

BFI IMPLEMENTATION TOOLKIT

THE BFI STRATEGY FOR ONTARIO

Growing a Baby-Friendly Ontario

BABY-FRIENDLY INITIATIVE STRATEGY ONTARIO





BABY-FRIENDLY INITIATIVE STRATEGY ONTARIO

This toolkit was prepared for Ontario hospitals and community health services as part of the **Baby-Friendly Initiative Strategy for Ontario**. This project is one of the Healthy Kids Strategy initiatives that enhance breastfeeding supports in Ontario, announced by the Minister of Health and Long-Term Care in September 2013.

As part of the BFI Strategy, Hospitals, Community Health Centres, Family Health Teams, Aboriginal Health Access Centres, Birthing Centres and Nurse Practitioner-Led Clinics are receiving training, tools and guidance to help them achieve the World Health Organization's Baby-Friendly Initiative (BFI) designation and adopt clinical best practices in infant feeding that meet BFI designation requirements.

The BFI Strategy complements two other provincial investments that support breastfeeding in Ontario:

- Expansion of Telehealth Ontario to provide 24/7 access to lactation expertise and breastfeeding support to mothers.
- Grants to community organizations, administered by the Best Start Resource Centre, to develop and deliver new, targeted breastfeeding support programs.

The BFI Strategy for Ontario is led by Michael Garron Hospital (formerly known as Toronto East General Hospital) with shared leadership support from the Provincial Council for Maternal Child Health (PCMCH) and the Best Start Resource Centre, Health Nexus (BSRC).

This toolkit is just one of the many resources that will be available to support you on your BFI journey, through the BFI Strategy for Ontario.

To learn more about the BFI Strategy for Ontario, and to provide feedback on this toolkit, please visit our microsite at www.bfistrategy@tehn.ca.

Growing a Baby-Friendly Ontario!





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Growing a Baby-Friendly Ontario!

INTRODUCTION

- **The Importance of the Baby-Friendly Initiative**
- **How to Use the Toolkit**
- **Toolkit Objectives**

THE IMPORTANCE OF THE BABY-FRIENDLY INITIATIVE

The Baby-Friendly Initiative (BFI) is an evidence-based program of the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF). It is a population health strategy that results in improved infant and mother health, and promotes the efficient use of resources within families, health care institutions, and society. The benefits of breastfeeding, and the risks of using alternatives, have been widely documented. Therefore, BFI is designed to improve infant health by supporting, promoting, and protecting breastfeeding.

BFI supports Best Practice standards-of-care for all mothers and infants. This is inclusive of practices that facilitate the initiation and efficacy of breastfeeding and promote early infant attachment. There is a growing body of evidence that BFI implementation increases breastfeeding rates. Therefore, health care facilities are encouraged to work towards becoming designated as “Baby-Friendly”.

Breastfeeding is the normal and unequalled method of feeding babies and is one of the most important contributors to infant health. Children who are not breastfed and women who do not breastfeed are both at higher risk for negative health outcomes as discussed in Chapter Two. Breastfeeding further confers economic benefits to the family, health care system, and workplace; thus, not breastfeeding is costly. Breastfeeding may be viewed from the perspective of providing food security for infants as it does not depend on available financial resources within the family.

Health Canada (2012) recommends breastfeeding exclusively for the first six months and continued breastfeeding for up to two years and beyond with the introduction of appropriate solids. This is important for emotional and physical development, growth, immunologic protection, and nutrition of infants and toddlers.

In Ontario, the Healthy Kids Panel submitted a report called *No Time to Wait: The Healthy Kids Strategy* to the Ministry of Health and Long-Term Care. The focus was on reducing childhood obesity, and one of the recommendations is implementing BFI in Ontario’s health care facilities. This Toolkit is one of the the initiatives of the Healthy Kids Strategy.



HOW TO USE THE TOOLKIT

This toolkit has been developed to give decision makers, BFI committees, and those involved with or thinking about BFI, an overview of what lies ahead. It is not intended to be a comprehensive “how to” document but provides a road map with relevant links and information gathered into one place to educate organizations about the process, from becoming aware of the importance of BFI to the prestigious achievement of receiving and maintaining BFI designation.

The BFI Implementation toolkit can be of use to all who work with mothers, babies, and their families, and in particular, to those who make decisions, develop policy, provide education to staff, and support BFI in their place of work. This could be:

- CEOs and directors.
- Managers and supervisors.
- Staff and client educators.
- Clinicians, including physicians and front-line service providers.
- Regional groups, committees, and networks.

The Toolkit is organized as follows:

- The first three chapters of the toolkit provide information and background about BFI and are therefore, most suited to those new to BFI, those who have not yet formally initiated their BFI journey, or for those who wish to refresh their knowledge.
- Chapter 4 speaks to the beginning of the journey and is therefore, most suited to those who are in the preliminary stages of BFI work.
- Chapters 5 and 6 address elements that have to be put into place to move towards BFI designation, and covers the intermediate stages of BFI implementation with Chapter Six focusing on education and changing organizational culture.
- Chapter 7 highlights the achievement and celebration of BFI designation and reaffirms the work of those in the advanced phase.
- Chapter 8 tells those who have achieved BFI designation about the requirements after the assessment and provides strategies to maintain the standard.
- Chapter 9 lists challenges that can be encountered at any point on the road to success and provides suggestions for solutions with the aid of those already on the journey.

TOOLKIT OBJECTIVES:

- Provides a roadmap for an organization’s BFI journey.
- Provides practical information about how to implement BFI.
- Provides resources and practice examples to assist on the journey.



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WHAT IS BFI?

- **History and background (1991)**
- **The Innocenti Declaration (1990)**
- **The WHO Code (1981)**
- **Health Canada (2012) and the Canadian Paediatric Society (2012)**
- **The BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services (2017)**

HISTORY AND BACKGROUND (1991)

The Baby-Friendly Initiative (BFI), better known internationally as Baby-Friendly Hospital Initiative (BFHI), is a global strategy to set minimum standards for maternity services to promote, protect, and support breastfeeding. It is part of a strategy to improve Infant and Young Child Feeding (IYCF). To be considered “Baby-Friendly,” health care facilities must be compliant with the *International Code of Marketing of Breast-milk Substitutes* (referred to as the WHO Code) and must follow the 10 Steps both reviewed below. Since BFHI began, it has grown worldwide (recognized in at least 152 countries) resulting in thousands of health care facilities being awarded Baby-Friendly designation.

BFI helps to improve the health status of mothers and children. It is an important prevention and health promotion strategy as breastfeeding is currently suboptimal, even in developed countries such as Canada, negatively impacting health. It is estimated globally that maternal and child under-nutrition is the cause of 3.5 million deaths with 35% of the disease burden in children younger than 5 years of age (Black et al., 2008). Mixed feeding (feeding some breastmilk and some formula) in the first six months of life has resulted in 1.4 million deaths and 10% of disease burden in children younger than 5 years of age. Developed countries are not immune, such as the United States, where 21% of post-neonatal mortality is considered preventable with six months of breastfeeding (Chen & Rogan, 2004). BFI, on the other hand, affects a positive change supported by research evidence discussed at the end of Chapter Two.

The principles of BFI are supported by the United Nations’ Convention on the Rights of the Child, a comprehensive international human rights framework. Numerous articles of this convention are supportive of BFI, particularly the right of children to the highest attainable standard of health, in part, by reducing infant mortality, and promoting breastfeeding (UNICEF, n.d.).

THE INNOCENTI DECLARATION (1990)

BFHI began the year after the Innocenti Declaration of 1990. This declaration was the outcome of a meeting at the Hospital of the Innocents in Florence, for WHO/UNICEF policymakers’ called, *Breastfeeding in the 1990s: A Global Initiative*.

The Innocenti Declaration remains relevant, beginning by declaring the enhanced health of infants and women by breastfeeding, and that the benefits increase with increased



exclusivity and duration of breastfeeding. It speaks to how all women should be enabled to exclusively breastfeed and for that to occur, an appropriate environment is required. Therefore, a breastfeeding culture must be reinforced, "... and its vigorous defense against incursions of a 'bottle feeding culture'" (UNICEF, n.d.). To achieve this, advocacy and efforts to increase mothers' confidence are required. Amongst other items, the document calls for all governments to develop national breastfeeding policies, set targets, develop key indicators, and to fully integrate the breastfeeding policies into their overall health and development policies. More information on the declaration may be found at: <http://breastfeedingcanada.ca/The-Code.aspx> and <http://www.unicef.org/programme/breastfeeding/innocenti.htm>



In 2005, the Innocenti Declaration was reviewed stating remarkable progress has been made but suboptimal breastfeeding, or no breastfeeding, and inadequate complementary feeding, "remain the greatest threat to child health and survival globally" (UNICEF, 2005). The 2005 document reports that simply improving breastfeeding could save the lives of more than 3500 children daily. The original operational targets were kept, and new ones added, recognizing that the community, family, and workplace also need to be targeted. The 2005 document included ten key points of *What Everyone Should Know about Breastfeeding*, which may be seen in Appendix 1.

THE WHO CODE (1981)

Included in the operational targets of the Innocenti Declaration is the need to abide by the WHO Code. Developed at World Health Assembly (WHA) meetings, the WHO Code was endorsed by 118 countries and a worldwide coalition of organizations called the International Baby Food Action Network (IBFAN) (WHO, 1991). The WHO Code addresses concerns over aggressive marketing of breastmilk substitutes, and their effect the world over. The aim is to protect vulnerable infants from inappropriate marketing and use of alternate products, and thereby contribute to safe and adequate nutrition for all infants. As well as consumers, the attention of the Code falls on health care providers and how both are influenced by formula manufacturing companies.

The International Code of Marketing of Breast-Milk Substitutes and subsequent WHA resolutions provide rules for health workers, governments, and industries to regulate the promotion of infant feeding products through marketing, and to protect and promote breastfeeding by ensuring the ethical marketing of breastmilk substitutes.

Although Canada gave its approval at the time, and has adopted a few provisions from the Code into other laws, it has not enacted legislation. Still, organizations wishing to be Baby-Friendly need to follow all the points in the Code. The products the Code addresses are: all breastmilk substitutes, follow-on formulas, baby foods, bottles and artificial nipples, and related equipment.

The 10 items that make up the WHO Code include:

1. No advertising of any of these products to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.
4. No company sales representatives to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealizing artificial feeding or pictures of infants on labels of infant milk containers.
7. Information to health workers should be scientific and factual.
8. All information on artificial infant feeding, including that on labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.
10. Manufacturers and distributors should comply with the Code's provisions even if countries have not adopted laws or other measures.

Mothers must be able to make an informed decision on how to feed their babies free of commercial influence. Some people may see feeding decisions as a personal or a lifestyle choice, and formula companies imply that breastfeeding and formula are almost equivalent. Mothers who are knowledgeable regarding the health outcomes and risks of using any formula can make an informed decision about feeding their infant and provide consent for formula feeding or medically indicated supplementation. There are occasional medical reasons for giving formula that will be discussed.

What may be a bit more insidious is how formula companies influence health care, clinicians, and service providers. Any items with a formula logo or name on it, like a measuring tape, poster or bottle, at medical facilities can inadvertently influence professionals and families. Gifts of equipment, space, food, research grants, sponsorship of professional events, or advertisement in professional publications have been shown to influence professionals. Even simply speaking at a formula company meeting lends credibility to the company and is considered a Code violation.

Without government legislation, it is even more important that professional groups uphold the Code. Professional organizations are, in fact, endorsing the Code in their position statements, many of which may be found at www.bfontario.ca/the-baby-friendly-initiative/position-statements/.

Some of these organizations are:

- Canadian Association of Midwives.
- Canadian College of Family Physicians.
- Canadian Hospital Association.
- Canadian Pharmacists Association.
- Ontario Public Health Association.
- Registered Nurses' Association of Ontario.
- Society of Obstetricians and Gynecologists of Canada.

See www.breastfeedingcanada.ca/TheCode.aspx for more information about:

- The WHO Code and subsequent WHA Resolutions.
- Frequently asked questions about the WHO Code.
- The Ontario Public Health Association (OPHA) Position Paper: *The WHO Code and the Ethical Marketing of Breastmilk Substitutes* (2010). This includes evidence of the effects of the WHO Code and WHO Code violations.

HEALTH CANADA (2014) AND THE CANADIAN PAEDIATRIC SOCIETY (2014)

Health Canada (HC) updated Canadian infant feeding guidelines in 2014 in a Joint Statement with the Canadian Paediatric Society (CPS), Dietitians of Canada (DC), the Public Health Agency of Canada (PHAC), and the Breastfeeding Committee for Canada (BCC). *Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months* www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php, is a comprehensive, referenced document inclusive of the 10 Steps, the WHO Code, recommendations on the use of breastmilk substitutes, and some advantages of breastfeeding. It also speaks to the introduction of complementary foods at 6 months of age and provides a link to growth charts for Canada found here www.dietitians.ca/Secondary-Pages/Public/Who-Growth-Charts.aspx. An additional Joint Statement, *Nutrition for Healthy Term Infants: Recommendations from Six to 24 Months*, can be found at www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/recom-6-24-months-6-24-mois-eng.php

CPS is in agreement with HC's breastfeeding recommendations and promotion of BFI as seen in the following CPS documents:

- *Nutrition for Healthy Term Infant, Birth to Six Months: An Overview* www.cps.ca/documents/position/nutrition-healthy-term-infants-overview.
- *The Baby-Friendly Initiative: Protecting, Promoting and Supporting Breastfeeding* www.cps.ca/documents/position/baby-friendly-initiative-breastfeeding.



