Breastfeeding Committee for Canada | Comité canadien pour l'allaitement

BFI Guideline Checklist

Critical Management Procedures
(Y=Yes; N=No; IP=In Progress)

Step 1a: Comply with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions.

In all facilities,

All staff [1] can:

Y	N	IP	
☐	☐	☐	explain how the Code protects them from conflict of interest
☐	☐	☐	explain how the Code protects families from commercial pressure
☐	☐	☐	list at least 2 products covered by the Code
☐	☐	☐	confirm that:

- they do not promote, distribute samples, coupons or display products covered by the Code to pregnant women/persons or mothers/birthing parents (products covered by the Code are kept out of sight of the public)
- manufacturers and distributors of products covered by the Code or their contracted personnel do not advise pregnant women/persons and mothers/birthing parents
- they do not accept gifts or personal samples or any financial/material inducement from producers or distributors of products covered by the Code
- teaching about non-human milk is always done individually with pregnant women/persons and mothers/birthing parents who made informed decisions
- teaching materials, posters, calendars, videos, websites, etc. are free of commercial endorsements, including all products covered by the Code
- equipment including weight graphs, office supplies, crib cards, measuring tapes are free of commercial endorsements (including company name or product name or logo)
- education is not sponsored or provided by producers or distributors of products covered by the Code
- they disclose to the facility any contributions received by producers or distributors of products covered by the Code, such as fellowships, study tours, research grants, conferences, or the like

Manager(s)[2] can explain that:

Y	N	IP	
☐	☐	☐	non-human milk, fortifiers and feeding equipment are purchased in the same manner as other pharmaceuticals and food
☐	☐	☐	fair market price means that:

- all products covered by the Code are paid for

[1] Staff: general term referring to all persons working for the facility, paid or non-paid, employed, contractual or holding professional privileges.
[2] Manager: any person in a leadership position, responsible and accountable for overseeing perinatal and child health.

- the price is discussed and determined with the same process as for other goods acquired by the facility (computers, beds, food, bedding, etc.)
- the price is fair and adequate according to amount purchased
- the purchased quantity does not exceed expected needs
- there are no value-add products or incentives, either financial or in-kind, attached to the price

☐ ☐ ☐ non-human milk, products or promotional items covered by the Code are not promoted, distributed or displayed

☐ ☐ ☐ manufacturers and distributors of products covered by the Code or their contracted personnel do not advise pregnant women/persons and mothers/birthing parents

☐ ☐ ☐ all independently run businesses operating on the facility sites are informed of the Code and do not display or discount products that are covered by the Code; these products may be sold at regular price to clients who request them

☐ ☐ ☐ education is not sponsored or provided by producers or distributors of products covered by the Code

☐ ☐ ☐ facility foundation and other charitable funding bodies do not accept funds from producers or distributors of products covered by the Code

☐ ☐ ☐ space, equipment and educational materials sponsored or produced by companies are not used when teaching parents about infant feeding

☐ ☐ ☐ financial or material inducements to promote products covered by the Code are not accepted by staff, students or volunteers working in this facility

Pregnant women/persons and mothers/birthing parents report that:

Y N IP

☐ ☐ ☐ they have not received any marketing materials, samples, coupons or gift packs that include products covered by the Code from the facility

☐ ☐ ☐ they have not received group instruction regarding the preparation, storage and feeding of non-human milk from the facility

Documentation

Y N IP

☐ ☐ ☐ purchase arrangements for non-human milk, specialty formula, fortifiers and feeding equipment used in this facility, including those for use in pediatric and special care units, show that the facility:

- does not promote products covered by the Code
- does not profit in a way that could influence care from a purchase agreement with a company whose products are covered by the Code
- purchases non-human milk and feeding equipment in the same manner as other pharmaceuticals and food
- purchases realistic volumes, in line with the amount of non-human milk anticipated to be used
- receives no free or low-cost supply arrangement attached to the purchase agreement, nor refunds on competitor contracts

☐ ☐ ☐ all documents (written, web-based, audio-visual) for client information and for continuing education are in compliance with the Code

Step 1b: Have a written Infant Feeding Policy that is routinely communicated to all staff, pregnant women/persons and parents.

In all facilities,

All staff can:

Y	N	IP	
☐	☐	☐	describe at least 2 elements that are in the facility's Infant Feeding Policy
☐	☐	☐	explain how the Infant Feeding Policy affects their work at the facility
☐	☐	☐	list at least 2 places where the summary of the policy is displayed

Manager(s)* can*:

Y	N	IP	
☐	☐	☐	describe at least 2 ways the Ten Steps are implemented at this facility
☐	☐	☐	describe the process for implementing, reviewing and auditing compliance with the policy
☐	☐	☐	explain how staff, students and volunteers are oriented to the Infant Feeding Policy
☐	☐	☐	identify practices that support informed decisions by pregnant women/persons and mothers/birthing parents related to infant feeding

Pregnant women/persons, postpartum mothers/birthing parents, parents of young children can:

Y	N	IP	
☐	☐	☐	list at least 1 place where they have seen the summary of the facility's Infant Feeding Policy
☐	☐	☐	describe at least 1 element in the facility's Infant Feeding Policy

Documentation

Y	N	IP	
☐	☐	☐	the policy and its summary indicate that the facility provides care and services consistent with the Ten Steps
☐	☐	☐	the summary of the policy is available in languages commonly understood by families served by the facility
☐	☐	☐	the policy is available on the facility's website
☐	☐	☐	the summary of the policy is posted where care and services are offered to pregnant women/persons and mothers/birthing parents and in common public areas
☐	☐	☐	there is a written policy showing evidence of support for staff members who are breastfeeding

Step 1c: Establish ongoing BFI monitoring and data-management systems.

