Appendix 1: Policy Checklist
The policy:
(Y = Yes; N = No; IP = In Progress)

Y	N	IP	
x	☐	☐	is created in collaboration with multiple stakeholders including community members, and addresses all of the *10 Steps to Successful Breastfeeding* • Policy updated to reflect 10 steps • Reviewed with staff • Reviewed with parents attending Well Baby Drop In
x	☐	☐	protects all babies through compliance with the provisions of the *WHO International Code of Marketing of Breast-Milk Substitutes*, and subsequent, relevant WHA resolutions prohibiting: ○ promotion of formula, human milk substitutes and feeding bottles or teats ○ pre and postnatal group instruction on human milk substitute use[4] ○ use or distribution of non-human milk (formula) gift packs with samples and supplies or other promotional materials to pregnant women or mothers ○ free gifts from formula manufacturers to staff and the facility (including food, gifts, pens, writing pads, measuring tapes, support for continuing education, etc.) ○ infant feeding education sessions and literature from companies whose products fall within the scope of *The Code*
x	☐	☐	indicates that educational materials should be impartial and do not endorse company brand names (e.g., by recommending only one brand of breast pump)
x	☐	☐	is reviewed on a regular basis in collaboration with multiple stakeholders. including community members, and includes a mechanism for evaluating the effectiveness of policy implementation
x	☐	☐	is posted in all areas open to families in summary form in the language(s) most commonly understood by families. The summary form clearly indicates how the policy is reflected in practice • English, French, Vietnamese and Chinese
x	☐	☐	is available to consumers or anyone who wishes a copy
x	☐	☐	is supported by clinical and community health practices reflecting current evidence-based standards
x	☐	☐	identifies policies and practices that support non-breastfeeding mothers

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

Appendix 2.1: Education and Orientation Checklist

Education of staff and physicians/midwives is appropriate to their role. For those directly involved with breastfeeding assessment, support and intervention, all of the 10 Steps are addressed. For this staff group, at least 20 hours (reflecting the core content as outlined in the UNICEF/WHO “20 hour course”) including three hours of supervised clinical instruction is strongly recommended.

All staff members (direct and indirect care), physicians, midwives and volunteers:
(Y = Yes; N = No; IP = In Progress)

Y	N	IP	
x	□	□	know that the BFI protects, promotes and supports □ breastfeeding families □ formula-feeding families by providing individual information on infant feeding free from commercial influences
x	□	□	know that *The Code* protects □ families against commercial pressure □ staff and physicians from conflicts of interest
x	□	□	confirm that they have been oriented to the breastfeeding policy

In addition, staff members providing direct care (of a random sample, at least 80%)**:**

Y	N	IP	
x	□	□	confirm they have received the described education or, if they have been employed in the facility less than six months, know when education will be provided
x	□	□	are able to correctly answer four out of five questions on basic evidence-based breastfeeding care
x	□	□	can describe two issues that should be discussed with a pregnant woman if she indicates that she is considering giving her baby something other than human milk
x	□	□	can describe information given individually to mothers who have made an informed decision not to breastfeed including cost implications, safe and hygienic preparation, feeding and storage of human milk substitutes
x	□	□	are able to demonstrate teaching of effective position and latch
x	□	□	are able to describe and demonstrate effective hand expression of breast milk
x	□	□	in addition to breastfeeding skills identified above, community health staff should be aware of the skills, knowledge and attitudes consistent with the “Core Competencies of Public Health" (Public Health Agency of Canada, 2009)

In addition, physicians (of a random sample, at least 80%):

Y	N	IP	
x	□	□	confirm that they have been oriented to the breastfeeding policy
x	□	□	can identify to whom mothers experiencing breastfeeding difficulties may be referred for direct breastfeeding care
x	□	□	can identify medical indications for supplementation

x ☐ ☐ if they provide clinical breastfeeding support to mothers, they are able to
x correctly answer four out of five questions on breastfeeding care
x demonstrate effective teaching of position and latch

In addition, non-clinical staff members (of a random sample, at least 80%)**:**

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

Education Materials

Y	N	IP	
x	☐	☐	a copy of the curricula or course outline for education on breastfeeding and lactation for various disciplines of staff is provided • Champlain Maternal Newborn Regional Program
x	☐	☐	a copy of information provided to mothers who are not breastfeeding is provided
x	☐	☐	a schedule for education of new employees exists • All new staff are booked into the earliest available course

Appendix 2.2: Breastfeeding Education for Hospital and Community Health Service (CHS) Employees, Physicians and Midwives

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

 Education is important to ensure successful outcomes in the assessment process.