THE 10 STEPS TO SUCCESSFUL BREASTFEEDING

The 10 Steps must be met to achieve BFI designation. In Canada, BCC (the national authority for BFI), has developed the *BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services* (2017) (referred to as the BFI 10 Steps and WHO Code Outcome Indicators). This document can be found at www.breastfeedingcanada.ca/BFI.aspx and lists the 10 Steps in their Canadian interpretation. More information on the 10 Steps, as developed by WHO/UNICEF, is accessible at www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse_s1/en.

- Step 1** Have a written infant feeding policy that is routinely communicated to all staff, health care providers and volunteers.
- Step 2** Ensure all staff, health care providers and volunteers have the knowledge and skills necessary to implement the infant feeding policy.
- Step 3** Inform pregnant women and their families about the importance and process of breastfeeding.
- Step 4** Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes. Encourage mothers to recognize when their babies are ready to feed, offering help as needed.
- Step 5** Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.
- Step 6** Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.
- Step 7** Facilitate 24 hour rooming-in for all mother-infant dyads: mothers and infants remain together.
- Step 8** Encourage responsive, cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
- Step 9** Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).
- Step 10** Provide a seamless transition between the services provided by the hospital, community health services, and peer-support programs. Apply principles of primary health care and population health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.

Each of these steps is further broken down into outcome indicators which are crucial to the BFI process and may be viewed on the BCC website at www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf. The Practice Outcome Indicators will be helpful for BFI committees when considering work plans.



WHAT ARE THE BENEFITS OF BFI?

- **The cost of using breastfeeding alternatives**
 - Children
 - Mothers
 - Families
 - Workplaces
 - Health care costs/Taxpayers
 - Environment
- **How unique is breastmilk?**
- **Protect the infant gut**
- **What is recommended if a baby needs a supplement?**
- **Are there medical reasons to use formula?**
- **Supplementing without medical indication**
- **Further hazards of formula and risks of powdered infant formula**
- **Caution regarding non-medical use of formula**
- **Breastfeeding questions and answers**
 - Should all babies be encouraged to breastfeed?
 - How to know what is safe to take while breastfeeding?
 - Is there a benefit to partially breastfeed and partially formula feed?
 - Is giving expressed breastmilk just as good as directly breastfeeding?
- **Populations with lower rates of breastfeeding**
- **Who benefits from Baby-Friendly?**

THE COST OF USING BREASTFEEDING ALTERNATIVES

Just as it is biologically normal that infants grow and develop in utero for approximately 40 weeks, so it is biologically normal that infants continue their growth and development at their mother's chests, with the breasts available to breastfeed. Because breastfeeding is biologically normal, one must consider what happens without the normal. Therefore, this is written from a risk point of view. Many benefits of BFI will be understood by appreciating more about breastfeeding itself.

CHILDREN:

Infants who are NOT breastfed experience higher rates of:

- Hospitalization for diarrhea (Kramer & Kakuma, 2012; Quigley et al., 2009; Horta & Victora, 2013).
- Respiratory diseases (Quigley et al., 2007; Duijts, et al., 2010; Horta, 2013).
- Otitis media (Ip et al., 2007; Ip et al., 2009; Bowatte et al., 2015).
- Sudden Infant Death Syndrome (Vennemann et al., 2009; Thompson et al., 2017).

- Mortality (Chen et al., 2004; Sankar et al., 2015).
- Necrotizing enterocolitis (Boyd et al., 2007; Sisk et al., 2008; Hair et al., 2016).
- Overweight and obesity (Horta et al., 2007; Ip et al., 2007; Horta et al., 2015).
- Atopic dermatitis (Kramer, 2011).
- Asthma and allergies (Kramer, 2011; Lodge et al., 2015) (there have been mixed reports from other studies).
- Childhood cancers: acute lymphoblastic leukemia, and some evidence of Hodgkin's disease and neuroblastoma (Ip et al., 2009; Martin et al., 2005; Amitay & Keinan-Boker, 2015).
- Type 2 diabetes, although further studies are needed (Horta et al., 2007; Ip et al., 2009; Horta et al., 2015).
- Pain response to procedural pain (Shah et al., 2009; Taplack & Erdem, 2017).



MOTHERS:

A mother who is NOT breastfeeding is at increased risk of:

- Type 2 diabetes (Bentley-Lewis et al., 2008; Chowdhury et al., 2015).
- Breast and ovarian cancers (Ip et al., 2009, Chowdhury et al., 2015).
- Postpartum depression (Dennis & McQueen, 2007; Ip et al., 2007; Dennis & McQueen, 2009).
- Less effective bonding with her new baby (Acheson, 1995; Charpak et al., 2005; Dumas et al., 2013).
- Earlier return of menses not allowing for natural spacing of children (Labbok et al., 1997; Peterson et al., 2000; Sundhagen, 2009; Chowdhury, 2015).

FAMILIES:

For a family in Ontario receiving an Ontario Works subsidy, formula can cost from 11% to 54% of the family's available income or \$560 to \$2868 for six months (INFACT Canada, 2004). According to the Registered Nurses' Association of Ontario (RNAO) in 2010, formula costs at least \$1800 per year. Not breastfeeding further adds burden to personal family and household budgets due to:

- Health and wellness concerns as noted above.
- Increased absenteeism to care for sick children.

WORKPLACES:

BFI Ontario's *Business Case for the Baby-Friendly Initiative* (2013) states that having a supportive work environment benefits employers in the following ways:

- Less absenteeism due to less illness amongst infants and small children.
- Reduced health care insurance costs per breastfed infant.
- Decreased maternal stress.
- Decreased employee turnover.
- Increased job satisfaction.
- Increased productivity of the breastfeeding employees.

Employers and workplaces can support the return of breastfeeding mothers to work by providing a supportive environment. According to Kosmala-Anderson & Wallace (2006); McPhillips et al. (2007); and Ortiz et al. (2004), a supportive environment may include:

- Information about available workplace support provided to pregnant staff.
- Child care and after-school care.
- Flexible hours and flexible scheduling.
- Access to (or provision of) breast pumps just prior to returning to work.
- Private room for pumping, a refrigerator for storing breastmilk.
- Onsite prenatal classes.
- Workplace policies: breastfeeding, maternity, paternity.

For more on action in the workplaces see:

- *Creating a Breastfeeding Friendly Workplace* (OPHA, 2008) at www.opha.on.ca.
- www.bfontario.ca/wp-content/uploads/2012/10/Business-Case-for-BFI.pdf.
- www.ottawabreastfeeds.ca/index.php/en/.



HEALTH CARE COSTS/TAXPAYERS:

To develop a breastfeeding culture, there will be expenses; however, the evidence suggests a significant return on investment (Coyte et al., 1999). Consider the potential to reduce health care costs:

- There is a high cost to the health care system, society, and families for not breastfeeding (Ball & Bennett, 2001).
- A U.S. cost analysis concluded that if 90% of babies were breastfed exclusively for six months, annual health care costs would be reduced by \$13 billion (Bartick & Reinhold, 2010).
- The cost of treating just three largely preventable illnesses - otitis media, gastroenteritis, and necrotizing enterocolitis - is estimated at \$3.6 billion in the United States (Weimer et al., 2001).
- In Canada the cost of otitis media alone is estimated at over \$600 million annually (Coyte et al., 1999).

ENVIRONMENT:

If every baby in the U.S. were breastfed, it would save approximately 86,000 tonnes of tin plate that would have been used to create 550 million cans, as well as 1230 tonnes of paper for paper labels (World Alliance for Breastfeeding Action).

HOW UNIQUE IS BREASTMILK?

Formula helps infants to grow but is otherwise not a similar substance to breastmilk.

Breastmilk contains:

- Thousands of bioactive factors not otherwise available to infants: e.g. anti-inflammatory, anti-fungal, anti-bacterial (Hamosh, 2001).
- Protective functions in the proteins, fats and carbohydrates, enzymes with digestive functions, hormones, growth factors, and more (Hamosh, 2001; Hosea Blewett et al., 2008).
- Compositions that differ both between women and within the lactation period (Field, 2005).

PROTECT THE INFANT GUT

Prior to labour the infant gut is sterile. The microbiota of the gut, or what used to be called flora, bacterial, viral and fungal microorganisms, is determined by mode of delivery (vaginal or caesarean), type of infant feeding (breastfeeding, formula feeding), infant hospitalization, gestational age, and use of antibiotics (Penders, 2006). Term infants, born vaginally, at home, and exclusively breastfed have the most “beneficial” gut microbiota (highest numbers of bifidobacteria and lowest numbers of *C. difficile* and *E. coli*) (Penders et al., 2006).

During vaginal delivery, the infant receives the mother’s vaginal and fecal flora, which colonizes the newborn’s gut. However; it is not the case with caesarean births. With caesarean births, the new immune system must deal with unfamiliar, often hostile bacteria like *Clostridium difficile*. Additionally, breastfed infants consistently have mainly Bifidobacterium and have fewer Clostridia species compared with formula-fed infants (Harmsen et al., 2000).

This matters because the newborn’s immune system is developing as the microbiota is being formed. “Good” gut bacteria are important for this and core gut microbiota is established in the first few weeks of life. The delivery method affects gut bacteria even months later (Azad et al., 2013).



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Infant diet affects changes in intestinal and pancreatic function (Le Huerou-Luron et al., 2010). Formula feeding increases intestinal permeability and absorption of bacteria. If there is an imbalance in the microbiota, a low-grade inflammatory response follows, from the time of birth, and this leads to weakness in the intestinal lining. This appears to lead to some chronic diseases like diabetes, obesity, and eczema. Breastmilk however appears to have a protective role, such as in coeliac disease (Palma, 2012).

It makes sense then that many interventions, including giving a bottle of formula “just in case,” may have large repercussions.

WHAT IS RECOMMENDED IF A BABY NEEDS A SUPPLEMENT?

After it has been determined that there is a medical reason to give a supplement, the choices – in recommended order – are as follows:

- Give mother’s own expressed breastmilk, expressed by hand and/or by pump.
- Give another mother’s milk. Health Canada recommends pasteurized human milk from appropriately screened donors, i.e., human milk from a milk bank.
- Commercial infant formula, cow-milk based. Soy-based infant formula is indicated only for infants with galactosemia or for those who cannot consume dairy-based products for cultural or religious reasons.
- Specialty formula for special medical purposes only when you detect or suspect that the formula-fed infant has the indicated conditions such as proven cow’s milk allergy.

Many more details are available on the Health Canada website under *Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months* at www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php#a4.



Whether medically indicated or non-medical supplementation, both need to be done after a mother has made an INFORMED decision. This is to ensure that she understands the risks/benefits and also to protect the health care professional if the baby should have a negative reaction or negative outcome. This is part of BFI and needs to be documented.

(Grand River Hospital, RN, IBCLC)

ARE THERE MEDICAL REASONS TO USE FORMULA?

Yes, where donor human milk is not available, in the cases of:

- Mothers with:
 - Severe illness, e.g., sepsis.
 - HSV-1 near a nipple where the baby’s mouth would touch (as long as active).
 - A few medications (found in the policy).
- Maternal medication with (check with Motherisk):
 - Radioactive iodine-131, although breastfeeding could resume after two months.
 - Chemotherapy, although a mother could resume breastfeeding after therapy stops.
- HIV infection: If replacement feeding is acceptable, feasible, affordable, sustainable, and safe.
- Infants with: Galactosemia, maple syrup urine disease, phenylketonuria, and other inborn errors of metabolism.

For details on medical reasons to use breastmilk substitutes, please download the following documents:

- *Acceptable medical reasons for the use of breastmilk substitutes* (WHO, 2009)
www.who.int/maternal_child_adolescent/documents/WHO_FCH_CAH_09.01/en/
- *Clinical Protocol #2: Supplementation* (Academy of Breastfeeding Medicine, 2009)
www.bfmed.org/Resources/Protocols.aspx.

SUPPLEMENTING WITHOUT MEDICAL INDICATION

What happens if supplementation is used without a medical indication? There is a risk of decreased maternal confidence and milk production (Merten & Ackermann-Liebrich, 2004; Sheehan et al., 2001; Ekstrom et al., 2003; Gagnon et al., 2005).

There is also a risk of:

- Less breast stimulation.
- Delayed lactogenesis II (milk “coming in”).
- Infant imprinting on feeding from a bottle.
- Being overfed.
- Sleeping through feeds.

Mothers whose babies receive two or more supplemental formula feeds are at increased risk of weaning in 7-10 days (Declercq et al., 2009; Hall et al., 2002; Szajewska et al., 2006).



I was very proud (too proud) when I had my daughter, and I did not want to ask for help. My husband kept encouraging me to reach out and ask for help. I think the email forum was wonderful for me. I could send out an email, for example, to Dr. Newman, with my questions and get a quick response – or to my doula and get a fairly quick reply, etc. I felt safe – I was at home sending the email or calling La Leche League (phone support was great) – but I was terribly shy to go in person. It’s all these challenges that a new mother has to get over. It can be really overwhelming.

(Mother, Auramarina)



If we could find a way to show the couple how important BOTH their roles are to the success of breastfeeding – I think we would be further ahead. I have heard so many sad stories of people saying that they tried nursing but it just didn’t work out – the baby screamed – partner didn’t know how to help – and formula was available.

(Mother, Auramarina)



I was so worried about supply. It took a lot of reassurance from lactation consultants to realize that I had enough milk.