In all facilities,

All direct care providers[3] can:

Y	N	IP	
☐	☐	☐	explain at least 2 reasons why monitoring of practices is important
☐	☐	☐	explain how practices are monitored in this facility

Managers can:

Y	N	IP	
☐	☐	☐	explain at least 2 reasons why monitoring of practices is important
☐	☐	☐	explain how BFI practices are monitored in the facility
☐	☐	☐	provide annual data for the facility on the required items in the standards
☐	☐	☐	provide calendar/minutes/resolutions of regular meetings of the quality improvement/BFI committee
☐	☐	☐	describe process used for quality improvement
☐	☐	☐	describe program evaluation used to improve breastfeeding rates

Documentation for Hospitals and Birthing Centres

Annual data shows[4]:

Y	N	IP	
☐	☐	☐	Early breastfeeding initiation rate (within first hour)
☐	☐	☐	Initiation rate (any breastfeeding)
☐	☐	☐	**Sentinel standard**: Exclusive breastfeeding rate from birth to discharge (minimum 75%)
☐	☐	☐	Medical supplementation rate
☐	☐	☐	Non-medical supplementation rate
☐	☐	☐	There is collaboration with others (e.g., community members, academia) to assess and understand the conditions that affect breastfeeding rates and disparities

Calculation of Breastfeeding Rates (Hospital/Birthing Centre):

Statistics on births 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	Number	% of T
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		

[3] Direct care providers: those who provide education, assessment, support, intervention, assistance and/or follow-up for infant feeding.

[4] Refer to section titled "Definitions" for terms such as "early breastfeeding initiation rate," "initiation rate," "exclusive breastfeeding," etc.

C	Infants who received at least one feed other than human milk without documented medical indication		
D	Non-breastfed infants		
	The hospital data above indicates that at least 75% of the infants born in this facility 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 infants born in this facility 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 indication (A + B)	Yes ◉	No ○

Data Sources
Please describe the sources for the above data.

All facilities are expected to maintain or increase their breastfeeding rates over their previous assessment data at the time of reassessment. The WHO's target is 80% exclusive breastfeeding from birth to discharge. It is expected that Canadian birthing facilities will strive to achieve this target in the future.

Documentation for Community Health Services

Annual data shows[5]:

Y	N	IP	
☐	☐	☐	Exclusive breastfeeding rate on entry to service (which coincides with hospital discharge)
☐	☐	☐	Any breastfeeding rate on entry to service (which coincides with hospital discharge rates)
☐	☐	☐	Exclusive breastfeeding rate at 6 months
☐	☐	☐	Any breastfeeding rate at 6 months
☐	☐	☐	Mechanism to monitor breastfeeding duration at 12 months or beyond
☐	☐	☐	Systematic monitoring of breastfeeding rates and trends within communities and shifts in overall population breastfeeding rates, as well as disparities among populations based on ethnicity, social economic status, education, geography, age, etc.
☐	☐	☐	Collaboration with others (hospital and community partners) to assess and understand cultural norms and conditions within the community that are affecting breastfeeding rates and disparities
In addition, if exclusive breastfeeding rate on entry to service is less than 75%			
☐	☐	☐	The any breastfeeding rate at entry to service is 75%
☐	☐	☐	Breastfeeding data for at least 3 years shows increases in breastfeeding rates
☐	☐	☐	Exclusive and any breastfeeding rates at a minimum of 2 other time points, including around 6 months

[5] Refer to section titled "Definitions" for terms such as "exclusive breastfeeding", "any breastfeeding" etc.

Calculation of Breastfeeding Rates: Community Health Services:

Statistics on births 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/birthing parents surveyed in the past year		

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

Sentinel standard: The data above demonstrates that the exclusive breastfeeding rate for infants entering into service in the past year was at least 75%	Yes ○	No ○
[If "No"] The data above indicates that the "any breastfeeding" rate (exclusive + non-exclusive) for infants entering into service in the past year was at least 75%	Yes ○	No ○
AND **Sentinel standard:** The exclusivity rate at 6 months is at least 50% **[If "No"]** The CHS provides data for at least 3 years, showing improvement in breastfeeding rates	Yes ○	No ○
There is a mechanism to monitor exclusive and non-exclusive breastfeeding rates at a minimum of 2 other time points, including around 6 months	Yes ○	No ◉
There is a mechanism to monitor breastfeeding duration at 12 months or beyond	Yes ◉	No ○

Bf rates (% of M)	Year		Year		Year	
	Excl	Any	Excl	Any	Excl	Any
Entry to service						
Duration rates Examples of time points (at least 2 needed)						
~ 2 months						
~ 6 months						

All facilities are expected to maintain or increase their breastfeeding rates over their previous assessment data at the time of reassessment.