 Education needs of individual institutions will vary in order to achieve expected outcomes.

The education should be appropriate to the role of the employee or health care provider. For those providing *hands-on* care, UNICEF recommends a minimum of 20 hours of education, including three hours of supervised clinical practice.

 Nurses and others providing direct breastfeeding care must be able to demonstrate certain skills and effectively teach mothers basic breastfeeding skills. As well as speaking to mothers, the assessment process involves asking specific questions of staff who offer direct breastfeeding care, observing their actions and examining breastfeeding outcomes.

 Physicians/midwives and other employees must be prepared to answer questions regarding protecting, promoting and supporting breastfeeding

Education can be provided to staff in a variety of ways, including computer modules, readings, supervised clinical practice, discussion groups, focused education sessions, self-paced learning modules, etc. For best results the mode of education should match the materials used. For example the UNICEF 20-hour course, *Breastfeeding Management and Promotion in a Baby Friendly Hospital,* is not a self-study module and should not be used as one. Effective implementation of policies relies not only on knowledge but also on the attitudes of the staff. Changing attitudes, though difficult and slower than acquiring knowledge, most likely occurs when a variety of strategies are employed.

To meet educational indicators, educational materials (written, visual and video) for use in employee and physician education must:

☒ comply with the provisions to the *WHO International Code of the Marketing of Breast-Milk Substitutes* (*The Code*) and subsequent relevant World Health Assembly (WHA) Resolutions[5]

x not include materials from companies whose products fall within the scope of *The Code*

x not be provided by companies whose products fall within the scope of *The Code*

☒ be referenced with up-to-date and, preferably, primary references

☒ promote evidence-based care and best practice

☒ be accurate and current

[5] See Appendix 11: Summary of the Provisions of *The Code* and subsequent resolutions

Documenting Staff Education: Commitment to Education

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

Documentation of staff education involves at least two processes.

1. Audits of breastfeeding outcomes

❑ Does the hospital or community health service meet the Baby-Friendly Practice Outcome Indicators?

☒ Are new staff members given appropriate orientation/education to provide the standard of care required?

2. **Documenting education provided to staff** (can be done in a number of ways):

☒ provide a schedule for orientation of new employees and document attendance

☒ provide schedules of in-service programs provided and document attendance

☒ record education support provided (e.g., funding provided for attending conferences or courses)

❑ provide a schedule for mentoring and education for individual employees by breastfeeding care clinicians and document attendance

❑ outline the process established to educate, and follow up with staff who are not able to meet standards of care as outlined in the hospital or community health service policy

❑ complete performance appraisals and encourage employees to contribute their record of breastfeeding education as part of the performance appraisal or professional competence requirements for registration/licensure/privileges

❑ provide up-to-date educational resources and research articles for use by hospital and community health services staff

Appendix 2.3-Support for Non-breastfeeding Mothers Checklist

The facility may have a separate Breastmilk Substitute Feeding Policy.

Manager provides:

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

Y	N	IP	
x	□	□	Written infant feeding policy or practices describe support for non-breastfeeding mothers
x	□	□	Written curriculum or course or session outline for training on supporting the non breastfeeding mother

Staff member providing direct care:

