeding cues include: restless sleep, rooting, slight sucking motions, tongue extension. Active feeding cues include: rooting around to whatever baby is in contact with, trying to position self into a breastfeeding position, fidgeting and squirming, breathing fast, light sounds or whimpering and fussing. Late feeding cues include: moving head frantically from side to side, crying, exhaustion and falling asleep.</td>
<td>Kellymom.com: Parenting/Breastfeeding – Hunger Cues – When Do I Feed Baby? Queensland Government – Baby Feeding Cues (signs)</td>
</tr>
<tr>
<td>8.1.2</td>
<td>Cue-based feeding supports baby’s physiology.</td>
<td>Cue-based feeding supports the baby’s anatomy, physiology and nutritional needs (Goldman, 1993; Horta, 2013). Cue-based feeding minimizes weight loss, encourages appetite control, and is strongly linked to breastfeeding success (De Carvalho, Robertson, Friedman, &amp; Klaus, 1983).</td>
<td>Lisa Marasco and Jan Barger – Examining the Evidence for Cue feeding of Breastfed Infants</td>
</tr>
<tr>
<td>8.1.3</td>
<td>Cue-based feeding supports ongoing breastfeeding.</td>
<td>Mothers who feed their babies on cue are more likely to establish a plentiful milk supply that continues to support her growing baby’s individual needs (De Carvalho et al., 1983; Hartman &amp; Prosser 1984).</td>
<td>Kellymom.com: Parenting/Breastfeeding – Milk Production</td>
</tr>
<tr>
<td>8.2</td>
<td>Mothers, babies, families and society benefit from sustained breastfeeding with the introduction of complementary foods at 6 months of age.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 8 and related appendices</td>
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<tr>
<td>8.2.1</td>
<td>Sustained breastfeeding up to 2 years and beyond is normal and beneficial for both the child and the mother.</td>
<td>The benefits of breastfeeding are dose related. Sustained breastfeeding provides nutrition, energy (Michaelson et al., 2003) and protection against infection (Fisk et al., 2011) during the introduction of solids and during the child’s second year. Continued breastfeeding promotes sensitive parenting (Britton et al., 2006) and has a moderate protection against obesity later in life (Horta &amp; Victora, 2013; Scott et al., 2012). It also protects mothers against breast cancer (Chang-Claude et al., 2000).</td>
<td>Health Canada, Canadian Pediatric Society, Dietitians of Canada and the Breastfeeding Committee for Canada – Draft – Nutrition for Healthy term Infants: Recommendations from Six to 24 Months</td>
</tr>
<tr>
<td>8.2.2</td>
<td>Infants are developmentally ready for solid foods at about 6 months of age (Kramer 2001; Kramer 2009).</td>
<td>Infants are developmentally ready for solid foods at about six months of life as evidenced by (Naylor &amp; Morrow, 2001): • Neck and shoulder muscles are strong enough for head coordination of tongue, lips and swallow. • Baby has lost the tongue-thrust reflex. • Baby is able to sit up. • Baby is ready and willing to chew. • Baby is able to grasp (using the pincer grasp) and put things to his mouth. • Baby is looking for table food. • Oral reflexes have developed. • Immune system is ready to handle other foods and to protect against pathogens and allergies. Complementary foods should be introduced once the baby is developmentally ready. They should include iron rich foods (Health Canada 2012).</td>
<td>Kellymom.com: Parenting/Breastfeeding – Breastfeeding Past Infancy: Fact Sheet</td>
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| 8.2.3                   | At about 6 months babies should be introduced to complementary, iron-rich foods while continuing to breastfeed for 2 years and beyond. | At about six months babies are physiologically and physically ready for complementary foods (Rapley, 2011; Wright et al., 2011). Although babies’ main source of nutrition after six months is still breastmilk, babies receive key nutrients (e.g., iron) through the introduction of complementary foods (Kramer, Kakuma, & World Health Organization, 2001). Breastfeeding has nutritional, immunological and developmental value past the age of 6 months (Goldman, 1993; Horta, 2013). Breastfeeding continues to provide food security. | Best Start Resource Centre – *Feeding Your Baby from 6 Months to 1 Year*  
World Alliance for Breastfeeding Action (WABA) *Activity Sheet 10: Breastfeeding and Food Security*  
World Health Organization (WHO) – *Complementary feeding*  
Ontario Society of Nutrition Professionals in Public Health – *Discussion Paper – Food Allergy Risk Reduction in Infants and Young Children* |
| 8.3                     | Mothers and babies are supported to wean at their own pace. | | Breastfeeding Committee for Canada – *BFI Practice Outcome Indicators for Hospitals and Community Health Services* – Step 8 and related appendices |
| 8.3.1                   | Breastfeeding can continue as long as mother and baby wish regardless of work, school or other life situations. | Breastmilk continues to provide substantial amounts of key nutrients past 6 months and well beyond the first year of life, especially protein, fat, and most vitamins (Dewey, 2001). Human milk composition changes to adapt to the child’s age and may provide a significant amount of fat (Mandel, 2005), important to healthy brain development throughout the early years. Breastfeeding and returning to work and school is possible, and provides continued benefits to both mother and baby (Goldman, 1993; Horta, 2013). Reduced milk intake results in reduced milk production allowing for a gradual process of weaning (Peaker & Wilde, 1996). | Best Start Resource Centre – *Returning to Work after Baby*  
Ontario Human Rights Commission on Pregnancy and Breastfeeding  
Ontario Public Health Association – *Breastfeeding Friendly Workplace* |
**Step 9** Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