Step 2: Ensure that staff have the competencies (knowledge, attitudes and skills) necessary to support women/birthing parents to meet their infant feeding goals.

In all facilities,

Staff can:

Y	N	IP	
☐	☐	☐	describe at least 2 reasons why breastfeeding is important for both mother/birthing parent and baby
☐	☐	☐	explain how the BFI protects, promotes and supports breastfeeding
☐	☐	☐	explain how the BFI influences their role at the facility
☐	☐	☐	describe how they welcome mothers/birthing parents to breastfeed anywhere, anytime
☐	☐	☐	find a private space within the facility for mothers/birthing parents to breastfeed or express milk if they request it
☐	☐	☐	explain how they would support breastfeeding mothers/birthing parents who are being criticized for breastfeeding in a public area
☐	☐	☐	refer families to a knowledgeable person within the facility or the community to respond to their questions or concerns about infant feeding

Additionally, indirect care providers[6] can:

Y	N	IP	
☐	☐	☐	apply the Infant Feeding Policy according to their role

In addition, direct care providers can:

See the WHO's Competency Verification Toolkit: Ensuring Competency of Direct Care Providers to Implement the Baby-Friendly Hospital Initiative and the BCC's Competency Verification for Direct Care Providers Working in Community Health Services.

Y	N	IP	
☐	☐	☐	offer timely information in an appropriate, respectful, sensitive manner
☐	☐	☐	discuss the importance of breastfeeding and the risks of not breastfeeding with pregnant women/persons and mothers/birthing parents
☐	☐	☐	assess effectiveness of breastfeeding
☐	☐	☐	support mothers/birthing parents to initiate and/or maintain breastfeeding
☐	☐	☐	support mothers/birthing parents to solve breastfeeding difficulties
☐	☐	☐	offer timely anticipatory guidance to mothers/birthing parents to prevent or overcome breastfeeding challenges
☐	☐	☐	refer pregnant women/persons and mothers/birthing parents to local breastfeeding resources
☐	☐	☐	provide evidence-based information about the safe preparation, storage and use of non-human milk, when its use is required

Midwives, nurse practitioners and physicians with perinatal and/or pediatric privileges, in addition to the indicators for staff, can:

Y	N	IP	
☐	☐	☐	identify mothers/breastfeeding parents experiencing challenges requiring knowledgeable breastfeeding care

[6] Indirect care providers: those who provide services to perinatal clients and could influence information communicated to them on topics addressed in the BFI indicators (examples: phlebotomist, immunization nurse).

☐	☐	☐	refer mothers/breastfeeding parents to care providers knowledgeable and skilled in breastfeeding, if necessary
☐	☐	☐	identify medical indications for supplementation
☐	☐	☐	prescribe necessary medications that are compatible with breastfeeding whenever possible

Manager(s) can:

Y	N	IP	
☐	☐	☐	explain their role in guiding, facilitating and overseeing the BFI at the facility
☐	☐	☐	describe the orientation to the Infant Feeding Policy of persons new to the facility
☐	☐	☐	describe the competency assessment process for the direct care providers they manage
☐	☐	☐	provide records of orientation to the Infant Feeding Policy and offer continuing education on topics covered in the Infant Feeding Policy (education offered by the facility or externally), in the last 2 years, for staff they manage

Documentation

Y	N	IP	
☐	☐	☐	all documents (written, web-based, audio-visual) for client information and for staff education are in compliance with the BCC BFI implementation Guideline

Key Clinical Practices

Step 3: Discuss the importance and process of breastfeeding with pregnant women/persons and their families.

In all facilities where pregnant women/persons receive services,

Direct care providers can:

Y	N	IP	
☐	☐	☐	explain when and how they discuss the importance of breastfeeding with pregnant women/persons
☐	☐	☐	describe 3 elements of the International prenatal protocol for discussion on breastfeeding (WHO/UNICEF, 2018, p.16):

- importance of breastfeeding
- global infant feeding recommendations of exclusive breastfeeding for the first 6 months and sustained breastfeeding for 2 years and beyond
- risks of giving non-human milk
- importance of immediate, uninterrupted skin-to-skin contact between mothers/birthing parents and children at birth
- importance of early initiation of breastfeeding
- importance of rooming-in
- basics of effective positioning and attachment
- recognition of infant feeding cues

☐	☐	☐	describe how they would facilitate informed decision making[7] with a pregnant women/ persons who felt unsure about breastfeeding or who did not wish to breastfeed
☐	☐	☐	discuss with pregnant women/persons at risk of premature birth, the importance of providing their colostrum/milk even if they decide not to breastfeed
☐	☐	☐	describe the provision of information on the preparation, storage and feeding of non-human milk on an individual basis as needed

***Manager(s) can*:**

Y	N	IP	
☐	☐	☐	show evidence of liaison and collaboration between hospitals and community facilities regarding breastfeeding care
☐	☐	☐	show that the prenatal protocol for discussion on breastfeeding includes the internationally recommended minimum content noted above

Pregnant women/persons can:

Y	N	IP	
☐	☐	☐	confirm direct care providers discussed breastfeeding with them
☐	☐	☐	explain what information they have received about the importance of exclusive, sustained breastfeeding and practices helpful to attain this goal, as detailed in the International Prenatal Discussion Protocol—page 16 WHO