Y	N	IP	
x	□	□	can describe how to help mothers make an informed decisions including the provision of □ the opportunity for a woman to discuss her concerns □ benefits of breastfeeding for baby, mother, family and community □ health consequences for baby and mother of not breastfeeding □ risks and costs of human milk substitutes □ difficulty of reversing the decision once breastfeeding is stopped
x	□	□	are able to correctly answer four out of five questions regarding the feeding of breastmilk substitutes, including 1. The risks and benefits of feeding various locally available commercial infant formula[6] 2. How to help a mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances 3. The safe and hygienic preparation, feeding, and storage of breast-milk substitutes[7] □ boiling and cooling water before mixing feeds □ correct proportions for mixing locally available commercial infant formulas □ methods for keeping feed and equipment clean □ importance of hygiene □ feeding baby safely with cup or bottle 4. How to teach preparation of feeding options the mother chooses and to ask the mother for a return demonstration of the preparation of the feed 5. Cue-based, baby-led feeding

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

Y	N	IP	
x	□	□	to make informed decisions about feeding their babies
x	□	□	to safely prepare, store and feed human milk substitutes in appropriate volumes
x	□	□	to feed their babies with cup or bottle

6 "Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system since they constitute a risk group." WHO/UNICEf Global Strategy for Infant and Young Child Feeding, p10.

7 WHO Guidelines for the safe preparation, storage and handling of powdered infant formula
English: http://www.who.int/foodsafety/publications/micro/PIF_Care_en.pdf
French: http://www.who.int/foodsafety/publications/micro/PIF_Care_fr.pdf

Appendix 3: Prenatal Education Checklist

The written minimum curriculum for prenatal education includes:

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

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

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

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

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

Y	N	IP	
x	☐	☐	expected health care practices supportive of establishing effective breastfeeding (e.g., immediate and prolonged skin-to-skin care, early and frequent skin-to-skin breastfeeds, 24 hour rooming-in, 24-hour support from partner or support person)

x □ □ the basics of breastfeeding
- x position and latch
- x hand expression of milk
- x infant feeding cues and cue-based feeding
- x expected normal feeding behaviours (frequency of feeds, output)
- x the benefits of skin-to-skin care for all infants (including those who will not be breastfed), and especially for premature infants
- x national guidelines for breastfeeding: exclusive breastfeeding for the first six months, addition of appropriate complementary foods at about six months, and sustained breastfeeding for two years and beyond

x □ □ breastfeeding support
- □ community professional follow-up
- □ mother-to-mother (peer) support groups

x □ □ rights of pregnant and breastfeeding women (the accommodation of breastfeeding women in the community, at school and in the workplace).

x □ □ these educational materials:
- x are available in the languages commonly used by clients
- x are current
- x have clear graphics or pictures
- x acknowledge original authors
- x do not promote the use of human milk substitutes or any products covered under *The Code*
- x are not produced by companies whose products are covered under *The Code*

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

Hospitalized women and women using the prenatal services (of a random sample, at least 80%):

Y	N	IP	
x	☐	☐	receive appropriate breastfeeding information as specified above (provision of this information is documented in their chart)

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

Y	N	IP	
x	☐	☐	current, appropriate and separate from breastfeeding information
x	☐	☐	free of promotional material that does not comply with *The Code*

Please see appendix 2.3 for more information regarding support for non-breastfeeding women.

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

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

Appendix 4: Birth and Skin-to-Skin Care Checklist
Prenatal Care
(Y = Yes; N = No; IP = In Progress)

Y	N	IP	
x	□	□	hospitals and community health services collaborate to provide information for families about skin-to-skin care and uninterrupted contact until completion of the first feeding

Pregnant mothers (of a random sample, at least 80%)**:**

Y	N	IP	
x	□	□	receive information about skin-to-skin care until completion of the first feeding
x	□	□	are encouraged to discuss skin-to-skin care with their physician/midwife/nurse

In hospital (of a random sample, at least 80%)