(Mother, Katie)

FURTHER HAZARDS OF FORMULA AND RISKS OF POWDERED INFANT FORMULA

Further hazards of formula include:

- Manufacturing errors: Mixing errors, contamination (INFACT Canada, 2006).
- Use of unproven and hazardous additives such as DHA and ARA (The Cornucopia Institute, 2008).
- Consumer errors: Mixing errors, contamination, storage errors (INFACT Canada, 2006).
- Inadequate attention to expiry dates.

Risks of powdered infant formula:

- Powdered infant formula is not sterile and may contain harmful bacteria for infants (*Cronobacter/Enterobacter Sakazakii*). It is safer to use a sterile, liquid infant formula to feed premature and low-birth weight infants less than two months of age, and for babies with weakened immune systems.
- For infants at the greatest risk, i.e., pre-term, low-birth weight, and immunocompromised infants, commercially-produced, liquid infant formulas, both concentrated and ready-to-use, are a better choice. See Health Canada (2010) at: <http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php#a11>.

CAUTION REGARDING NON-MEDICAL USE OF FORMULA

In Canada, there are high formula supplementation rates despite a high maternal intention to breastfeed (Public Health Agency of Canada, 2009). Apart from intention (Caulfield et al., 2008), various factors influence a mother's decision to breastfeed such as her breastfeeding self-efficacy (McQueen et al., 2011; Blyth et al., 2004) as well as her support and role models (Sikorski et al., 2003). However, beyond the individual, there is a host of factors that influence this decision such as societal pressures (Spurles & Babineau, 2011), hospital policies regarding formula (Schwartz et al., 2002), and nurse and physician knowledge (Freed et al., 1995, Hellings & Howe, 2000).

The most common reasons for in-hospital formula supplementation are non-medical indications (Ekstrom et al., 2003) such as maternal concerns (perceived lack of milk, fatigue) (Gagnon et al., 2005) and infant weight loss. The standards of supplementation for infant weight loss have been questioned (Noel-Weiss et al., 2008).

Health care facilities, policies, and providers have a strong impact on mother-infant dyads achieving exclusive breastfeeding patterns (Gagnon et al., 2005; Tender et al., 2009). At the same time, there is strong evidence that women need further breastfeeding support in addition to standard care (Aksu et al., 2011; Beake et al., 2012). Discussing breastfeeding early in pregnancy and pre-pregnancy impacts breastfeeding outcomes (Arlotti et al., 1998). Women want health care providers to share information on breastfeeding at any stage and to personalize it to their baby (Miracle et al., 2004).



BREASTFEEDING QUESTIONS AND ANSWERS

SHOULD ALL BABIES BE ENCOURAGED TO BREASTFEED?

The World Health Organization recommends that breastfeeding is the best feeding option for all babies including:

- Infants born weighing less than 1500 grams.
- Infants born at less than 32 weeks gestational age.
- Newborns at risk of hypoglycemia, those who are ill, those whose mothers are diabetic.

HOW TO KNOW WHAT IS SAFE TO TAKE WHILE BREASTFEEDING?

The safety of particular medications and herbal products during breastfeeding may be found in the following reputable places:

- *Medications and Mother's Milk*, (Hale 2017; published every two years) www.springerpub.com/medications-mothers-milk-2017.html.
- LactMed: A National Library of Medicine Database on Drugs and Lactation at www.nlm.nih.gov/pubs/factsheets/lactmedfs.html.
- Motherisk at www.motherisk.org/women/index.jsp.

IS THERE A BENEFIT TO PARTIALLY BREASTFEED AND PARTIALLY FORMULA FEED?

Yes. There is a dose-response relationship meaning that the more exclusively a baby breastfeeds and the longer a baby breastfeeds, the more benefit (Ip, 2007; Sisk, 2007). Still, if the decision is combination feeding or just formula feeding, it is definitely beneficial to an infant and a mother to combination feed.

IS GIVING EXPRESSED BREASTMILK JUST AS GOOD AS DIRECTLY BREASTFEEDING?

No. Pumping and/or hand expressing breastmilk and feeding by bottle has become more common (Thorley, 2011), and this may be of concern. Expressed breastmilk still has the nutritive properties and is healthy but it is not the same as at-the-breast feeding. The following is a sample of some differences.

- Babies fed at the breast have better appetite regulation (DiSantis et al., 2011).
- Mothers who hold their babies skin-to-skin enjoy increased milk production, oxytocin release, mother-baby bonding, and more maternal confidence. These babies also cry less (Moore et al., 2012).
- Mothers produce antibodies to the viruses they are exposed to and in turn pass these antibodies on to their babies (Jackson & Nazar, 2006; Labbok et al., 2004). More recent research suggests that through the act of suckling, babies who have contact with viruses before their mothers will cause the mothers' breasts to develop antibodies (Riskin et al., 2012).
- Breastfeeding supports the normal development of facial muscles, jaw, teeth, and facial symmetry. Misaligned teeth and the need for braces are lower for breastfed children. Breastfed children may have fewer problems with sleep apnea and snoring in later life (Palmer et al., 2008).
- Breastfeeding at the breast is also about relationship building.



Telling moms that baby's weight is decreasing and supplementation is needed already tells a mom 'your milk is not good enough,' and it will set them off nursing on the wrong foot. It puts moms in the mindset that their milk and supply aren't good enough. Then the supplementing mom starts looking at numbers.

(Mother, Melissa)



POPULATIONS WITH LOWER RATES OF BREASTFEEDING

Mothers at greater risk of deciding to formula feed or using early formula supplementation are:

- Those with lower socioeconomic status and/or less education (Dennis & McQueen, 2009).
- Younger mothers (Glass et al., 2010; Millar & Maclean, 2005).
- New immigrants (Dennis & McQueen, 2009).
- Mothers who are single, smoke, or have not participated in prenatal classes (Horta et al., 2007).
- Obese mothers (Donath & Amir, 2008).

Data from Ontario's Better Outcomes Registry and Network (BORN) suggests that the following populations have lower exclusive breastfeeding rates at discharge (Best Start Resource Centre, 2014):

- Women under 20 years of age.
- Women with a BMI >30.
- Women who are single.
- Women who live in areas with greater rates of unemployment and low income.
- Women from visible minorities.
- Women who gave birth by caesarean section.
- Women who received pain management in labour.
- Women who had pre-existing or pregnancy-related health conditions.
- Women who had mental health concerns.
- Women with higher rates of substance use (including alcohol and tobacco).

These mothers benefit from effective strategies providing support, in particularly peer support and education, see www.beststart.org/index_eng.html.



I was very lucky to have a very supportive husband, parents, and lots of breastfeeding friends. I would have given up if I didn't have the different supports I had.

(Mother, Katie)

WHO BENEFITS FROM BABY-FRIENDLY?

The short answer is everybody benefits. When risks and benefits of infant feeding are reviewed, the method of infant feeding influences health long after childhood and for a mother, long after she stops breastfeeding. Those who benefit are individuals, families, communities and workplaces. The Breastfeeding Committee for Canada share another look at benefits to BFI in a document called, *Who Benefits from Baby-Friendly?* This document, found at www.breastfeedingcanada.ca/documents/webdoc42.pdf, includes benefits to staff providing care for mothers and babies within a health care facility, and for the facility itself, not the least of which is being able to meet well-respected global assessment criteria.

There is a growing body of evidence that BFI implementation increases breastfeeding rates. Ingram et al. (2011) evaluated the effects of BFI in a community setting. Mothers there experienced significantly increased breastfeeding rates at eight weeks. The study also showed that after attending a training course, there were significant improvements in staff breastfeeding knowledge, attitude and self-efficacy. Their organization found that following educational training of staff, there was improved consistency of breastfeeding advice and confidence amongst staff that help breastfeeding mothers.

In a Cochrane review, (Renfrew et al., 2012) demonstrated:

- Exclusive breastfeeding was significantly prolonged with use of WHO/UNICEF training.
- All forms of extra support analyzed together showed an increase in duration of any breastfeeding (includes partial and exclusive breastfeeding).
- All forms of extra support together had a larger effect on duration of exclusive breastfeeding than on any breastfeeding.
- Lay and professional support together extended duration of any breastfeeding significantly.
- Lay support extended breastfeeding exclusivity.

DiGirolamo et al. (2008), analyzed data from a longitudinal survey and found BFI practices most consistently associated with breastfeeding beyond six weeks are: breastfeeding initiation within one hour of birth; giving only breastmilk; and not using pacifiers. Breastfeeding overnight as needed and not giving pain medications to the mother during delivery were also protective against early breastfeeding termination.

A high quality, randomized control trial demonstrated that the implementation of BFI resulted in an increase in the duration and exclusivity of breastfeeding. Specifically, this experimental intervention demonstrated a large increase in exclusive breastfeeding at 3 months and a significantly higher prevalence of any breastfeeding at all ages up to and including 12 months (Kramer et al., 2001).

CHAPTER 3

BFI IN CANADA/ONTARIO

- **Breastfeeding Committee for Canada (BCC)**
- **Baby-Friendly Initiative Ontario (BFI Ontario)**
- **How BFI Ontario can help you**
- **What types of organizations can become Baby-Friendly?**

BREASTFEEDING COMMITTEE FOR CANADA (BCC)

Just as each country has a national organization responsible for BFI implementation, designation, and maintenance, BCC is the Canadian national BFI authority. BCC was established in 1991, as a Health Canada initiative, following the World Summit for Children. BCC is a registered, not-for-profit organization, with a broad membership of professionals and consumer groups, working to facilitate the assessment and monitoring of the progress of BFI within its borders. It is BCC that assesses and designates health care institutions as Baby-Friendly.

Canada's first Baby-Friendly Hospital was designated on July 1, 1999, Brome-Missisquoi-Perkins Hospital in Cowansville QC, followed by St. Joseph's Healthcare, Hamilton in 2003. This is the same year that the Practice Outcome Indicators were developed. Much work was done nationally in addition to liaising internationally. In 2011, the launch of the Baby-Friendly Hospital Initiative in Canada celebrated its 20th anniversary. A complete history of BCC is also a look at recent breastfeeding history and may be found at: www.breastfeedingcanada.ca/aboutus.aspx.

The BCC website tracks designated and re-designated facilities. BCC works closely with BFI Ontario to support BFI designation in Ontario. For a list of designated facilities please consult the BCC document "Baby Friendly Facilities in Canada" which can be found at www.breastfeedingcanada.ca/BFI.aspx

The BCC website is regularly updated to inform readers of which facilities are designated. Other facilities working towards designation may wish to liaise with those designated for various supports. Information on the BCC website is critical to the BFI journey for health care institutions and is found at www.breastfeedingcanada.ca/default_en.aspx.

BABY-FRIENDLY INITIATIVE ONTARIO (BFI ONTARIO)

Baby-Friendly Initiative Ontario (BFI Ontario) is the provincial authority for BFI in the province of Ontario. BFI Ontario is a non-profit multidisciplinary organization consisting of health care professionals, service providers and consumers within Ontario who are interested in protecting, promoting and supporting breastfeeding by implementing BFI. Over 350 members represent various organizations and all geographic regions in Ontario. Membership prices differ for single memberships or groups of varying sizes.

Partnered with BCC, BFI Ontario supports organizations to achieve BFI designation or implement BFI principles as Best Practice standards. BFI Ontario is the contact between hospitals or community facilities and BCC for all matters related to the pre-assessment and the external assessment process.

Through knowledge exchange and translation, advocacy, the sharing of resources, and provincial monitoring surveys, BFI Ontario provides ongoing expert advice and recommendations on policy and guidelines to government, health facilities, community agencies, and professional organizations.



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HOW BFI ONTARIO CAN HELP YOU

BFI Ontario welcomes anyone who is interested in protecting, promoting, and supporting breastfeeding through implementation of BFI and supports members through:

- A website to inform about the BFI journey at www.bfiontario.ca.
- A Members Area on the website that allows access to shared resources developed by members and not available in the public domain, including policies, signage, and education modules.
- A BFI Ontario *Ask an Assessor* teleconference is held periodically to answer questions from organizations.
- General meetings held by teleconference four times per year (accessible by teleconference).
- A BFI Ontario resource team comprised of members with expertise in various aspects of BFI implementation, including staff from some designated facilities. To connect the resource team, email bfiontario.ca.

BFI Ontario encourages organizations and individuals to become members. Membership fees are nominal and support the work of the organization. Members have access to the website's Members Area that allows for private sharing of resources between members.

WHAT TYPES OF ORGANIZATIONS CAN BECOME BABY-FRIENDLY?

The Baby-Friendly Initiative is relevant to many facilities that work with new mothers. All facilities are encouraged to use Best Practices as they care for mothers, babies, and families.

Facilities that may become designated are:

- Hospitals.
- Birthing Centres.
- Community health services, such as:
 - Public health units.
 - Community health centres.
 - Nurse practitioner-led clinics.
 - Aboriginal Health Access Centres.
 - Family Health Teams
(in discussion with BCC).

To be considered a community health service (CHS) eligible for BFI designation, organizations must be publically funded, apply Population Health Principles, and offer services that meet the criteria in the Outcome Indicators. If a facility or service is unsure whether they qualify for designation, it is best to discuss this with BCC before proceeding on the BFI journey. Please note, facilities that do NOT qualify for designation are welcome to use the Outcome Indicators to audit practice and outcomes.