[7] Informed decision making about infant feeding is the process whereby pregnant women/persons and mothers/birthing parents receive evidence-informed information and support to make infant feeding decisions, which include:

- the opportunity for women/parents to discuss their concerns
- the importance of breastfeeding for babies, mothers/birthing parents, families and communities
- the health consequences for babies and mothers/birthing parents of not breastfeeding
- the effects and costs of human milk substitutes
- the difficulty of reversing decisions once breastfeeding is stopped

☐ ☐ ☐ confirm they had sufficient opportunity to discuss infant feeding decisions with knowledgeable care providers (see below under documentation)

In community health services,

Manager(s) can:

Y	N	IP	
☐	☐	☐	describe strategies used to increase public awareness and support of breastfeeding in the community
☐	☐	☐	describe outreach strategies used to address the needs of pregnant women/persons in order to reduce infant feeding inequities

Pregnant women/persons can:

Y	N	IP	
☐	☐	☐	confirm they had sufficient opportunity to discuss infant feeding decisions with knowledgeable care providers
☐	☐	☐	explain what information they received on the importance of exclusive breastfeeding
☐	☐	☐	respond to at least 2 questions on the content of the prenatal information they have received on breastfeeding

Documentation

In all facilities where pregnant women/persons receive services:

Y	N	IP	
☐	☐	☐	information provided to clients (online education, website, print materials) is compatible with the international prenatal protocol for discussion on breastfeeding and specifically addresses: o expected healthcare practices supportive of establishing effective breastfeeding (immediate and uninterrupted skin-to-skin care; early and frequent breastfeeds; 24h rooming-in and facilitate family support during day and night) o basics of effective breastfeeding (position and latch); hand expression of milk; responsive, cue-based feeding; expected normal feeding behaviours (frequency of feeds, output); the benefits of skin-to-skin care for all infants (including those who will not be breastfed) and especially for premature infants o Global and National Guidelines for Breastfeeding: exclusive breastfeeding for the first 6 months, addition of appropriate complementary foods at 6 months and sustained breastfeeding for 2 years and beyond o breastfeeding support (professional follow-up, peer support groups) o rights of pregnant and breastfeeding women/persons (accommodation of breastfeeding women/persons in the community, at school and in the workplace)
☐	☐	☐	educational materials: o are appropriate to the demographics of the population served o are current, evidence-based and acknowledge the source o do not promote the use of human milk substitutes or any products covered under the WHO Code o are not produced by companies whose products are covered under the WHO Code
☐	☐	☐	Women/parents who have made informed decisions not to breastfeed, individually receive written materials on the safe preparation, storage and feeding of non-human milk that are current, appropriate, separate from breastfeeding information and compliant with the WHO Code

Step 4: Facilitate immediate and uninterrupted skin-to-skin contact at birth. Support mothers/birthing parents to respond to the infant's cues to initiate breastfeeding as soon as possible after birth.

In hospitals and birthing centres,

Direct care providers can explain:

Y	N	IP	
☐	☐	☐	at least 2 benefits of skin-to-skin for the mother/birthing parent and 2 for the infant
☐	☐	☐	implementation of immediate, uninterrupted skin-to-skin contact between the mother/birthing parent and the infant for at least one hour or longer as the mother/birthing parent wishes
☐	☐	☐	how to show mothers/birthing parents to safely position and monitor their infant while skin-to-skin
☐	☐	☐	how to monitor infant's temperature, coloration, breathing and responsiveness in a non-intrusive manner
☐	☐	☐	documentation process when/if immediate skin-to-skin contact with the mother/birthing parent is interrupted or delayed
☐	☐	☐	skin-to-skin contact with the partner at birth, only if the mother/birthing parent is ill or unavailable
☐	☐	☐	how to begin/resume skin-to-skin with the mother/birthing parent as soon as possible if it has been delayed or interrupted
☐	☐	☐	how to support mothers/birthing parents to breastfeed in response to their infants' cues
☐	☐	☐	how to keep mothers/birthing parents and infants skin-to-skin when transfer to another area is required

Manager(s) can describe:

Y	N	IP	
☐	☐	☐	the policies and procedures related to skin-to-skin after vaginal and caesarean birth
☐	☐	☐	how data on skin-to-skin at birth informs quality improvement

Mothers/birthing parents report that:

Y	N	IP	
☐	☐	☐	their infant was placed skin-to-skin with them immediately after birth (vaginal or caesarean) unless there was a justifiable medical indication which was clearly explained to them
☐	☐	☐	they were shown how to ***safely*** position and monitor their infants during skin-to-skin
☐	☐	☐	their infants remained skin-to-skin for at least one hour without interruption after birth or as long as they wanted
☐	☐	☐	their partner or designate held the baby skin-to-skin if mother/birthing parent was ill or unavailable
☐	☐	☐	skin-to-skin began/resumed as soon as possible if it was delayed or interrupted at birth
☐	☐	☐	they were supported to respond to their infants' feeding cues
☐	☐	☐	**Sentinel standard**: they offered the breast to their baby within one hour after birth
☐	☐	☐	routine procedures and measurements were delayed until after the first breastfeed
☐	☐	☐	injections required by the infant were given while the infant was on their mother's/birthing parent's chest, preferably at the end of the first feed to decrease pain
☐	☐	☐	skin-to-skin was maintained if they were transferred to another area