Y	N	IP	
□	□	□	at birth, babies are placed **skin-to-skin** with their mothers.[8] An unhurried environment and unlimited skin contact facilitate safe transition of the newborn and a successful first feeding
□	□	□	mothers are supported to breastfeed in response to their babies' cues
□	□	□	skin-to-skin contact remains uninterrupted, at least until the completion of the first breastfeed, unless there is a medical indication, which should be documented in the baby's chart
□	□	□	routine measurements are delayed until completion of the first feeding (where required by statute, eye ointment may be applied within the first hour)
□	□	□	required medications are given while the baby is on the mother's chest
□	□	□	routine observations of the baby (temperature, breathing, colour and tone) and mother continue throughout the period of skin-to-skin contact (if the health of either gives rise to concern, separation may be medically indicated; however, skin-to-skin care will begin as soon as medical status permits)
□	□	□	if the mother must be transferred to a different area before the baby has completed this first feeding or the mother has not indicated she wishes to terminate skin-to-skin contact, transfer should be done by stretcher or wheel chair with skin-to-skin contact maintained
□	□	□	mothers and babies delivered by caesarean are treated in the same way as mothers and babies delivered vaginally, with respect to skin-to-skin care (if the caesarean was under general anaesthetic, babies are placed skin-to-skin with their mother as soon as the mother is responsive and alert, with the same procedure followed)
□	□	□	the mother's designate holds the baby skin-to-skin if mother is ill or unavailable
□	□	□	mothers are encouraged to look for signs that their babies are ready to feed during this first period of contact and if needed, help is offered

[8]Skin-to-skin means the naked baby is placed on his/her mother's naked chest immediately at birth then dried and covered with a warm blanket.

If babies are cared for in a special care nursery

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

Appendix 5.1: Breastfeeding Care Checklist

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

Mothers and staff can describe and demonstrate (of a random sample, at least 80%):

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

Y	N	IP	
x	□	□	**effective position and latch:** □ the baby's body is aligned close to and facing the mother, unencumbered by blankets or the like □ the baby's mouth is wide open □ the baby's chin is touching the breast □ more of the areola below the nipple is in the baby's mouth (requiring the mouth be off-centre with greater cover by the lower jaw such that the nipple is high in baby's mouth) □ the baby's cheeks are full and no dimpling is evident □ the baby begins rhythmic bursts of sucking □ the nipples are not distorted after the feeding □ the mother's hand supports baby's neck and shoulders (without pushing the baby's head onto the breast)
x	□	□	**effective hand expression of milk**: all mothers are taught how to hand express their milk as this is often more effective than a mechanical pump for expressing colostrum, especially in the first 24 hours
x	□	□	**cup feeding**

Continuum of Care

Y	N	IP	
x	□	□	a reliable and formal system is in place for communicating a mother's breastfeeding progress to community health employees as she moves from hospital to the community
□	□	x	families with unresolved breastfeeding issues are discharged from hospital or birthing centre with written plans that □ support their breastfeeding goals □ provide information regarding follow-up with an appropriate health care provider or health care service
x	□	□	mothers and families are aware of and can access assistance with breastfeeding within 48 hours of discharge
x	□	□	mothers and families are aware of the signs that their infant is breastfeeding effectively, and they know when to seek help.

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

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

Y	N	IP	
☐	☐	x	are shown how to hand express milk within six hours of delivery and encouraged to express milk at least six times in the first 24 hours and at least eight times in each 24 hour period thereafter
x	☐	☐	know how to store milk, where to obtain equipment and how to clean it
x	☐	☐	are given extra support when they have been or are separated from their babies, or when their baby is ill
x	☐	☐	report they have been given appropriate information on how to maintain lactation during separation, during illness or while at work or school

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

Y	N	IP	
x	☐	☐	appropriate storage and handling of expressed breastmilk
x	☐	☐	maintenance of lactation during separation of mother and baby

Appendix 5.2: Breastfeeding Education Materials for Families Checklist

Breastfeeding Education Materials for Families

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

Materials

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

Y	N	IP	
x	□	□	include accurate information to parents with particular attention to information on:
			□ position and latch (see Appendix 4)
			□ hand expression of milk
			□ infant feeding cues
			□ expected normal feeding behaviours (see Appendix 8.1)
			□ community professional follow-up
			□ mother-to-mother support groups
x	□	□	comply with the provisions of the WHO *Code for the Marketing of Breast-Milk Substitutes* (*The Code*) and subsequent relevant World Health Assembly (WHA) Resolutions
x	□	□	encourage breastfeeding: exclusively during the first six months from birth and continued after the introduction of complementary foods for two years and beyond
x	□	□	are reviewed on a regular basis
x	□	□	contain clear graphics or pictures
x	□	□	acknowledge original authors
x	□	□	use innovative communication strategies such as social media and social marketing aimed at the entire population as well as targeted toward populations with lower breastfeeding rates within the community.