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<tr>
<td>9.1</td>
<td>Breastfeeding is best established without the use of artificial nipples or the use of pacifiers.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 9 and related appendices</td>
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<td>9.1.1</td>
<td>Mothers should be encouraged to care for their infants without the use of pacifiers, especially when breastfeeding is not yet established.</td>
<td>Parents can learn to soothe their infants in a variety of ways that do not include pacifiers, such as skin-to-skin holding, rocking, swaying, singing, talking, and massaging. The use of pacifiers may be a marker of breastfeeding difficulties or a reduced motivation to breastfeed (Kramer, 2001). Pacifier use is associated with greater incidence of otitis media (Niemela et al., 2002; Warren et al., 2001). Longer pacifier use (more than one year, and particularly more than five years) is associated with dentition problems (Warren, 2001). Pacifiers can harbour and transmit pathogens, pose a suffocation hazard if attached to the infant, and a choking hazard if used when they are worn or damaged. Pacifier use in healthy term babies may not significantly affect the prevalence or duration of exclusive or partial breastfeeding (Jaafar, 2012). Evidence to assess short-term breastfeeding difficulties or long-term effects of pacifiers is lacking. The use of supplemental bottles without adequate breast stimulation and milk removal is likely to result in a reduced and/or inadequate milk supply or the inability to maintain an adequate milk supply. It may not provide the conditions for the use of the Lactational Amenorrhea Method of birth control.</td>
<td>Kellymom.com: Parenting/Breastfeeding – What should I know about giving my breastfed baby a pacifier? International Breastfeeding Centre – Information Sheets See Step 5 See Step 3</td>
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<tr>
<td>9.2.1</td>
<td>If supplementation is needed, mothers should be encouraged to use alternative feeding methods.</td>
<td>The World Health Organization recommends that the following alternate feeding methods be used when supplementing healthy term infants. These feeding methods have not been found to be detrimental to babies (Howard et al., 2000): a) cup or spoon b) syringe or dropper c) feeding tube used at the breast or, if the baby is unable to latch, on a finger.</td>
<td>World Health Organization/UNICEF – Acceptable reasons for use of breast-milk substitutes World Health Organization (WHO) – Complementary feeding World Health Organization – Global Strategy for Infant and Young Child Feeding</td>
</tr>
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<td>9.2.2</td>
<td>Mothers need evidence-informed, current information to make informed decisions regarding the use of artificial nipples and pacifiers.</td>
<td>There has not been enough research to provide evidence regarding the use of alternate feeding methods, such as cup feeding. Anecdotal evidence links the use of alternate feeding methods to greater breastfeeding success. Cup feeding may benefit the mother-infant dyad when multiple supplements are required (Howard 2003). Babies are more likely to be exclusively breastfed upon hospital discharge if a cup was used as opposed to an artificial nipple for supplementation (Flint, New, &amp; Davies, 2008).</td>
<td>Bandara et al.; Round Table Discussion – Use of Alternative Feeding Methods in the Hospital</td>
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Step 10 **Provide a seamless transition between the services provided by the hospital, community health services and peer support programs.**