Mothers/birthing parents of infants cared for in the NICU report that they:

Y	N	IP	
☐	☐	☐	were supported to place baby skin-to-skin as soon as the baby was stable
☐	☐	☐	were shown how to safely position and monitor the baby during skin-to skin contact

In community health services,

Direct care providers who give care in the prenatal period can describe:

Y	N	IP	
☐	☐	☐	at least 2 benefits of skin-to-skin for the mother/birthing parent and 2 for the infant
☐	☐	☐	education to promote immediate, uninterrupted and safe skin-to-skin between mothers/birthing parents and infants at birth and the role of support persons according to the Appendices C and D of chapter 4 of the *Family-Centred Maternity and Newborn Care: National Guideline*

Manager(s) can:

Y	N	IP	
☐	☐	☐	explain education and health promotion activities that are in place to promote immediate, uninterrupted and safe skin-to-skin between mothers/birthing parents and infants at vaginal and caesarean births and how partners are involved
☐	☐	☐	show that skin-to-skin is included in the materials and resources used for prenatal education

Pregnant women/persons can:

Y	N	IP	
☐	☐	☐	describe at least 2 benefits of skin-to-skin for the mother/birthing parent and 2 for the infant
☐	☐	☐	confirm they have been shown how to safely position their infants skin-to-skin regardless the type of birth
☐	☐	☐	confirm they have been informed on what to observe to ensure safe skin-to-skin

Documentation

In hospitals and birthing centres:

Y	N	IP	
☐	☐	☐	percentage of infants placed skin-to-skin within 5 minutes of birth[8]
☐	☐	☐	percentage of infants with uninterrupted skin-to-skin for one hour or more unless documented medical indication
☐	☐	☐	percentage of infants offered the breast within one hour of birth (vaginal or caesarean) unless documented medical indication delays breastfeeding initiation

In community health services:

Y	N	IP	
☐	☐	☐	education and related materials promote immediate, uninterrupted and safe skin-to-skin between mothers/birthing parents and infants at birth and the role of support persons

[8] The use of terms "as soon as possible" and "up to five minutes" are intended to signal those attending the birth that an occasional delay may be necessary to allow them time for brief assessment of a critical medical issue. The assessment of the standard allows for a delay of up to five minutes under these circumstances.

Step 5: Support mothers/parents to initiate and maintain breastfeeding and manage common difficulties.

In all facilities,

Direct care providers can:

Y	N	IP	
☐	☐	☐	demonstrate appropriate counselling skills, for example see https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/10/Having-meaningful-conversations-with-mothers.pdf
☐	☐	☐	assess effectiveness of breastfeeding, including pertinent maternal/infant history and observation (mother/breastfeeding parent, infant and feeding)
☐	☐	☐	provide appropriate anticipatory guidance
☐	☐	☐	describe/demonstrate practices that increase breastfeeding success (such as early frequent feeding, responding to cues, effective positioning and latch, skin-to-skin, hand expression)
☐	☐	☐	describe timely strategies to prevent/address common breastfeeding challenges (such as sore nipples, engorgement, breast refusal, infant who cries frequently, etc.)
☐	☐	☐	describe/demonstrate effective breastfeeding support for infants not feeding effectively at the breast
☐	☐	☐	describe strategies, including alternate feeding methods, to overcome feeding challenges

Manager(s) can:

Y	N	IP	
☐	☐	☐	show written information outlining prenatal and postnatal education for breastfeeding mothers/birthing parents
☐	☐	☐	show written information outlining postnatal education for non-breastfeeding mothers/birthing parents
☐	☐	☐	explain how mothers/birthing parents with unresolved breastfeeding issues are cared for (individualized written plans that are communicated to timely and reliable, knowledgeable support in the community; when needed, follow-up is accessible earlier than the routine 24 to 72 hours after discharge[9])
☐	☐	☐	show evidence of collaboration across the continuum of services to support mothers/birthing parents (see Step 10)

Mothers/birthing parents can:

Y	N	IP	
☐	☐	☐	describe the importance of initiating breastfeeding as soon as possible after birth
☐	☐	☐	demonstrate comfortable and effective position and latch
☐	☐	☐	explain how they know their infants are breastfeeding effectively
☐	☐	☐	demonstrate hand expression
☐	☐	☐	demonstrate cup feeding if applicable to their situation
☐	☐	☐	report they have been given timely and appropriate information on how to maintain lactation during challenges such as separation or illness

[9] CPS position statement Facilitating Discharge from hospital of healthy term Infant: At time of discharge, infants must have an appropriate follow-up plan in place that includes contact information for a primary care provider; a scheduled follow-up visit 24 to 72 hours post discharge—in hospital, clinic or at home—with a qualified care provider. Hearing and newborn screens have been scheduled (if they were not conducted in-hospital); appropriate follow-up for jaundice; vitamin D supplementation if breastfed; other follow-up, as required.