Suggestions

Materials[9]

9 Adapted from the Jones, F. & Green, M. The Baby Friendly Initiative, 2006. HA

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

Appendix 6.1: Data Collection of Breastfeeding Rates
The facility documents data collection on breastfeeding rates including:
Hospitals & Birthing centres breastfeeding rates
(Y = Yes; N = No; IP = In Progress)

Y	N	IP	
☐	☐	☐	initiation of breastfeeding **at birth**
☐	☐	☐	exclusive breastfeeding from birth to discharge (minimum 75% of total births per annum) *If the exclusive breastfeeding rate (breastfed babies, babies fed mother's own expressed breastmilk or donor human milk) from birth to discharge is less than 75% in any one month, the facility demonstrates*
☐	☐	☐	the rate of exclusively breastfed infants plus infants supplemented due to documented medical reasons is at least 75% of total births
☐	☐	☐	supplementation rate, both medically and non-medically indicated
☐	☐	☐	any breastfeeding

Community Health Centres breastfeeding rates

Y	N	IP	
			On entry to service (which coincides with hospital discharge)
x	☐	☐	exclusive breastfeeding rate (goal is minimum 75%)
			If the exclusive breastfeeding rate on entry to service is less than 75%, the facility demonstrates,
x	☐	☐	the "any breastfeeding rate" is at least 75%
x	☐	☐	provides data for at least three years, showing increases in breastfeeding initiation, exclusivity and duration rates
			Breastfeeding duration rates
x	☐	☐	mechanism to monitor exclusive, total[10] and any breastfeeding rates at around two, four, six months and breastfeeding duration at twelve and eighteen months and beyond (this may coincide with immunization schedules)
			Population Health Principles and Breastfeeding Rates Surveillance
x	☐	☐	systematically monitors breastfeeding rates and trends within communities and monitors shifts in overall population breastfeeding rates, as well as disparities between populations based on, ethnicity, social economic status, education, geography, age, etc.
x	☐	☐	collaborates with others (e.g., community members, academia) to assess and understand the cultural norms and conditions within the community affecting breastfeeding rates and disparities

[10] Definition of "total" breastfeeding: babies who were supplemented at some time and are now exclusively breastfeeding again

See Appendix 6.3: Hospital Data and Appendix 6.4: CHS Data

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

Mothers confirm that (of a random sample, at least 80%):
(Y = Yes; N = No; IP = In Progress)

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

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

Y	N	IP	
x	☐	☐	to make informed decisions[11] about feeding their babies
x	☐	☐	to safely prepare, store and feed human milk substitutes in appropriate volumes
x	☐	☐	**if they are using human milk substitutes as a supplement to breastfeeding,** on preserving and improving the breastfeeding relationship

11 Note: Supporting informed decision making includes the provision of :

Y	N	IP	
x	☐	☐	the opportunity for a woman to discuss her concerns and information regarding: ☐ benefits of breastfeeding for baby, mother, family and community ☐ health consequences for baby and mother of not breastfeeding ☐ risks and costs of human milk substitutes ☐ difficulty of reversing the decision once breastfeeding is stopped

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

Y N IP

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

Appendix 6.2: Medical Indications for Supplementation (adapted from WHO, 2009)

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

INFANT CONDITIONS

Infants who should not receive human milk or any other milk except specialized formula:

- those with classic galactosemia - special galactose-free formula is needed
- those with maple syrup urine disease - a special formula, free of leucine, isoleuceine and valine is needed
- those with phenylketonuria - a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring)

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

- those born weighing less than 1500 g (very low birth weight)
- those born at less than 32 weeks of gestation (very preterm)
- those who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischemic stress, those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or human milk feeding)
- those with a significant weight loss in the presence of clinical indications (mother's milk production not established)
- those who fail to regain birth weight by two weeks after birth[12]
- those exhibiting clinical indications of insufficient milk intake (no bowel movements, or fewer than one a day [in the first two weeks of life], or meconium five or more days after birth
- those with an average weight gain[1] of less than:
- 115 g/week : 2 weeks-4 months
- 85 g/week : 4-5 months
- 60 g/week : 6-12 months

[12] If a baby is monitored intensively and begins to gain weight again within two weeks even if the birth weight has not been regained, it may be appropriate to wait another few days before giving supplements.