CHAPTER 4



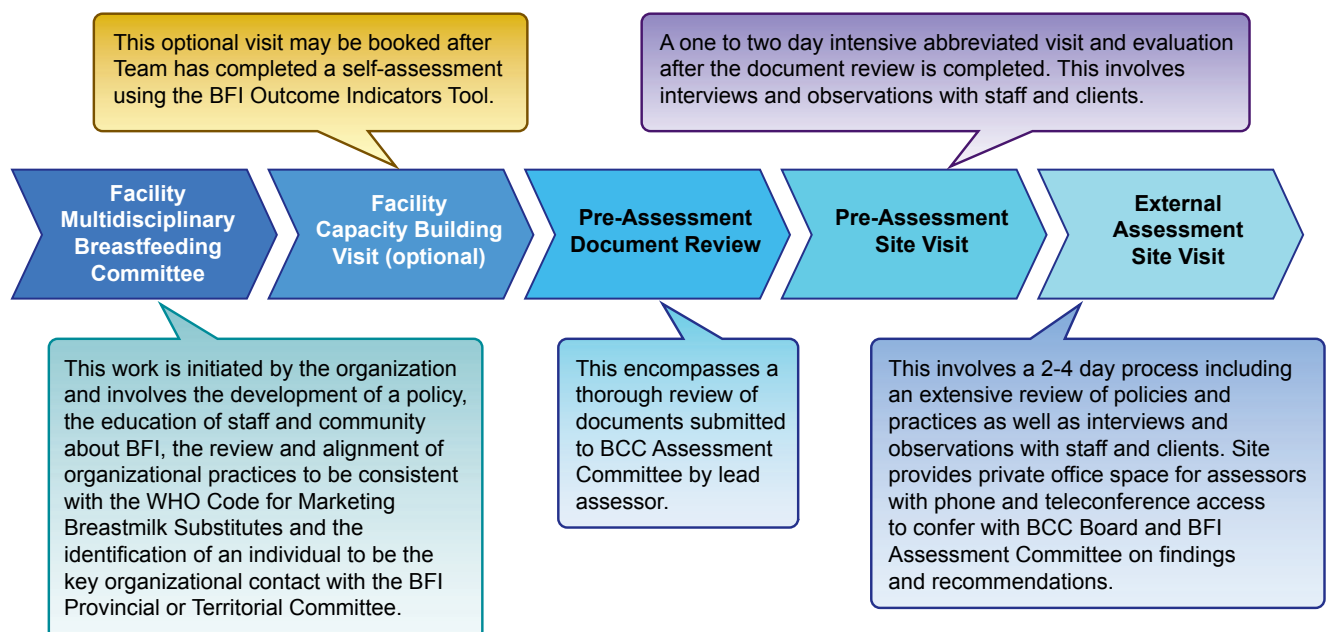
THE JOURNEY TO DESIGNATION: THE BEGINNING

- **Assemble a multi-disciplinary committee and working group**
 - Assemble a multi-disciplinary BFI committee
 - Establish a working group
- **Review the Outcome Indicators**
- **Apply for an Ontario Certificate of Intent**
- **Complete a self-assessment**
- **Develop a work or action plan**
- **Apply for a BFI Certificate of Participation**
- **Comments from those who are Baby-Friendly**

There are commonalities that each institution needs to consider in their journey towards Baby-Friendly designation. These are outlined in this chapter; however, there is not one set of instructions that is going to work for all organizations, and no set order. Consider the following suggestions that need to be personalized to your institution, and use along with the key links and appendices. Included are lessons learned and comments from experienced BFI travelers.

A process summary for achieving Baby-Friendly may be found at www.breastfeedingcanada.ca/documents/2012_06_25_BFI_assessment_Process_Summary.pdf.

STEPS TO BECOMING BABY-FRIENDLY





ASSEMBLE A MULTI-DISCIPLINARY COMMITTEE AND WORKING GROUP

1. Assemble a multi-disciplinary BFI committee:

This committee includes a mix of professionals, para-professionals, administrators, several family members (parents), and liaison partners. Consider who may lead the initiative, someone knowledgeable about breastfeeding with a passion for improving health outcomes and with the skills to lead a team. If possible, consider including an International Board Certified Lactation Consultant (IBCLC) in the leadership of this initiative. In many current Baby-Friendly institutions, the lactation consultant took a leading role. You will find your committee members becoming the champions in their respective area or discipline.

In a **hospital** setting, include every professional group, i.e., nurses from the birthing unit and mother-baby units, paediatric unit, operating room, special-care nursery; lactation consultants; clinical nurse specialists; social workers; dietitians; educators; managers; directors; community representatives; family representatives; birthing centres; pharmacists; support from unit clerk; housekeeping, ward aids; purchasing departments; midwives; and physicians inclusive of each physician group, i.e., family physicians, obstetricians, paediatricians, and anaesthetists. Consideration should be given to representation from emergency rooms, labs, and other areas where mothers or babies may be regularly seen, or you may later choose to liaise with staff from these areas. To assist with Step 10 in assuring a smooth transition to the community, hospitals will want to include or liaise with representatives of community agencies and breastfeeding peer support in their committee.

In a **health unit** or **health department**, consider cross-department representation such as public health inspectors; epidemiologists; and members from school health teams, dental health teams, and sexual health teams; and so on. Many of the above-mentioned may become breastfeeding “champions” in their area.

In a **community health centre** (CHC), consider cross-department representation such as physicians, nurses, social workers, dietitians, staff leading Canada Perinatal Nutrition Program (CPNP) or Canadian Action Programs for Children (CAPC) groups, and staff from the Early Years programs. In the two community health centres already designated, the International Board Certified lactation Consultant (IBCLC) was the BFI committee chairperson. Include a representative or liaison from the local hospital to help facilitate seamless transitions.

TIP: Ensure the committee has at least a few “breastfeeding savvy” members as well as “influencers” and maybe an “influential opposer” since with more knowledge and understanding, they could become leading advocates. See information on stakeholders in *Toolkit: Implementation of Best Practice Guidelines, Second Edition*, Chapter 2B, page 35 at www.rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition (available in English and French).

2. Establish a working group:

Identify who are the “worker bees” that are leading the committee; a small group or individual needs to be identified and given time to lead the process. To date, this person has often been an International Board Certified Lactation Consultant (IBCLC), but it could be a staff nurse, dietitian, health promoter or someone else with interest, knowledge, leadership skills and passion. The BFI lead/s should consider becoming members of BFI Ontario to have access to the array of materials, tools, and shared experiences on the BFI Ontario website. They will also be able to network, get support, and exchange ideas on BFI Ontario teleconferences. The BFI lead will be in communication with the provincial BFI committee, i.e., BFI Ontario.

TIP: Be sure to discuss the process. Be clear about roles and responsibilities. Address questions such as: who is the BFI lead, to whom do they report, to whom is feedback received (positive and negative), who has the authority to disseminate action items and time frames for completion, how involved are managers and senior management? The process may be revised as facilities proceed but discussions early on may prevent problems.

REVIEW THE OUTCOME INDICATORS

A) As a multi-disciplinary committee, review the Outcome Indicators found at:

- www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf
- and,
- www.bfiontario.ca/baby-friendly-initiative-outcome-indicators

B) A helpful resource to review is related to Step 4 on skin-to-skin care; it is found at Mother-Baby Dyad Care www.pcmch.on.ca/initiatives/mother-baby-dyad-care.

C) Look at other available resources. There are additional resources on the BCC and the BFI Ontario websites. BFI Ontario membership is inexpensive and includes additional resources for each step (shared by others who have completed this journey at least once).



APPLY FOR AN ONTARIO CERTIFICATE OF INTENT

You are now ready to apply for a free Certificate of Intent. Simply send an email stating your interest in becoming involved in the BFI journey and also submit the name and contact information of your BFI lead. This certificate will be issued if your facility has thought carefully about BFI implementation and made a decision to use the Outcomes Indicators to guide and inform practice. For more information and to obtain the certificate, contact BFI Ontario at bfiontario.ca.

The Certificate of Intent serves as an introduction of the facility to BFI Ontario. In return, the facility receives the name of a BFI contact-person who is knowledgeable about BFI experiences within Ontario, and who will provide ongoing guidance and support throughout the BFI journey. The Certificate of Intent may be seen as a stepping-stone of acknowledgement and recognition; if necessary, it may be renewed after one year.

COMPLETE A SELF-ASSESSMENT

A self-assessment will reveal your facility's strengths, areas needing work, and assist you in developing work plan. To complete the self-assessment:

- Start collecting your facility's breastfeeding initiation, duration rates, and exclusivity rates.
- Audit your practice and outcomes using the Appendices of the Outcome Indicators as a checklist.

The self-assessment is an opportunity to become aware of strengths and areas that need improvement. From this exercise, ideas for a work plan will start to percolate. Rather than trying to complete a lot at once, and risk becoming overwhelmed, consider more attainable short-term goals. Perhaps start working on something that several of your committee members are passionate about, or an area where you may have some confidence. For example, you could start by looking at WHO Code compliance, or ensuring babies are rooming-in almost all the time, or implementing skin-to-skin care.



We used the BFI Outcome Indicator document as our work plan. We had a breastfeeding committee that met monthly, and we worked through the document. I had a flow sheet for each step where I wrote what we needed to do, who was responsible for the task, and what the target date for completion was. Some of the steps required several people to work on them; some were individuals and some required people from outside of the team (like physicians).

(Grand River Hospital, RN, IBCLC)

DEVELOP A WORK OR ACTION PLAN

What goes into your work plan will become clear from your self-assessment.

- Ensure the BFI Indicators will be implemented.
- Ensure compliance with the International Code of Marketing of Breast-Milk Substitutes.
- Include informing members of the community about BFI and the importance of breastfeeding.
- Work plans may be organized around:
 - The 10 Steps or otherwise.
 - One Baby-Friendly health department used these categories for their work plan:
 - Resource Review.
 - Resource Development (Feeding Cues, Skin-to-Skin...).
 - Policies.
 - Training.
 - Surveillance.
 - Partnerships.
 - Administration.



A sample work plan for Toronto Public Health (TPH) may be viewed in the member's only section of www.bfontario.ca.

Please refer to Appendix 7 for work plans and checklists from:

- Centretown Community Health Centre.
- Somerset West Community Health Centre work plan.
- St. Joseph's Healthcare, Hamilton BFI work plan.
- Timiskaming Health Unit Logic Model.
- Toronto East General Hospital Constant Vigilance checklist.

Once a work plan is in place, facilities have the option to arrange a capacity building visit with a lead assessor. Inquire with the person assigned to be your contact person and discuss potential fees.



We started looking at the postpartum unit and removed anything that had a formula company logo. We were surprised how much there was, tape measures, weighing scale paper, even posters on the wall were promoting formula through their logos or other insidious marketing practices. It was an easy step to start with, and it encouraged staff to keep going.

(St. Joseph's Healthcare, RN IBCLC)

APPLY FOR A BFI CERTIFICATE OF PARTICIPATION

This free certificate is issued if your facility has completed a self-appraisal using the BFI Indicators; developed an action plan to ensure that the Outcome Indicators and the WHO Code will be implemented; reviewed breastfeeding initiation and duration rates; and established a multidisciplinary breastfeeding committee. For more information and to apply, contact BFI Ontario at bfi@bfiontario.ca.

The Certificate of Participation provides another point of contact and opportunity for your facility to share your progress in the BFI journey, and to receive guidance and support as needed. The Certificate of Participation is another stepping-stone of recognition. Celebrate the progress!

Please note there are four certificates that mark progress as follows:

NAME	ROLE	ORGANIZATION
Ontario Certificate of Intent	After your facility has thought carefully about the Practice Outcome Indicators, have decided to work towards the indicators, and have a multi-disciplinary committee in place.	The facility is given the name of a BFI contact-person and offered ongoing guidance.
BCC Certificate of Participation	After a self-appraisal and development of a detailed action plan.	Provides another point of contact and opportunity to receive guidance and support as needed.
BCC Certificate of Completion	After a pre-assessment site visit by a BFI lead assessor.	BCC and BFI Ontario will provide information and assistance in formulating a plan to make needed changes.
BCC Certificate of Commitment	After a BFI external assessment site visit, if the designation is NOT achieved and some additional criteria need to be met.	BCC and BFI Ontario will provide information and support in formulating an action plan.

Congratulations! You have made great progress already!



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COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY



We began our formal journey at Toronto East General Hospital (TEGH) in March 2003 with the development of a BFHI committee. Some groundwork had taken place a few years earlier with the development of a Breastfeeding Policy based on the 10 Steps. The very first thing that our BFHI committee did was a self-appraisal. This helped us see exactly where we were at and what we needed to improve on. From there you need to focus on what needs to get done first. For us, it was the education piece so that we could improve practice and the care we give to moms and babies. At first, we developed some “To-Do Lists” and called them “BFHI Action Plan,” “Timelines” and “Becoming Baby-Friendly Task List.” Then, in March 2004, BCC published the “Practice Outcome Indicators”. They were a godsend. This document tells you exactly what you need to do and was updated in July 2011 and is on the BCC website. This document is your best friend and best guide for BFI. Now, thanks to BFI Ontario and Best Start, we have “The Baby-Friendly Initiative: Evidence-informed Key Messages and Resources” document, another very helpful tool to guide you.

(Toronto East General Hospital, RN, IBCLC)



Do a self-assessment and identify gaps. We did a self-assessment very early. From that, we formulated a work plan and identified the resources needed to move forward.

(Toronto Public Health, RN, Health Promoter)



We began our journey with developing a policy but people did not know about breastfeeding and did not understand the terminology such as ‘promoting and protecting’ breastfeeding, and that made our policy development difficult. If I was to do it again I’d start with some education.

(Community Health Centre, Health Promoter)



Document your work. This has paid off in spades for us. We kept paper records of all activities, memos, work plans. Our system crashed in the middle of the BFI journey, and if we hadn’t had paper, we would have been in trouble. Assessors took not only our document binders but also our three binders that documented our BFI journey; it really informed the Assessors. We have also used paper copies for presentations and personal visits, as sample materials, and can take a binder with us for presentations. The paper copies also help with sustainability planning.