☐ ☐ ☐ explain when and where to seek knowledgeable help throughout their breastfeeding experience

☐ ☐ ☐ describe their feeding plan if they have unresolved breastfeeding issues

Mothers/birthing parents who do not breastfeed or do not breastfeed exclusively can:

Y N IP

☐ ☐ ☐ report they received individualized information about maintaining milk supply (if appropriate to their situation), informed decision making, and the safe preparation, storage and use of human milk substitutes

☐ ☐ ☐ describe the importance of the feeding relationship

In hospitals and birthing centres,

Breastfeeding mothers/birthing parents separated from their infants:

Y N IP

☐ ☐ ☐ are offered timely assistance to express their milk within 1–2 hours after birth and at least 8 times per 24 hours to initiate and maintain milk supply

Documentation

Y N IP

☐ ☐ ☐ written information provided to clients (website, resources) is compatible with the above information

Step 6: Support mothers/parents to exclusively breastfeed for the first six months, unless supplements are medically indicated.

In all facilities,

Direct care providers can:

Y	N	IP	
☐	☐	☐	discuss the importance of exclusive breastfeeding
☐	☐	☐	discuss the BCC's medical indications for supplementation[10]
☐	☐	☐	explain how they support mothers/birthing parents with informed decision making
☐	☐	☐	inform mothers/birthing parents who intend to "mix-feed" (both breast and formula feed) about how to establish a milk supply and how to make sure the baby is receiving enough milk
☐	☐	☐	document the rationale when supplements have been recommended, including medical reason and evidence of the mother's/birthing parent's participation in the decision making, in addition to their consent
☐	☐	☐	describe the safe preparation, storage and use of human milk substitutes and the importance of feeding in response to infant cues

Manager(s) can:

Y	N	IP	
☐	☐	☐	explain how regular data analysis informs policy implementation and practice change

Mothers/birthing parents can confirm that:

Y	N	IP	
☐	☐	☐	their infants, younger than 6 months, are exclusively breastfed, or that they made informed decisions not to breastfeed or to supplement for medical or personal reasons
☐	☐	☐	they are aware of recommendations about breastfeeding exclusivity (6 months) and duration (2 years and beyond after the introduction of appropriate complementary foods at 6 months)
☐	☐	☐	they were supported to make informed decisions regarding the use of expressed milk, pasteurized donor milk or human milk substitutes
☐	☐	☐	they were offered timely information in an appropriate, respectful and sensitive manner

Documentation

Y	N	IP	
☐	☐	☐	breastfeeding surveillance information as described in Step 1c

[10] See BCC document titled "Medical Indications for Supplementation."

Step 7: Promote and support mother-infant togetherness.

In all facilities,

Y	N	IP	
☐	☐	☐	breastfeeding is welcome in all public places
☐	☐	☐	appropriate spaces for comfortable breastfeeding/milk expression exist in public and private areas
☐	☐	☐	signs welcoming breastfeeding are displayed in all public areas of the facility and at offsite locations while programs are taking place
☐	☐	☐	staff returning to work are encouraged and accommodated to continue breastfeeding/expressing milk

In hospitals and birthing centres,

Direct care providers can explain how:

Y	N	IP	
☐	☐	☐	mothers/birthing parents and infants remain together and are separated only for medically justifiable reasons and for the shortest possible duration; this variance is noted in the baby's chart
☐	☐	☐	examinations, procedures and education occur with the mother/birthing parent present; if the mother/birthing parent is unable to be present, then a person of their choosing is present
☐	☐	☐	information is given to mothers/birthing parents about safe infant sleep using harm-reduction messaging about bedsharing and swaddling/tight bundling
☐	☐	☐	mothers/birthing parents are encouraged to hold their infants skin-to-skin and/or to breastfeed during infants' painful procedures

Direct care providers caring for mothers/birthing parents of infants in NICU can explain how:

Y	N	IP	
☐	☐	☐	they support mothers/birthing parents to stay close to their infants as much as possible, day and night

Manager(s) can explain how:

Y	N	IP	
☐	☐	☐	policies and procedures relating to mother-infant togetherness (rooming-in, support for painful procedures, etc.) are implemented
☐	☐	☐	adherence to policies and procedures relating to mother-infant togetherness (rooming-in, support for painful procedures, etc.) is ensured
☐	☐	☐	they ensure that care providers facilitate mothers/birthing parents of infants cared for in the NICU to stay close to their infants as much as possible, day and night

Mothers /birthing parents of infants cared for on the postpartum unit report that they:

Y	N	IP	
☐	☐	☐	were supported to stay with their infants from birth (vaginal or caesarean) without interruption, day and night, unless there was a justifiable medical reason for separation that was explained to them
☐	☐	☐	could have a support person of their choice stay with them day and night
☐	☐	☐	were encouraged to hold their infants skin-to-skin and/or to breastfeed during their infants' painful procedures
☐	☐	☐	received information about safe infant sleep using harm-reduction messaging about bedsharing and swaddling/tight bundling

Mothers /birthing parents of infants cared for in the NICU report that:

Y	N	IP	
☐	☐	☐	they were encouraged to stay close to their infants as much as possible, day and night
☐	☐	☐	when separation of mother/birthing parent and baby is unavoidable, alternative feedings (tube, cup or bottle) are coordinated with mother's/birthing parent's presence to maximize breastfeeding opportunities
☐	☐	☐	were supported to practice kangaroo care (continuous or intermittent skin-to-skin)