MATERNAL CONDITIONS

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

- severe illness that prevents a mother from caring for her infant (e.g., sepsis)
- herpes simplex virus type 1(HSV-1) - direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved
- maternal medication, including:
- sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available;
- radioactive iodine-131 is better avoided given that sager alternatives are available - a mother can resume breastfeeding about two months after receiving this substance
- excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression of electrolyte abnormalities in the breastfed infant and should be avoided
- cytotoxic chemotherapy requires that a mother stop breastfeeding during therapy

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

- breast abscess - breastfeeding should continue on the unaffected breast; feeding on the affected breast can resume once treatment has started
- hepatitis B - infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter
- hepatitis C
- mastitis - if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition
- substance use, including:
- maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies
- alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby
- mothers should be encouraged not to use these substances and given opportunities and support to abstain and apply harm reduction principles

Appendix 6.3: Calculation of Breastfeeding Rates – Hospitals

Statistics on Birth in the last year	Number	**% of T**
T	**Total Births in the last year**	100
Births by C-section without general anaesthesia		
Births by C-section with general anaesthesia		
Infants admitted to NICU or similar units		

Statistics on Infant Feeding

A	Infants exclusively breastfed (or fed human milk) from birth to discharge
B	Infants who received at least one feed other than human milk (human milk substitute, water or other fluids) in the hospital because of documented medical reason
C	Infants who received at least one feed other than human milk without any documented medical reason

The hospital data above indicates that at least 75% of the babies delivered in the past year were exclusively breastfed or fed human milk from birth to discharge (A)	Yes	No
[If "No"] The hospital data above indicates that at least 75% of the babies delivered in the past year were exclusively breastfed or fed human milk from birth to discharge, or if they received any feeds other than human milk, this was because of documented medical reasons (A + B)	Yes	No

Data Sources

Please describe the sources for the above data

Appendix 6.4: Calculation of Exclusive Breastfeeding Statistics: Community Health Services

Statistics on Birth in the last year	Number	% of T
T	Total Births in the service area in the last year	100
M	A representative sample of mothers surveyed in the past year	

Statistics on infant feeding	Number	**% of M**
A	Babies exclusively breastfeeding or receiving only human milk on entry to service (exclusive breastfeeding rate)	
S	Babies breastfeeding with supplementation on entry to service ("any breastfeeding" rate)	

The data above demonstrates that the exclusive breastfeeding rate for babies entering into service in the past year was at least 75%	x Yes	□ No
[If "No"] The data above indicates that the "any breastfeeding" rate for babies entering into service in the past year was at least 75% *AND* The CHS provides data for at least 3 years, showing increases in breastfeeding initiation, exclusivity and duration rates	x Yes	□ No

Bf rates (% of M)	Year	Year	Year	Year
Initiation rate				
Exclusivity rate				
Duration rate ~ 2m				
~ 4m				
< 6m				
~ 12m				
Other				

There is a mechanism to monitor exclusive and total[13] breastfeeding rates at around two, four, six months and breastfeeding duration at twelve and eighteen months and beyond (this may coincide with immunization)	x Yes	□ No
Breastfeeding rates and trends within communities are systematically monitored	x Yes	□ No

Shifts in overall population breastfeeding rates as well as disparities between populations based on ethnicity, socioeconomic status, education, geography, age, etc.) are monitored	x Yes	□ No
There is collaboration with others (e.g. community members, academia) to assess and understand the cultural norms and conditions within the community affecting breastfeeding rates and disparities	x Yes	□ No

13 Definition of total breastfeeding: babies who were supplemented at some time and are now exclusively breastfeeding again.