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<tbody>
<tr>
<td>10.1</td>
<td>Strategies which promote family, peer and professional support matter for breastfeeding success.</td>
<td></td>
<td>Breastfeeding Committee for Canada – BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 10 and related appendices</td>
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<tr>
<td>10.1.1</td>
<td>Mothers and babies benefit from consistent support, evidence-informed care and appropriate interventions.</td>
<td>Babies benefit from close monitoring until their pattern of weight gain has been established (Public Health Agency of Canada, 2000). Professional support can provide immediate and long-term interventions to support continued and long-term breastfeeding (Barros et al., 1995; Haider et al., 1996; Haider et al., 2000; Lutter et al., 1997; Neyzi et al., 1991; Palda et al., 2004; Renfrew et al., 2012).</td>
<td>Public Health Agency of Canada – Family-Centred Maternity and Newborn Care: National Guidelines Chapter 6 Early Postpartum Care of the Mother and Infant and Transition to the Community specifically: Transition to Home and Community and Maternal and Newborn Support Outcomes (This resource is currently not available online.)</td>
</tr>
<tr>
<td>10.1.2</td>
<td>Mothers and families benefit from evidenced-informed information provided throughout all community programs and services.</td>
<td>Mothers benefit from anticipatory guidance about common breastfeeding problems. Consistent information will ensure that mothers (and health care providers) are aware that breastfed babies have different growth patterns than babies given breastmilk substitutes (de Onis et al., 2006; Marchand, 2010). Education of all health care professionals who are involved with the family will ensure consistent messaging (Cattaneo &amp; Buzzetti, 2001).</td>
<td>Public Health Agency of Canada – Family-Centred Maternity and Newborn Care: National Guidelines – Chapter 7: Breastfeeding (This resource is currently not available online.) Health Canada, Canadian Paediatric Society, Dietitians of Canada &amp; Breastfeeding Committee for Canada: Nutrition for Healthy Term Infants Dietitians of Canada – WHO Growth Charts adapted for Canada See Step 2 Dadcentral.ca – 24hr Cribside Assistance: A site for Dads, by Dads</td>
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<td>10.1.3</td>
<td>Mothers and babies benefit from peer support networks.</td>
<td>Peer support can be given through formal and informal networks, mentoring groups, professional or para-professional community sites (e.g., breastfeeding clinics, drop-ins, parenting groups) (Renfrew et al., 2012).</td>
<td>Breastfeeding Buddies and similar peer support programs are run by many public health units in Ontario. La Leche League Canada Other parent support programs providing peer to peer breastfeeding support (e.g., Life with a Baby)</td>
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<td>10.2</td>
<td><strong>A culture supporting the Baby-Friendly Initiative protects, promotes and supports breastfeeding and responsive parenting.</strong></td>
<td>To create a culture supporting BFI, messages can be incorporated into many social and health care initiatives (e.g., food security, attachment, obesity strategy, poverty strategy). A culture that supports BFI principles in local communities promotes longer duration of breastfeeding (Hoddinott, Chalmers, &amp; Pill, 2006; Palda et al., 2004; Sikorski et al., 2003). Breastfeeding is a human right and can be done anytime and anywhere (Ontario Human Rights Commission, 2008). Breastfeeding and breastmilk feeding is beneficial to mother and baby when mothers return to work or school (Goldman, 1993; Horta, 2013). Valuing skin-to-skin contact and cue-based feeding supports all mothers regardless of feeding method and promotes responsive parenting.</td>
<td>Breastfeeding Committee for Canada - BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 10 and related appendices Provincial Council for Maternal and Child Health – Placemat Template for CEOs and Administrators Ontario Human Rights Commission – Policy on discrimination because of pregnancy and breastfeeding</td>
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<td>10.2.1</td>
<td>The creation of a culture supporting BFI should be promoted in all health care and community settings.</td>