In community health services,

Direct care providers can explain how:

Y	N	IP	
☐	☐	☐	to encourage mothers/birthing parents to hold their infants skin-to-skin and/or to breastfeed during their infants' painful procedures
☐	☐	☐	information is given to mothers/birthing parents about safe infant sleep using harm-reduction messaging about bedsharing and swaddling/tight bundling

Manager(s) can explain how:

Y	N	IP	
☐	☐	☐	adherence to policies and procedures relating to mother/birthing parent-infant togetherness is ensured

Pregnant women/persons can explain that they:

Y	N	IP	
☐	☐	☐	were given information about the importance of uninterrupted rooming-in with their infants from birth (vaginal or caesarean), unless there was a justifiable medical reason for separation
☐	☐	☐	were encouraged to have a support person of their choice to stay with them day and night
☐	☐	☐	were encouraged to hold their infant skin-to-skin and/or breastfeed during their infants' painful procedures
☐	☐	☐	received information about skin-to-skin and/or breastfeeding during their infants' painful procedures

Mothers/birthing parents can explain that they:

Y	N	IP	
☐	☐	☐	were encouraged to provide skin-to-skin care in the home environment, regardless of feeding decisions
☐	☐	☐	were encouraged to hold their infant skin-to-skin and/or breastfeed during their infants' painful procedures
☐	☐	☐	received clear information about safe sleeping, using harm-reduction messaging about bedsharing and swaddling/tight bundling

Documentation

Y	N	IP	
☐	☐	☐	if mother/birthing parent and baby are separated, the reasons are documented
☐	☐	☐	written information provided to clients (website, resources) is compatible with the above information

Step 8: Encourage responsive, cue-based feeding for infants. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

In all facilities,

Direct care providers can:

Y	N	IP	
☐	☐	☐	describe infant feeding as part of the relationship between mother/birthing parent and child—not simply a means of providing food
☐	☐	☐	describe responsive, cue-based feeding
☐	☐	☐	give anticipatory guidance about sustained breastfeeding and introduction of age-appropriate complementary foods

Manager(s) can:

Y	N	IP	
☐	☐	☐	show written resources that are given to all mothers/birthing parents about responsive cue-based feeding and the introduction of age-appropriate complementary foods
☐	☐	☐	provide a written feeding policy or practices describing individual support to mothers/birthing parents using human milk substitutes

Mothers/birthing parents can:

Y	N	IP	
☐	☐	☐	describe at least 2 feeding cues other than crying
☐	☐	☐	describe responsive, cue-based breastfeeding
☐	☐	☐	explain what information they received about the introduction of age-appropriate complementary foods and sustained breastfeeding

Mothers/birthing parents who are giving human milk substitutes to their infants can:

Y	N	IP	
☐	☐	☐	describe how to choose, safely prepare, feed and store human milk substitutes
☐	☐	☐	describe age-appropriate responsive, cue-based feeding
☐	☐	☐	explain what information they received about the introduction of age-appropriate complementary foods

In hospitals and birthing centres,

Direct care providers can also:

Y	N	IP	
☐	☐	☐	discuss with mothers/birthing parents of preterm, sick or non-cueing infants how to observe their infants' subtle signs and behavioural-state shifts to help them determine when it is appropriate to breastfeed (note: some preterm babies may not show signs of cueing in the first few weeks)
☐	☐	☐	bring preterm, sick or non-cueing infants to their mothers/birthing parents as soon as they are showing feeding cues, when mothers/birthing parents and infants are cared for in different areas
☐	☐	☐	assess breastfeeding progress with mothers/birthing parents at appropriate intervals

Mothers/birthing parents of preterm, sick or non-cueing infants report that:

Y	N	IP	
☐	☐	☐	they were given information about their infants' subtle signs and behavioural-state shifts that can help them determine when it is appropriate to breastfeed
☐	☐	☐	they were supported to feed their milk or donor milk as soon as the infant was deemed stable
☐	☐	☐	medications and other treatments were scheduled to cause the least interference with infant feeding
☐	☐	☐	they were supported to do non-nutritive breastfeeding to assist with transitioning to breastfeeding
☐	☐	☐	their desire to breastfeed was respected and feedings (tube, cup or bottle) were coordinated with their presence at the bedside as much as possible

In community health services,

Pregnant women/persons* can *also explain what information they have received on:

Y	N	IP	
☐	☐	☐	responsive cue-based feeding
☐	☐	☐	introduction of age-appropriate complementary foods
☐	☐	☐	sustained breastfeeding

Mothers/birthing parents can confirm they received information about:

Y	N	IP	
☐	☐	☐	timely anticipatory guidance about contraceptive methods compatible with breastfeeding
☐	☐	☐	age-appropriate normal feeding behaviours and their implications for feeding
☐	☐	☐	overcoming breastfeeding challenges that may occur with the growing child
☐	☐	☐	women's rights to accommodation in the community, school and workplace that support and sustain breastfeeding

Documentation

Y	N	IP	
☐	☐	☐	written information provided to clients (website, resources) is compatible with the above information

Step 9: Discuss the use and effects of feeding bottles, artificial nipples and pacifiers with parents.