(Toronto Public Health, RN, Health Promoter)



CHAPTER 5



THE JOURNEY TO DESIGNATION: THE MIDDLE – PART 1

- **Breastfeeding policy**
- **Document binders**
 - Binder contents
 - Binder guidelines
 - Comments from those who are Baby-Friendly
- **Data collection**
 - Data collection requirements
 - Comments from those who are Baby-Friendly
- **Understand the involved costs**
 - Cost highlights
 - Comments from those who are Baby-Friendly
- **WHO Code compliance**
 - Personal experiences with breastfeeding
 - Comments from those who are Baby-Friendly
- **Skin-to-skin**

There are a number of things to think about early in the process; particularly, developing a comprehensive breastfeeding or infant feeding policy, document binders, data collection, and costs. Considerations in becoming WHO Code compliant are included as well as a little guidance on skin-to-skin care.

Please remember that this toolkit is not a set of ordered directions. Each facility's priorities will be different. One facility may work on an aspect of the Outcome Indicators while another will develop policy. One may start with skin-to-skin care while another focuses on staff education. This section then provides ideas of what is involved for these topics, and lessons learned by others.

BREASTFEEDING POLICY

Organizations may already have a breastfeeding policy. If your organization doesn't have a policy that meets Baby-Friendly criteria, consider adapting a breastfeeding or infant feeding policy developed by others. Please refer to Appendix 7 for policies from:

- Centretown Community Health Centre.
- Grand River Hospital.
- Somerset West Community Health Centre.
- Toronto East General Hospital.



In addition, there are policies and policy templates available online:

- Grand River Hospital at www.grhosp.on.ca/Childbirth.
- Policies for public health units, one in English and French, are available on the BFI Ontario Members Area resource section.

A family-friendly version of the breastfeeding policy needs to be posted for the public to access. Please refer to Appendix 7 for family-friendly policies from:

- Toronto East General Hospital
- A sample BFI policy poster for the public from Ottawa Public Health (OPH) is available in both official languages on the BFI Ontario site.

The point to which the policy is developed will vary from one facility to the next based on readiness and priorities. Once the policy is in place, other measures in a work plan will be supported by it.



At TEGH our Breastfeeding Policy a.k.a. “Our Promise to Families” is posted in our Family Birthing Centre in the top 10 languages spoken by our patient population. We had them translated professionally.

(Toronto East General Hospital, RN, IBCLC)

DOCUMENT BINDERS

Review of the facility’s documents is an excellent opportunity to ensure that evidence-based practice is embedded in all policies, protocols, and procedures. Future review dates should be noted on the documents. Current documentation is collected together in a binder for review by BFI assessors during the pre-assessment document review. The assessors will examine all documents related to maternal child. This will include brochures given to parents, education curriculum for staff, policies, and the facility’s website. See point 3.1 at www.breastfeedingcanada.ca/documents/BCC_BFI_Assessment_Process_and_Costs_English.pdf.

Facilities need to **prepare three identical binders**, two that are submitted and a third for themselves. The BCC sets out what exactly needs to be included in the binder and all required content is listed below. Within six weeks of receipt of the documents, the lead assessor will provide a written report to both the facility and the BFI Ontario Assessment Committee, and the binders eventually get returned. According to those who have achieved Baby-Friendly designation, preparing a document binder is much more work than originally anticipated and should be started early in the process.

Please **submit paper copies**. Even submitting electronic documents is not an option even though it is quite likely that documents are all available electronically. It may help a facility to save everything in electronic format and to print it out when the time comes to send the document binder. Documents that are not available in electronic format, such as sign-in sheets from an educational workshop, may be scanned and saved for the facility’s records. You may want to archive binder documents for each BFI external assessment.

BINDER CONTENTS:

- Cover letter.
- Self-appraisal using the Outcome Indicators.
- Breastfeeding or infant feeding policy for staff and/or the public.
- A record of staff orientation to the policy.
- Related policies.
- Copy of any staff education that has been given, i.e., in-services, breastfeeding activities, symposia, online training.

- Staff attendance records for such education session or program.
- Patient/client education materials related to prenatal, birthing and postpartum, handouts and posters.
- Data that has been collected.
- Any gift packs that are given out.
- Copies of translations in different languages of the breastfeeding or infant feeding policy for families or other translated documents and resources.
- Demographics.

A facility may use resources from other agencies and will need to add them. If clients or patients of your facility use relevant information from another facility, that must also be added. For example, if women delivering at your hospital take prenatal classes at your local health unit, you will need to add the prenatal curriculum. If women attending your community health centre give birth at the local hospital and receive printed breastfeeding information there, you will need to include that in the document binder.



BINDER GUIDELINES:

- Streamline and avoid duplication.
- Ensure the binders are well organized for a straightforward review.
- Organize resources across the perinatal continuum of care, i.e., prenatal to postpartum, and from community to hospital to community. This helps ensure your resources contain consistent language and messages, avoiding conflicting information to parents.

- Where there are provincial or regional resources, use these rather than re-inventing the wheel. Provincial and regional resources are likely to be updated regularly. The Best Start Resource Centre has some excellent resources.
- Language of the patient teaching material included in the binder should be empowering, at about grade 8 reading level or lower if they are for the public, with clear key messages and illustrations (see suggestions in Appendix 5.2 of the Outcome Indicators).
- The document review would be much simpler if facilities kept handouts to a minimum. More is not better. Research shows paper handouts are poorly used by new parents whereas web-based resources are popular.

All documents must meet Baby-Friendly requirements, including WHO Code compliance. *The Baby-Friendly Resource Checklist* from Ottawa Public Health and a similar checklist from Toronto Public Health are available in Appendix 7. With permission from the above-mentioned organizations, others may wish to utilize these documents.

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:

Hospitals:

Binder contents for Toronto East General Hospital may be found in Appendix 7.



The binder had a cover letter describing our journey. Then each step had a summary letter describing what we had done to achieve the requirements in that particular step. We described our challenges and our successes. Then coordinating documents followed. We made three identical binders, two that went to the assessors and one that we kept for our own records. We designated two people who were responsible to put the binders together. It is a huge task! Advice – don't leave it to the end. Get started early and keep adding to the binder as you go along. After designation, keep it up to date.

(Grand River Hospital, RN, IBCLC)



We took stock of all of our documents and requested information from the Women's and Infants' Program and organized them in a binder with titles

- The Outcome Indicators hospital data sheet.
- Current updated policies.
- Education curricula.
- Patient handouts.
- Information posted in patient rooms.
- Discharge packages.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)

Community Health Centres:



The binder was organized by steps with an introduction, including committee members. It was very labour intensive, and three copies were provided. Then we needed to review all new documents regularly. At our centre, we had one point-person who did the initial scan, the IBCLC then reviewed each document.

(Community Health Centre, RN, IBCLC)

Public Health:



We provided the assessors with the required content throughout eight binders divided in the following order:

- **General Information binder:** Where we provided an overview of our organization and information about the City of Ottawa to provide some context. Information about our direct care teams was also provided.
- **Self-Appraisal binder:** That was divided into the 10 Steps, and we provided some documentation to support our work on each of the steps. For Step 10, for example, we included a list of community partners; Breastfeeding Symposium synopsis, Breastfeeding Challenge posters, and so on. In this binder, we also included our fact sheets on LAM, Hunger Cues, Hand Expression, and Skin-to-Skin, which were all developed to support our designation.
- **Policy binder:** Where our policy and policy plaque were provided and information about our breastfeeding rooms.
- **Data Collection and Stats binder:** Required stats were provided and information on our Infant Feeding Surveillance System.
- **Staff Education binder:** Where a copy of the training curriculum we used was provided.
- **Prenatal binder:** Where prenatal modules were provided as well as facilitator's manuals.
- **Resource binder #1:** With internal resources that Ottawa Public Health had created.
- **Resource binder #2:** With resources created by external agencies that Ottawa Public Health uses. These two resource binders were subdivided by team: Environment, immunization and so on, and then divided by resources that those teams used with the general population (at a display, handed out) versus those only used on a one to one basis.

We had a master's student working pretty much full time on the resource binders for at least a month with help from the BFI team as well. Our master's student reviewed each and every fact sheet (internal and external) against a checklist that we created. She flagged ones that required revisions or re-consideration of their use.

(Ottawa Public Health, PHN)



The resource binders were definitely the most time consuming and labour intensive to manage.

(Public Health, BFI Lead)

DATA COLLECTION

Data collection needs to be thought of early in the process. It is important to monitor the intake of human milk as a health indicator and for program evaluation. Exactly what information is captured varies by the type of facility, hospital, or community health service and some facilities may wish to capture data in addition to what is required.

BCC revised their data collection requirements in 2012, the details of which are on a document called, *Breastfeeding Definitions and Data Collection Periods* on the BCC website (found at http://breastfeeding-canada.ca/documents/BCC_BFI_Breastfeeding_Definitions_and_Data_Collection_English.pdf). There are now three breastfeeding categories: exclusive, non-exclusive, and no breastfeeding. This is different from former categories, which are sometimes used for research and, provide insight into the non-exclusive category: exclusive, total, predominant, partial, and no breastfeeding.

Through BORN Ontario, data is collected at discharge from hospital and is closely aligned with data required for the assessment. BCC and the administrators of BORN are in touch in an attempt to achieve even greater alignment. Many other data elements are collected by BORN and include skin-to-skin and medical supplementation.

DATA COLLECTION REQUIREMENTS:

The following section comes from Step 6 of the Practice Outcome Indicators.

Hospitals and birthing centres:

- Describe a reliable system of data collection.
- Provide annual data for the facility showing:
 - Breastfeeding initiation rates.
 - Exclusive breastfeeding rates of babies from birth to discharge (minimum 75%).
 - Supplementation rates (medically-indicated and non-medically indicated).

Community health facilities:

- Describe a reliable system of data collection of breastfeeding rates. It is expected that breastfeeding duration rates are monitored to reflect the current WHO and Health Canada recommendations of exclusive breastfeeding to 6 months and continued breastfeeding to 2 years and beyond.
- Provide annual data showing:
 - Exclusive breastfeeding rates of babies on entry to the community service, which coincides with hospital discharge (goal is at least 75%).
 - If the exclusive breastfeeding rate on entry to service is less than 75%, a facility needs to demonstrate that “any breastfeeding rate” is at least 75% and provide data for at least three years, showing increases in breastfeeding initiation, exclusivity, and duration rates.
 - A mechanism on entry to community service to monitor exclusive, total, and any breastfeeding rates at around 2, 4, and 6 months and breastfeeding duration at 12 and 18 months and beyond (this may coincide with immunization schedules). Three points in time are required.
- Provide data for at least three years, showing increases in breastfeeding initiation, exclusivity, and duration rates.



- Describe 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.
- Many more details are found the Outcome Indicators, Appendix 6.

Breastfeeding Definitions and Data Collection Periods may be found at:

- www.bfontario.ca/wp-content/uploads/2012/10/BCC-Breastfeeding-Definitions-Data-Collection-Dec-31-2012-final.pdf

For calculation of breastfeeding statistics see:

- *Calculation of Exclusive Breastfeeding Statistics: Hospitals and Birthing Units* found at www.breastfeedingcanada.ca/BFI.aspx.

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



Using BORN works well to give us lots of good information as well as working with the numbers to see where the concerns are. We found through using BORN that much of our non-medical supplementation is happening with our primiparous C-sectioned mothers.

(Grand River Hospital, RN, IBCLC)



We collect data on skin-to-skin after both vaginal birth and C-section, intention rate, supplementation rate, intention to combination feed, rate if ever supplemented, and rate of supplementation at discharge.

(Montfort Hospital, Manager)



This was the toughest area for us, especially in the beginning. We collected most of the data manually, and it took away from client care time. This was the part that delayed us for over two years to pursue our designation. We could not wrap our heads around how we were ever going to get this done. It meant ensuring everyone documented appropriately; the definitions were extremely confusing for front-line staff and there were too many of them... exclusive, total, predominant, partial, none. We had posters up reminding staff of the definitions... I think this is better now. We did not have the ability to pull stats out of our old electronic medical records (EMR); it was a ton of work. We are just over a year into a new EMR, and it continues to be challenging to pull numbers from it, as we need an IT person to do that.

(Manager, Somerset West Community Health Centre)



I liked the detailed categories for infant feeding (exclusive, total, predominant, partial, formula). It is difficult to say “exclusive” if there was one bottle in last seven days so we said “total”. We got the computer tech to add to the computer system, so we could record our breastfeeding data. Remember to collect data on each client’s entry to service. It would be nice to have one countrywide form. There is a provincial CHC group and the new medical documentation system does not include breastfeeding and data collection. We initially hired a student to enter a lot of the data. We get exclusivity rates from the birth record; discharge breastfeeding from the discharge sheet; and collect 1, 2, 4 weeks, 2, 4, 6 months, 9, 12, 18, 24 months to 3 years, so we could demonstrate duration of breastfeeding and the change over time. The 6 months point is a sticky point since some people start solids before or a family member gave something.

(Somerset West Community Health Centre, RN, IBCLC)



On the Rourke Baby Record used by doctors, it’s unclear if foods are ticked at 6 months, whether this was a point of discussion or was the baby actually given solid foods? So we asked doctors and nurses to write if the mother at each visit was currently feeding exclusively or not.

(Somerset West Community Health Centre, RN, IBCLC)



We have a full-time dedicated nurse who does data collection. Each day, each chart is audited regarding the baby’s feeding record looking for exclusive breastfeeding and documented rational for supplementation. It is her job to do all stats for our Health Service.