Data Sources

Please describe the sources for the above data

Appendix 7: Mother Baby Togetherness Checklist
Staff and mothers confirm the following:
Mothers (of a random sample, at least 80%):
(Y = Yes; N = No; IP = In Progress)

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

In the facility

Y	N	IP	
x	☐	☐	breastfeeding is welcome everywhere
x	☐	☐	appropriate facilities for comfortable breastfeeding exist in both public and private areas
x	☐	☐	signs welcoming breastfeeding are displayed in all public areas

Appendix 8.1: Baby-Led Feeding Checklist
Staff and mothers confirm that:
(Y = Yes; N = No; IP = In Progress)

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

Timely Anticipatory Guidance (timely information given and opportunity for discussion)

x	□	□	age-appropriate normal feeding behaviours[14], frequency of feeds, output and infant states and their implications for feeding
x	□	□	possible breastfeeding problems, their solutions and available resources that will assist with breastfeeding
x	□	□	all contraception methods compatible with breastfeeding, including the Lactation Amenorrhea Method (LAM)

Complementary feeding with continued breastfeeding

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

[14] See 8.2 Initiation of Lactation

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

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

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

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Appendix 9: **Artificial Teats Checklist**

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

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

Appendix 10.1: Continuum of Care Checklist

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

Appendix 10.2: Primary Health Care and Population Health Principles Checklist

Community Health Services apply principles of Primary Health Care and Population Health to support the continuum of care and create strategies that affect the broad determinants that improve breastfeeding outcomes.
Community Health Services show mechanisms to engage and collaborate with multiple stakeholders to assess, understand and address breastfeeding rates, trends and disparities in the community. This may include:
(Y = Yes; N = No; IP = In Progress)

Y	N	IP	
x	□	□	collaborate and partner with others (e.g., primary health care partners, community members) to assess and understand the cultural norms and conditions within the community effecting breastfeeding rates and disparities

Apply population health promotion strategies to promote breastfeeding for the entire population as well as address disparities between populations.

x	□	□	participate in and support research focused on increasing breastfeeding rates and strategies for reducing disparities
x	□	□	create supportive environments in workplaces and the community to welcome breastfeeding mothers
x	□	□	advocate for and with others for breastfeeding policies and rights in workplaces and the community
x	□	□	use communication strategies including social marketing and social media to reach diverse populations
x	□	□	apply a diversity and inclusion lens to breastfeeding program development and implementation
x	□	□	use community development principles to engage stakeholders to determine appropriate, accessible and affordable service delivery to support breastfeeding in the community (e.g., building capacity to create peer support programs and establishing primary health care drop-in clinics)
x	□	□	evaluate program and service delivery effectiveness to improve breastfeeding rates
x	□	□	advocate for accessible and affordable human donor milk in the region
x	□	□	communicate and advocate for *The Code* compliance in the community and through local and national policy and legislation
x	□	□	incorporate the importance of sustaining breastfeeding in emergency preparedness plans

Appendix 11.1: The WHO Code of the Marketing of Breast Milk Substitutes Compliance Checklist

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

Y	N	IP	
x	□	□	Human milk substitutes, products or promotional items that fall within the scope of *The WHO Code* are not promoted, distributed or displayed
x	□	□	teaching materials including posters, calendars, videos and teaching sheets should be free of commercial endorsements including human milk substitutes, bottles, soothers and artificial nipples
x	□	□	equipment including weight graphs, office supplies and measuring tapes are free of commercial endorsements
x	□	□	all independently-run businesses operating on the facility site(s) are informed of *The WHO Code* and do not display or discount products that fall within the scope of *The WHO Code*. These products may be sold to clients who request them
x	□	□	staff and physician education is not sponsored or provided by companies whose products fall within the scope of *The WHO Code*
□	□	x	hospital foundations and other charitable funding bodies do not accept funds from companies whose products fall within the scope of *The WHO Code*

Purchase arrangements for formula, specialty formulas and fortifiers used in facility, including those for use in Pediatric and Special Care Units confirm that the facility:

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