In all facilities,

Direct care providers can:

Y	N	IP	
☐	☐	☐	support mothers/birthing parents to make informed decisions regarding the impact of bottles, artificial nipples and pacifiers on feeding cues and breastfeeding
☐	☐	☐	describe the safe use of feeding alternatives recommended for breastfed infants requiring supplementation (cups, spoons, etc.)
☐	☐	☐	explain to mothers/birthing parents the safe cleaning and use of feeding equipment, artificial nipples and pacifiers when they are utilized
☐	☐	☐	give anticipatory guidance to breastfeeding mothers on how to feed and care for their infants without the use of pacifiers
☐	☐	☐	confirm that if nipple shields are used, breastfeeding assessment is documented and the mother/birthing parent receives support, information and follow-up
☐	☐	☐	confirm that bottles or other alternate feeding methods are not used to evaluate infant feeding readiness for small, sick or preterm babies

Managers can:

Y	N	IP	
☐	☐	☐	confirm that mothers/birthing parents are supported to make informed decisions regarding the use of feeding bottles, artificial nipples and pacifiers

Mothers/birthing parents can:

Y	N	IP	
☐	☐	☐	give 2 reasons why bottles, artificial nipples and pacifiers are not routinely recommended
☐	☐	☐	describe the information they have received about how to feed and care for their breastfeeding infants without the use of artificial nipples and pacifiers
☐	☐	☐	describe the options that were discussed with them about how to feed a supplement when their infants needed it
☐	☐	☐	confirm that, if their infant was given a bottle, artificial nipple or pacifier this was their informed decision or a medical indication that was discussed with them and they gave consent

In hospitals and birthing centres,

Mothers/birthing parents of infants in NICU:

Y	N	IP	
☐	☐	☐	can explain the role of non-nutritive suckling (breast, finger, pacifier) when infants are unable to breastfeed
☐	☐	☐	confirm that they were supported to provide non-nutritive suckling at the breast or skin- to-skin care for pain control and calming

Documentation

Y	N	IP	
☐	☐	☐	shows the effects and use of bottles, artificial nipples and pacifiers

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

In hospitals and birthing centres,

Direct care providers can describe:

Y	N	IP	
☐	☐	☐	how they assess effective feeding prior to discharge
☐	☐	☐	how they create appropriate individualized discharge feeding plans
☐	☐	☐	the referral process to community resources: care providers knowledgeable and skilled in breastfeeding
☐	☐	☐	how families are included in discharge planning

Manager(s) can describe:

Y	N	IP	
☐	☐	☐	a process for the transition from hospital to community health services
☐	☐	☐	liaison and collaboration between the hospital, community health services and peer support groups to coordinate breastfeeding messages and offer continuity of care
☐	☐	☐	program evaluation used to improve breastfeeding rates at the facility
☐	☐	☐	engagement of stakeholders and community partners to determine appropriate, accessible and affordable services to promote, protect and support breastfeeding

Mothers/birthing parents can:

Y	N	IP	
☐	☐	☐	confirm they were involved in their individualized discharge plans
☐	☐	☐	confirm that they were informed that they would be contacted by a care provider within 2 days from discharge
☐	☐	☐	describe at least one way to access breastfeeding support 24 hours/day
☐	☐	☐	confirm that they were given information on how to access peer support programs

Mothers/birthing parents of infants in NICU:

Y	N	IP	
☐	☐	☐	have a detailed discharge infant feeding plan, including where and when to follow up with health care providers and access to peer support

In community health services,

Direct care providers can describe:

Y	N	IP	
☐	☐	☐	the follow-up assessment and support provided to mothers/birthing parents following hospital discharge
☐	☐	☐	how they assess effective feeding and address identified variances
☐	☐	☐	anticipatory guidance to overcome common breastfeeding concerns
☐	☐	☐	the types of services available to support feeding from infancy until the child is 2 years or older
☐	☐	☐	the information (written or web-based) available to mothers/birthing parents on effective feeding and when/how to seek assistance when needed
☐	☐	☐	how families are included in care planning

Manager(s) can describe:

Y	N	IP	
☐	☐	☐	an adequate process for the transition from hospital to community health services; follow-up is available earlier than routine 48 hours after discharge when needed
☐	☐	☐	liaison and collaboration between the hospital, community health services and peer support groups to coordinate infant feeding messages and offer continuity of care
☐	☐	☐	program evaluation used in the facility to improve breastfeeding rates in the community
☐	☐	☐	the engagement of stakeholders and community partners to determine appropriate, accessible and affordable services to promote, protect and support breastfeeding
☐	☐	☐	universal and targeted approaches used by the facility for breastfeeding health promotion strategies

***Mothers/birthing parents can describe*:**

Y	N	IP	
☐	☐	☐	how to obtain assistance for breastfeeding concerns within 24 hours of discharge from hospital/birthing centres
☐	☐	☐	how to access routine follow-up for infant feeding assessment and assistance
☐	☐	☐	timely access and effective breastfeeding support in the early weeks and as long as needed

Documentation:

Y	N	IP	
☐	☐	☐	shows evidence of liaison and collaboration across the continuum of care
☐	☐	☐	describes up-to-date information on community resources related to infant feeding, including professional support and peer support groups