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<td>10.2.2</td>
<td><strong>A culture supporting BFI provides support to mothers, partners and babies.</strong></td>
<td>In a BFI supportive culture, families are supported as they go through life changes and challenges including work and school.</td>
<td>See Step 8 Best Start Resource Centre – Breastfeeding Matters: An important guide to women and their families – Section 5: Frequently Asked Questions and Section 6: Getting Help</td>
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<td>10.3</td>
<td>The determinants of health should be considered when counselling mothers regarding breastfeeding.</td>
<td>First, consider the determinants of health.</td>
<td>Breastfeeding Committee for Canada - BFI Practice Outcome Indicators for Hospitals and Community Health Services – Step 10 and related appendices</td>
</tr>
<tr>
<td>10.3.1</td>
<td>Mothers who are more at risk for not breastfeeding, or shorter breastfeeding duration require more support and information that should be tailored to their situation.</td>
<td>The following are considered risk factors for not breastfeeding: - lower socio-economic status - lower education - younger age - lack of support - smoking - being without a partner</td>
<td>Public Health Agency of Canada – What Determines Health - World Health Organization – Global Strategy for Infant and Young Child Feeding (Arlotti et al., 1998; Kistin et al., 1994; Lutter et al., 1997; Mickens et al., 2009; Olson et al., 2010).</td>
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<td>11.1</td>
<td>Compliance with the WHO International Code of Marketing of Breastmilk Substitutes and its subsequent resolutions is essential and ethical.</td>
<td>Code violations act as an endorsement of breastmilk substitutes and related products and thus undermine breastfeeding (WHO, 1981). The marketing influence of formula companies affects breastfeeding negatively (Semenic, 2012). The creation of a relationship between formula companies and health care providers creates brand loyalty and dependency. Formula companies and representatives are not educators and provide biased information directly and indirectly to mothers, health care providers and through company sponsored research. Company sponsored research is more likely to show favourable results towards the sponsor (Lundh, 2012). Compliance with the WHO International Code of Marketing of Breastmilk Substitutes and its subsequent relevant resolutions is linked to greater breastfeeding exclusivity and duration (Rosenberg et al., 2008).</td>
<td>WHO and Breastfeeding Committee for Canada – Introduction to The International Code of Marketing of Breastmilk Substitutes and all subsequent resolutions</td>
</tr>
<tr>
<td>11.1.1</td>
<td>Compliance with the WHO International Code of Marketing of Breastmilk Substitutes and its subsequent resolutions is essential, ethical and non-negotiable.</td>
<td></td>
<td>INFACT Canada – Breastfeeding Protection and the International Code</td>
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| 11.1.2                  | Informed decision-making is the heart of ethical practice.     | Health care providers can facilitate informed decision-making by providing accurate and evidence-based information. This should include the risks of formula feeding. The information should be provided before challenges are encountered and show respect and sensitivity to individual circumstances, feelings, wishes and concerns. | OPHA Position Paper – Informed Decision-Making and Infant Feeding  
Venter – The Ethics of Informed Decision Making |
References

Introduction


Step 1


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**Step 2**

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**Step 3**

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**Step 5**


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doi: 10.1111/j.1651-2227.2010.01812.x
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**Step 6**

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**Step 7**


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**Step 8**


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Step 10


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The World Health Organization International Code of Marketing of Breastmilk Substitutes


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