(Toronto East General Hospital)



Data collection is only as good as the people who enter the data. Also, the Rourke Baby Record only gives two options, exclusive or formula, but often neither is accurate. It would be good to develop a provincial data-collection tool for community health centres.

(Centretown Community Health Centre, RN, IBCLC)



Initially, it is important to do a manual review of the charts to ensure that you are not missing information. Assessors audit charts manually to ensure your charting is consistent with your data.

(St. Joseph’s Healthcare, Hamilton, RN, IBCLC)



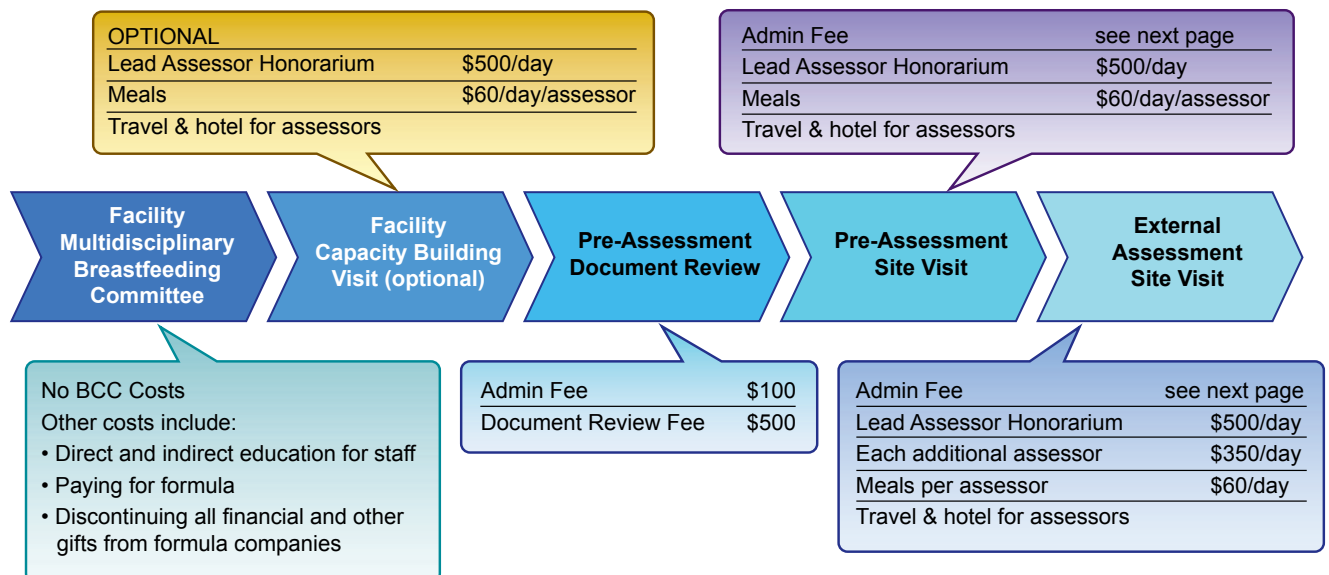
At the present time, we regularly do manual chart audits on about half of all of our discharges on a monthly basis. The lactation consultant is responsible for doing this. This is time consuming, but we feel that it gives us the most accurate information. It is important to see why supplementation is happening (medical or informed decision) and when it is happening. At times, we have audited who initiated the supplementation to see if there were trends with specific staff. We have also audited who the family doctor was for clients who had chosen to not breastfeed to see if there were trends. All of this information allowed us to assess what education or changes were needed. It is hoped in the future we will be able to use BORN.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)

UNDERSTAND THE INVOLVED COSTS

There are costs involved in becoming designated as Baby-Friendly. Costs vary depending on the size of the facility and how much change is needed to meet criteria. The last few steps for becoming Baby-Friendly designated typically take a few months. Therefore, the costs below are spread out over this time. See figure below for a summary of costs related to the designation process as of 2017. More details may be viewed at: www.breastfeedingcanada.ca/BFI.aspx.

ASSOCIATED COSTS FOR BFI



COST HIGHLIGHTS:

- For a pre-assessment for a hospital or birthing centre with over 200 birth per year or a community health service with over 200 infants at entry into service, the following fees apply: Administration fee \$525, Document review fee \$500. When the organization is ready for a site visit the honorarium for the lead assessor is \$500 per day and \$50 per diem. Other expenses include travel and hotel.
- For a pre-assessment for a hospital or birthing centre with 200 or fewer births per year or a community health service with 200 or fewer infants at entry into service, the following fees apply: Administration fee \$350, Document review fee \$500. When the organization is ready for a site visit the honorarium for the lead assessor is \$500 per day and \$50 per diem. Other expenses include travel and hotel.
- For an external assessment for a hospital or birthing centre with over 200 birth per year or a community health service with over 200 infants at entry into service, the following fee applies: Administration fee \$1450. The honorarium for the lead assessor is \$500 per day and for each additional assessor is \$350 per day and \$50 per diem for each assessor. Other expenses include travel and hotel.
- For an external assessment for a hospital or birthing centre with 200 or fewer births per year or a community health service with 200 or fewer infants at entry into service, the following fee applies: Administration fee \$975. The honorarium for the lead assessor is \$500 per day and for each additional assessor is \$350 per day and \$50 per diem for each assessor. Other expenses include travel and hotel.
- Should an additional external assessment be required there will be an additional cost.
- Additional costs to the institution vary greatly and may include costs related to designated staff time to implement BFI, staff education, number of sites or campuses, paying for formula, and less grant money from formula companies.
- Travel costs vary depending on location. Assessors are assigned with consideration to travel distance to minimize costs.

Costs associated with designation will vary by type of facility. Hospitals and community health centres may all have additional expenses from formula purchase needs. Each organization must be involved in staff education; however, hospitals have the additional challenge to educate rotational staff. Where formula grant money has been accepted, budgetary considerations may be largest.

Remember, with time, there will also be savings. Think about the cost of formula decreasing with lower supplementation rates and cost savings with fewer cases of necrotizing enterocolitis. There will be less need for infant linens with increased skin-to-skin, and generally lower costs from fewer ill infants and mothers.

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



It was costly with costs for assessors, staff education, posters with breastfeeding policies in all common areas and all areas that mothers go. However, our breastfeeding data speaks to how effective it was. It was worth it.

(Somerset West Community Health Centre, RN, IBCLC)



One thing that helped the journey in our organization was presenting our Board with a five-year plan, which included staff time and budget as part of the original proposal. When they accepted the proposal to work towards BFI designation, it included the budget so no questions were asked five years later when that annual budget included the costs for the assessment.

(North Bay Parry Sound District Health Unit, RN)



When we were working on re-designation the second time around, I did an RNAO Best Practice Guideline Fellowship which gave me dedicated time and financial support to the hospital to help work on set projects.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)



I think we need to be creative in diverting existing resources to support Baby-Friendly implementation. We used late career funding each year to have one of our Lactation Consultants do work to enhance our Baby-Friendly practices. One year she worked on a skin-to-skin initiative; another year, she focused on improving teaching moms hand expression before discharge.

(Toronto East General Hospital, Director, RN, MScN)



There is definitely a significant cost. At Grand River Hospital, we never did accept any grant money, so we did not lose that. The first time was more expensive than the second time since many of the changes had happened, and it had become the culture of the hospital. Being creative and careful (in reaching Baby-Friendly) is really important.

(Grand River Hospital, RN, IBCLC)



The purchase of formula and supplies is an ongoing cost that must be considered. As the culture changes, those costs do go down since less and less formula is used.

(Grand River Hospital, RN, IBCLC)



I had designated time and money put aside for me to do this. I worked about two to three days a week for approximately six months the first time. Several other lactation consultants worked on the binder. Most of the work we tried to do during quiet times on a shift, but the reality is that it is often very busy, so extra money was needed. It was definitely a team effort of everyone pitching in with the various pieces. My job was to identify what needed to be done, see who could do it during their workday and pull all the education pieces together and figure out how best to implement them. I think having one designated person helped to keep the costs down, instead of several people trying to coordinate what was needed.

(Grand River Hospital, RN, IBCLC)



I do not have designated time as the lead anymore, so I try to do most of it on my normal work hours. I am still doing a little to pull the pieces together that need to be done for our celebration and follow-up for our re-designation. If I have something that needs extra attention or can't get done in a normal day, I check to verify the time required and get the approval for the hours needed.

(Grand River Hospital, RN, IBCLC)

WHO CODE COMPLIANCE

As stated in Chapter One, the WHO Code provides rules for health workers, governments, and industries to regulate the promotion of infant feeding products through marketing, and to protect and promote breastfeeding by ensuring the ethical marketing of breastmilk substitutes. The Baby-Friendly Initiative includes adherence to this Code. Mothers must be able to decide how to feed their babies free of commercial influence.

The products the Code addresses are:

- All breastmilk substitutes.
- Follow-on formulas, which are marketed for older babies.
- Baby foods.
- Bottles and artificial nipples.
- Related equipment.
- Any information concerning their use.
- Any advertising to the public.

Here are some example requirements and violations:

WHO CODE REQUIREMENT	WHO CODE VIOLATION EXAMPLES
No advertising any products to the public.	<p>Gift shops that sell cards or balloons with images of bottles, soothers, or dolls with bottles.</p> <p>Gift shops or pharmacies that sell formula or any feeding supplies like bottles or soothers.</p> <p>Bottles that come into mothers' rooms are advertising a product and providing hospital endorsement of it.</p>
No free samples to mothers.	<p>Mothers should not be sent home with formula "because they need it" or "just in case they need it".</p> <p>Formula should not be placed where families or the public can see it.</p>
No gifts or personal samples to health care workers.	<p>Look for formula logos on measuring tapes, growth charts, or posters and do not accept such items.</p> <p>Watch out for "free" educational sessions including breastfeeding education provided by formula companies.</p>

Research has demonstrated that formula companies influence health care and health care professionals by their gifts. Any items with a formula logo or name on it can inadvertently influence professionals and families. Work with your BFI networks to work out the details of what may be Code violations in your facility.

These are additional items that violate the Code. It is against the Code:

- To accept money from formula companies for education.
- To accept a lunch-and-learn from a formula company.
- To speak at a formula company lunch.
- To have images of bottles on information for the public, including a bottle being held by a grandparent.
- To accept money for research or equipment.
- To provide formula printed information sheets for parents even if the information is about breastfeeding.

- To have parenting magazines at your facility that advertise formula or are sponsored by formula companies.
- To participate in baby shows sponsored by formula companies.
- To write articles for baby show magazines or parenting magazines when sponsored by formula companies.
- To accept gifts to support any organizational operations, including a supporting foundation.

Be aware that the Code is consistently being broken around new mothers with welcome baskets, contests, “free” diaper bags with infant “supplies”, coupons, phone applications, hospital gift packs, baby shows, claims that one formula is better than another or one bottle nipple is more like a mother’s nipple than another. There are other examples of the Code being broken at www.infactcanada.ca/breaking_the_rules.htm.

Fair market price needs to be paid for any formula and related supplies. Review existing formula purchase or “free contract” details in both hospital and community settings. Hospitals and facilities with current formula contracts do not need to wait until the contract has nearly expired to take action. To address concerns such as having an emergency supply, gain an understanding of where and how families in the community would get formula if needed.

If formula must be used in hospital, teach mothers that the particular brand being used is not an endorsement of that brand. Teach her to give the formula with a method that does not interfere with breastfeeding like cup feeding or spoon feeding. Ensure the mother is fully informed. There is more on informed consent later in this chapter and more on formula in Chapter 9: Challenges and Solutions.



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PERSONAL EXPERIENCES WITH BREASTFEEDING:



My first visit to my OB, I received a formula sample and coupon. Then, in hospital, I was separated from my baby to get stitched. Why? If we did that to a goat, the kid would die. I was told, “the baby will do OK without you” but this is wrong.

(Mother, Melissa.)



I never had formula in the house, but if we had there were many times I would have used it. There were times when our son wouldn't latch; times when I was so worried that I had no milk. If I had formula, we would have reached for it. Instead, I would go to a breastfeeding support drop-in and get help and reassurance.

(Mother, Katie)

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



To ensure Code compliance we did multiple things:

- Sent an informational PowerPoint by email to staff.
- Completed a Code-compliance team activity.
- Talked a lot about it with the resource review team.
- Created a memo for Healthy Families staff because they do a lot of clinics in partnership with others. Since we can't enforce other agencies to become Code compliant we had to figure out how to address this. We created a memo to explain the Code. Toronto Public Health staff must comply with the Code, and if they are working in partnership, they can only distribute Toronto Public Health approved resources. If staff from the partnering agencies hand out non-Code compliant materials, we can't control that. Our resources are WHO Code compliant. We also have an approved list of resources from other agencies e.g., Public Health Agency of Canada, Best Start Resource Centre, Health Canada, that have gone through an approval process.

(Toronto Public Health, RN, Health Promoter)



The Code helps you make the right ethical decisions. Would you accept donations to a respiratory unit from a cigarette company?

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)

SKIN-TO-SKIN

Much has been written on the value of skin-to-skin to transition all newborns to life outside the womb. Please be aware of the following skin-to-skin related resources:

- Mother-Baby Dyad Care at www.pcmch.on.ca/initiatives/mother-baby-dyad-care.
- Skin-to-skin support for Kangaroo Mother Care at www.skintoskincontact.com.
- As well as the following shared resources accessible in Appendix 7:
 - Sioux Lookout Meno Ya Win Health Centre policy for skin-to-skin care.
 - Sioux Lookout Meno Ya Win Health Centre policy for skin-to-skin care in the OR.
 - Trillium Health Centre skin-to-skin posters (set of eight).



“

At Trillium Health Partners, we spend a lot of time speaking to staff and families about the importance of hand expression while they are in hospital. We are taking a more proactive approach to breastfeeding and spending our time helping women and families in the first 24 hours after birth. We are being patient with babies while ensuring that colostrum is getting to them, and we are getting babies to spend significant time skin-to-skin while in hospital.

(Trillium Health Foundation, Manager)

The following two quotes from mothers show how disempowering or empowering experiences can be:

“

The nurses tried to teach me to self-express in the hospital. They would grab my boob and compress it. It hurt a lot, but I didn't have any milk to express yet.

(Mother, Katie)

“

It was so wonderful to have my son on my chest right after birth. We could see him start making mouth movements and get ready to breastfeed. Then he even found his way to my breast and started suckling. It was an amazing time.

(Mother)





THE JOURNEY TO DESIGNATION: THE MIDDLE – PART 2 (EDUCATION AND CULTURE)

- **Education**
 - Education requirements appropriate to role
 - Breastfeeding courses
 - Education content
 - Regarding education, BCC comments on education
 - How to provide BFI education on a daily basis
 - The value of face-to-face education
 - Funding education
 - Comments from those who are Baby-Friendly
- **Keys to success for adult learning**
 - Principles of adult learning
 - Principles of facilitation
 - Consider starting sessions with self-reflection
 - Use humour and be creative
 - Evaluation
 - Sustainability and leadership
 - Comments from those who are Baby-Friendly
- **Practice issues**
 - Communication
 - Comments from parents and those who are Baby-Friendly
 - Ensuring standardized informed consent
 - Decreasing supplementation rates
 - Embracing the formula feeding family
 - Comments from those who are Baby-Friendly
- **Changing culture**
 - Effect change with prenatal breastfeeding classes
 - Comments from those who are Baby-Friendly
- **Lessons learned**
- **Checkpoint**



This section is essential to your success as this part involves many people in your organization. Up to this point, members of the BFI committee have hopefully been raising the profile of BFI. The effort to become Baby-Friendly has mostly been within the BFI working group and BFI committee. Others are now involved, since health care professionals need to do formal standardized breastfeeding education, re-examine their practices, and through that evaluate their attitudes. It is often easier to get professionals engaged by emphasizing that BFI is about Best Practice and includes all mother-baby dyads. Some of the strategies below will assist this part of your journey. These efforts will assist in changing culture, and will over a period of time, have a positive impact on breastfeeding outcomes.



One of the gaps in the system is that it's difficult to find the right information. For example: I believe that in our breastfeeding support program, 58 matches were made last year – 58!! BUT how many babies were born in Ottawa last year? Thousands. Why is it that more people don't know about this program?

(Breastfeeding peer-support volunteer)

EDUCATION

Education is one of the most encompassing and time consuming aspects of BFI implementation. With the help of the information in this section, organizations can create their own comprehensive and sustainable education plan.

EDUCATION REQUIREMENTS APPROPRIATE TO ROLE:

PCMCH has recognized the following roles and distinct requirements:

- **Awareness:** All staff/volunteer groups that have exposure to mothers/babies, e.g., volunteers, housecleaning, clerical staff, phlebotomists, social workers, occupational therapists, physiotherapists, dietitians/nutritionists as well as key policy decision-makers.
- **Direct Contact:** Staff that are directly involved with breastfeeding assessment, support and intervention, e.g., nurses (obstetrics, family practice, public health), nurse practitioners, midwives and physicians (family physicians, paediatricians, obstetricians) who work in prenatal, birthing, postnatal, neonatal or general paediatric units or in the community with childbearing and childrearing families.
- **Specialist:** Staff whose primary role is to address breastfeeding problems and special challenges beyond the direct contact level, i.e., lactation consultants (IBCLCs) who may be working as staff in a clinical setting (hospital, public health, community health centres) or in independent practice.

All education must include information about BFI, the 10 Steps, and the WHO Code. For staff with **Direct Contact** (according to the definitions above), at least 20 hours of education is recommended. This should include three or more hours of supervised clinical practice. Education should reflect the core content as

outlined in the *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care: Section 3: Breastfeeding Promotion and Support in a Baby-Friendly Hospital: A 20-Hour Course for Maternity Staff* (referred to as the WHO 20-Hour Course).

Educational requirements for various people in your organization may take some discussion such as students and replacement staff. The basic idea is that any student coming into your facility needs to be aware of BFI and what this means; they need to understand the 10 Steps and what your current improvement efforts are focused on in order to support the change and to learn Best Practices. This includes medical, nursing and allied health students at any level.

Replacement staff, such as nurses from other units or agencies as well as physicians doing locums, need **Awareness** education (as described above). However; case by case consideration should be given depending on the length of placement. For more information:

- Check the Appendices of the Practice Outcome Indicators for details related to education requirements and what an assessor could be asking staff in terms of knowledge and practice.
- See the *Breastfeeding Curriculum and Educational Resources* on the PCMCH website at: www.pcmch.on.ca/search_page/breastfeeding.
- Work with the various networks and your BFI Ontario contact-person.

BREASTFEEDING COURSES

OPTIONS FOR THOSE PROVIDING DIRECT BREASTFEEDING CARE:

The following are a list of courses that do meet at least 20 hours and are aligned with BFI. Course links and details are provided in Appendix 5.

- BFI 20-Hour Course toolkit is a Canadian version of the WHO 20-Hour Breastfeeding Course available through workshops offered by the BFI Strategy for Ontario. Available at www.bfistrategy@tehn.ca.
- In-house lactation consultants or educators may offer the course to their fellow staff members and may also include staff from other facilities in their area.
- Ontario Public Health Association – *Breastfeeding Curriculum for Undergraduate Health Professionals*.
- Quintessence Foundation courses are presented in Ontario by Kathy Venter.
 - *Breastfeeding: Making a Difference Level 1 (Direct Contact)* is the Canadian version of the WHO 20-Hour Course breastfeeding course.
 - *Breastfeeding: Making a Difference Level 2 (Direct Contact and Specialist)* is more in-depth than Level 1.
- RNAO offers three learning strategies:
 - *Breastfeeding e-learning*, based on the WHO 20-Hour Course (Direct Contact).
 - *Breastfeeding: Fundamental Concepts: A Self-Learning Package*.
 - *Mother/Infant Self-Reflection Guide for Nurses and Clinical Case Studies*.
- The International Breastfeeding Centre offers e-learning, webinars, a Lactation Medicine course, and other resources.
- Toronto Public Health has developed *Breastfeeding e-learning Modules based on the Breastfeeding Protocols for Healthcare Providers*. They provide in depth information about basic and advanced breastfeeding topics including how to address breastfeeding challenges.
- University of Manitoba offers a free online course *Multidisciplinary Breast Feeding Education*.

Links to these and other education resources can be found in Appendix 5.

OPTIONS FOR THOSE THAT DO NOT PROVIDE DIRECT BREASTFEEDING CARE:

- *Healthy Mothers Healthy Babies* Best Start Resource Centre online course that takes about 60-90 minutes, available in English and French, and meets Baby-Friendly criteria. Individuals who do the course receive a certificate and this course can also provide an introduction to breastfeeding and BFI to all staff. For more information check www.beststart.org/courses/
- BFI Strategy for Ontario's BFI 101 E-Learning Course www.bfistrategy@tehn.ca
- Quintessence Foundation offers a half-day course for physicians and policy makers.

EDUCATION CONTENT:

If you plan to deliver training yourself, we suggest you first use the *BFI 20-Hour Course Toolkit* as it is very comprehensive. Train the trainer workshops are being offered through the BFI Strategy. To enquire about hosting or participating in a BFI 20-Hour Course workshop contact BFI Strategy trainers through www.bfistrategy@tehn.ca.

If you wish to develop additional materials, here are some resources that can help you:

- The Outcome Indicators at www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf (available in English and French).
- As applies, *Breastfeeding for the Health and Future of Our Nation* at www.beststart.org/resources/breastfeeding/index.html.
- See Appendix 7 for fun and educational activities from Toronto Public Health.



REGARDING EDUCATION, BCC COMMENTS ON EDUCATION:

- Education can be provided by: online 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 WHO 20-Hour Course is not a self-study module and should not be used as one. In fact, many organizations have found that self-study needs to be complemented with face-to-face activities or sessions.
- 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 (Outcome Indicators, Appendix 2.2).
- Records need to be kept of who has completed training and which training has been taken. This may be tracked by human resources, a nurse educator, or others.
- Facilities may require completion of yearly breastfeeding modules similar to other compulsory education programs, such as the Neonatal Resuscitation Program. Several health units host scheduled breastfeeding update workshops once a year or more and encourage staff to attend.
- For professionals who have privileges to practice at the facility (hospital or community), the review board granting privileges may require breastfeeding education hours as a prerequisite condition.

HOW TO PROVIDE BFI EDUCATION ON A DAILY BASIS:

Use all available communication tools to ensure comprehensive, ongoing and sustainable education as suggested below:

- Education needs to be ongoing beyond the classroom. Several communication strategies may be used to enhance learning. Communicate with staff using:
 - Email.
 - Minutes.
 - “Bullet rounds” or “huddles” (mini-daily meetings and brief rounds for physicians and other staff).
 - In-services.
 - White board care plans.
 - Signs or bulletin boards.
 - Activities in staff room.
 - Friendly competitions.
 - Staff skill days.
 - Weekly information newsletters.

THE VALUE OF FACE-TO-FACE EDUCATION:

As tempting as it may be to use less expensive online education, it is worth considering the expense of at least some face-to-face educational sessions. When deciding on activities, consider how people learn, not just by being told or by taking an online course. Some of the learning associated with becoming Baby-Friendly relates to our own values and beliefs. This type of learning tends to occur most effectively in conversation with others and through self-reflection that is stimulated by meaningful dialogue. Learning is also enhanced with others when working through case scenarios, situations and role-playing.

FUNDING EDUCATION:

It has been said that education is the most costly aspect of BFI implementation. Understanding the importance of education to provide Best Practice and improve outcomes assists decision makers in prioritizing and finding creative solutions. Some suggestions are listed below:

- Use the *BFI 20-Hour Toolkit* and the train-the-trainer workshop so that staff can teach the course.
- Use in-house expertise for part of the training.
- Assign pre-reading as part of the education.
- Others from outside the facility were invited to participate on their own time free of charge. Others were invited to participate in the course for a fee. The funds collected covered the speaker fees.
- Use online education that can be done by staff when the facility is quiet.
- Reprioritize funds by the facility.

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



At our Community Health Centre, healthcare providers such as nurses, dieticians, physicians and nurse practitioners had to complete the full 20-hour training though some of the training was pre-reading requirements. A social worker has access to the emergency baby-cupboard, so she required training. One-hour training was also completed by our administrative assistants and corporate providers.

(Centretown Community Health Centre, RN, IBCLC)



If staff members were not healthcare professionals but worked with families a three-hour training was provided. This training included medical receptionists and Early Years Centre staff. Part of the training included practical information (such as how to handle examination room rotation when a mother was using one to breastfeed). Other logistics and scenarios were discussed like, “what would you do if a mother came into the centre asking for formula?”

(Centretown Community Health Centre, RN, IBCLC)



A public health unit also had informal but intentional discussions with security guards and cafeteria staff to inform them about BFI and the “breastfeeding anytime, anywhere” message.

(Public Health Unit)



At our hospital, I gave basic information during our “education days.” For example: what is BFI, why is it important, what difference does it make to the mother, baby, hospital, and community? The first time I did a presentation on BFI basics for our childbirth staff as well as at each quality council.

(Grand River Hospital, RN, IBCLC)



I used the key indicators for each step as a guide. I did a cheat sheet for the nurses, volunteers, unit aids, clerical staff, family physicians, paediatricians, etc. Each cheat sheet was specific to what that particular discipline needs to know about BFI; so I modified the presentation accordingly, and then presented it to them.

(Grand River Hospital, RN, IBCLC)



For our teaching components, it was better to use in-house expertise and also to hire an external knowledgeable facilitator. We did a learning-needs survey in advance so the facilitator knew what areas of breastfeeding to focus on.

(Centretown Community Health Centre, RN, IBCLC)

“

Prior to educating staff, exclusive breastfeeding wasn't really highly valued, but that changed.

(Community Health Centre, RN, IBCLC)

“

We did extensive education to Healthy Families staff, especially public health nurses. Each PHN received about 36 hours of education.

(Toronto Public Health, RN, Health Promoter)

“

Staff has to be really informed and confident to inform the population.

(Hospital, Manager)

“

The education piece was done mostly within the hospital. The lactation consultants at the time taught the equivalent of the WHO 20-Hour Course. The staff had a reading package that was mandatory prior to two 8-hour classroom sessions. There were also three hours of supervised clinical experience that was supervised by a lactation consultant or breastfeeding champion. The staff was paid to attend the educational sessions and also for the reading time. All of this happened many years ago, as we have been designated for over 10 years. Presently, it is an expected qualification and responsibility. Newly-hired staff are expected to have the WHO 20-Hour Course prior to hiring or obtain it within six months. We provide clinical breastfeeding orientation with a lactation consultant for 12 hours minimum.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)



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KEYS TO SUCCESS FOR ADULT LEARNING

There are a few considerations when teaching adults.

PRINCIPLES OF ADULT LEARNING:

Consider the following Seven Principles of Adult Learning in your teaching and while facilitating meetings. These may also serve as a guide for nurses working with families. These principles are modified from www.literacy.ca/professionals/professional-development-2/principles-of-adult-learning while the examples are largely from a hospital nurse educator.

1. Adults must want to learn. They learn best when they have an inner motivation.

Poll the nurses or intended audience for topics they would like to learn more about. A list of potential topics could be presented. Nurses could be asked to put a checkmark beside each item that interests them. The topics with the most checkmarks will help decide what teaching is done.

Each summer, I put up a poster in the nursing station for the staff to add their ideas, and that helped me plan in-services for the fall.

2. Adults will learn what they feel they need to learn. They are practical and want to know, “How is this going to help me right now?” Be practical, be direct.

With each teaching session, even informal, make it clear how this applies to work. Make it hands on, practical learning. Educators can also bring awareness to a need by asking, “Have you ever wondered how you could help more in ‘this’ situation?” And then address that topic.

3. Adults learn by doing, make it relevant. Enable them to use new skills immediately to see their relevance.

It is not good to talk about hand expression unless staff are also able to practice teaching a patient. Start with practicing on model breasts, discuss video clips and compare experiences.

4. Adult learning focuses on problems. Adults start with a problem and then work to find a solution.

Draw out the experience of the group. Once a problem has been identified, someone around the table will usually be able to share some solutions. With reflection and discussion, staff usually find a way to problem solve; which is also much more empowering than telling them what to do.

5. Adults are affected by prior experience. Experience can be an asset and a liability. Discuss the learners’ experience, negative or positive, and then use it to build a positive outcome.

In a round-table discussion, ask the learner to share what works best for them. I try to set up afternoon discussions/in-services a few times a week. I might use an article to guide the discussion or a reference to CPS, American Academy of Pediatrics (AAP), or another legitimate evidence-based body. I might play a video and ask for feedback, for example, “How could this be incorporated into practice?”

6. Adults learn best in an informal situation. Involve them. Let them discuss issues and decide on possible solutions.

Present learners with various breastfeeding scenarios and situations. Divide the group so that small clusters work through a scenario and report back to the whole group. Between themselves, the small clusters can often develop a list of ideas to resolve the breastfeeding problem. Keep the atmosphere light.

7. Adults want guidance and information. They appreciate the ability to make informed decisions from the options presented.

Policies and procedures need to be followed, but where there are options, make that clear. There are always clinical judgments to be made. If they present a real situation related to breastfeeding, ask them what they think. Problem solve together.

PRINCIPLES OF FACILITATION:

These principles apply to health care professionals and could also be used by them when working with patients/clients. The following information is evidence-based and adapted from <http://rnao.ca/bpg/guidelines/resources/breastfeeding-fundamental-concepts-selflearning-package>:

- Share control of content and process, collaborate.
- Involve local champions.
- Base the information on the learner's needs.
- Frame the information around prior experience. Be aware of barriers and work to overcome them.
- Make learning relevant to the situation.
- Plan for interaction, visual demonstrations, and practice time.
- Minimize didactic time (talking to) approaches.
- Build self-responsibility.
- Reward learning, build confidence.
- Keep the environment comfortable, non-threatening, and trusting.



CONSIDER STARTING SESSIONS WITH SELF-REFLECTION:

The RNAO website provides a helpful breastfeeding self-reflection guide. A self-reflection exercise on pages two and three addresses attitudes, beliefs, knowledge, and skills.

Four case studies with potential responses are available on pages 4 - 11.

- www.rnao.ca/sites/rnao-ca/files/Breastfeeding_Educational_Resources_-_Self-Reflection_Guide_for_Nurses_and_Clinical_Case_Studies.pdf.

In addition, there is a learning needs assessment from RNAO called *Breastfeeding: Fundamental Concepts. A Self-Learning Package*.

- www.rnao.ca/sites/rnao-ca/files/Breastfeeding_Fundamental_Concepts_-_A_Self-Learning_Package_2012.pdf.

USE HUMOUR AND BE CREATIVE:

Consider utilizing or adapting these ideas:

- During group teaching, pin knitted or fabric breasts onto someone to demonstrate positioning and latch. Use a doll (any doll) that has a neck that can move.
- Bring parenting magazines to a meeting, divide staff into two teams that each have a wall space, table space, or Bristol board to place their magazine finds. Ask one team to find, cut and paste all images of breastfeeding, and the other group is to paste images related to bottles and formula. Compare, have fun, make your point with humour. Summarize findings.
- Adapt this parent-magazine activity for shift workers; for example, let it run over multiple shifts keeping it in the staff room or at the nursing station (where non-nurses could also 'play'). Keep the momentum by using teams, divided by last name (those whose names are A – L could be one team, M – Z another), birthdate, or other. After the deadline, report back to the staff.
- Post fun or interesting facts about breastfeeding or formula in the nursing station.

- During rounds, regularly discuss a breastfeeding scenario.
- Create little fun incentives. To encourage nurses to participate in sessions provided by GOLD Lactation Online Conference (www.goldlactation.com), one nurse educator had nurses put their name into a draw every time they participated in a conference session. At the end of a week a name was drawn for a treat and the nurse's name was posted somewhere visible.
- Post and email small posters containing breastfeeding images, cartoons, a breastfeeding fact, a "warm fuzzy," or something controversial, remembering the purpose is to stimulate conversation. One health department did this and called them "Start the Conversation." Post-designation, they are continuing this with posters called "Continue the Conversation."
- Use role-playing for sticky situations. A classic situation is talking about the hazards of formula in various scenarios: A mother who wants to give a bottle of formula once a day so her husband can feed; a mother who plans to combination feed; a mother who is really tired; a mother and baby who have a medical reason to give formula. Make up a little story around each and role-play. Think of other common situations and make scenarios around them.
- Suggest to BFI committee members to start BFI bulletin boards. Imagine raising awareness for health inspectors, emergency-room staff, lab techs, others.
- Write single statements on one index card each. Write some true statements and some false about a given topic and bring to nurses. Ask the nurses to decide as a group which statement is true and, which is false. This activity is very engaging and good to stimulate conversation.

EVALUATION:

When considerable investments are made to provide education, it is important that these efforts are also evaluated for their effectiveness. Some tips to guide your evaluation plan are given below.

- Workshop or in-service facilitators should follow-up with an evaluation as feedback is important for refining or developing additional sessions to address emerging needs.
- For evaluations, scales are commonly used and provide quantitative understanding of different attitudes, needs, or other items that express a point of view (Polit & Beck, 2012).
- There is a sample evaluation available in Appendix 7, which combines scales and some open-ended questions.
- The following table is an example of a scale used to measure understanding, confidence, and intention; this was part of a larger evaluation. Note the "before" and "after" in-service evaluations were completed by participants after the workshop when they had a better idea of what they **did** or **did not** know.
- To evaluate training programs, there are four levels to consider:

BEFORE WORKSHOP					STATEMENTS	AFTER WORKSHOP				
strongly disagree						strongly disagree		strongly agree		
1	2	3	4	5	I understand reasons to teach hand expression	1	2	3	4	5
1	2	3	4	5	I am confident that regularly teaching hand expression will be helpful for mothers and babies	1	2	3	4	5
1	2	3	4	5	I intend to use this skill regularly	1	2	3	4	5

Provided courtesy of S. Boersma RN, MScN

- Reaction – measured by participant satisfaction.
- Learning – measured by a change in knowledge, attitude, confidence, intention, or skill.
- Behaviour – measured by a change in behavior as a result of learning.
- Results – measured by patient outcomes.
(Kirkpatrick and Kirkpatrick, 2007)

- Think about what you want to evaluate **before** you begin and be sure to follow through with the evaluation.

SUSTAINABILITY AND LEADERSHIP:

BFI implementation is a team effort that fosters collaboration. It is, therefore, wise to develop strong leadership for the overall strategy, as well as leaders in different areas of the organization or from different disciplines.

- Ongoing staff education, policies, procedures, and documentation requirements will assist in ensuring long-term sustainability (Davies, 2010).
- Management involvement and support has been shown to facilitate nursing practice change (McCormack, 2011).
- Leadership in the form of role models, leaders, champions, or administrative support is the most influential predictor of continued use of guidelines (Davies, 2010).
- Review the BFI Strategy for Ontario Sustainability Tool www.tegh.on.ca/bins/content_page.asp?cid=3-22-6657-7618&lang=1 (English and French).

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



I must say that I feel the key to our success was the strong leadership of our director and her management team. The nurse educators and support from the senior hospital administrators were also a key element. Our nurse educators embraced the 10 Steps and demonstrated a solid commitment to the promotion and education of breastfeeding Best Practices. The entire BFHI committee had individual strengths and talents and contributed to the journey in their own way. There was a “groundswell” of interest and perhaps a bit of “peer pressure” that helped everyone get on board.

(Toronto East General Hospital, RN, IBCLC)



The biggest difference was when our clinical director, along with the hospital board and CEO, made it clear that we are doing this; it is Best Practice, we do not have a choice because it is what is best for our patients, and off we went.

(Grand River Hospital, RN, IBCLC)



I believe that having the government now backing the initiative will help you have more buy-in. It is very important to have the unit managers and senior management on board to support and set the culture for Best Practice and quality of care. It is important for the regular staff to feel supported by them. Find champions from each team, they help support change from within. Physicians need to be an integral part of the team; they can be a change agent with their supportive attitudes and care. Physicians see the clients initially with antenatal care; attitudes and information to make an informed decision about infant feeding start with them.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)

ADDITIONAL COMMENTS:



- Make sure there are champions at the front line. Look for staff who are highly influential with their peers; they could serve as champions and role models. Find champions from each team, they help support change from within.
- Tell each area what they are doing well, and then discuss areas that are in need of development. Nurture positive relationships today for tomorrow's advocates.
- Physicians and midwives need to be an integral part of the team. To get them on board educate and stress that this is BEST PRACTICE, not just a good idea. Find a physician and a midwife champion to encourage others.
- Once the doctors got on board, it changed many of the “naysayers.”

(health care providers)

PRACTICE ISSUES

The goal of effective education is to change practice. The following section will focus on several practice issues that can be a challenge during BFI implementation.

COMMUNICATION:

BFI implementation involves communication both with internal staff and staff from other agencies in addition to parents and their support networks. Language can be used positively or negatively. Inconsistent messages can be a source of confusion and frustration. It is imperative, therefore, to consider language and communication when providing formal or informal education to staff or clients/patients and in everyday interactions.

- Do not present breastfeeding as difficult, rule-laden, or medicalized.
- Having the infant physician or midwife discuss the importance of exclusive breastfeeding is helpful. Parents highly respect their opinion.
- Remember that it is an emotional issue for some people, staff, and mothers. Be sensitive.
- Set the tone for a very accepting atmosphere and an inclusive environment.
- Be realistic with expectations. Breastfeeding may take a while, sometimes weeks, before it happens smoothly, and then it is so much easier. Encourage mothers to stick with it, as they will be glad they did.
- Make supportive comments like, “Quite a few mothers find breastfeeding difficult at the beginning, especially on day two and three, and many of them find it gets easier.” Whereas comments like, “you look so tired” undermine confidence and a desire to persevere.
- See Diane Wiessinger’s article called, *Watch your language!* at <http://www.whale.to/a/wiessinger.html>.
- Remember mothers may still choose to formula feed. Be accepting. Support the mother once an informed decision has been made.



Breastfeeding can be an emotional issue, and it is important to communicate that clients will be respected however they choose to feed their baby. Many women on staff had not been successful at breastfeeding due to lack of support, and I was pleased at how they embraced BFI. Instead of feeling threatened they were able to recognize the obstacles they had faced.

(Community Health Centre, RN, IBCLC)

To ensure all families receive consistent and accurate information, it is a good idea to plan multiple ways of communication:

- Provide peer-support options. Encourage families to use all forms of peer support available, preferably beginning in pregnancy. The value of peer support cannot be overstressed. Consider reviewing the resources from Best Start: *Developing and Sustaining Breastfeeding Peer-Support Programs and Breastfeeding Peer Support-Toolkit* found at www.beststart.org/cgi-bin/commerce.cgi?search=action&category=B00E&advanced=yes&sortkey=sku&sortorder=descending
- Involve fathers and family members. There is a growing body of research about fathers, their desire to be involved, and the support they both give and need. Engage fathers using resources like *Step By Step: Engaging Fathers in Programs for Families* found at www.beststart.org/resources/howto/pdf/BSRC_Engaging_Fathers.pdf.
- Consider options to encourage prenatal education in physicians' offices, using resources such as the resources from Best Start: *Breastfeeding Matters: An important guide to breastfeeding for women and their families* (referred to as *Breastfeeding Matters*) booklet and Breastfeeding Your Baby posters found at www.beststart.org/resources/breastfeeding/index.html.
- Ensure staff support families with informed decision making regarding infant feeding. For more information read the BFI Strategy for Ontario *Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding* at www.breastfeedingresourcesontario.ca/resource/informed-decision-making-having-meaningful-conversations-regarding-infant-feeding
- Inform expectant parents of skin-to-skin, breastfeeding, and risks of formula feeding while conducting prenatal hospital tours (virtual or in-person).
- Provide information packages and online tours to those who do not attend a tour.
- Provide breastfeeding information during hospital pre-admission.
- Have the approach to care and the approach to breastfeeding readily accessible on the facility's website. Be sure to include that a mother ultimately decides how she feeds her baby, but also include the breastfeeding policy.
- Provide a welcoming environment.
- Provide educational videos in patient rooms.
- Conduct routine discharge teaching.
- Review breastfeeding services, peer and professional. Ensure that clients know about resources available in the community. Search the Bilingual Online Ontario Breastfeeding Services directory at www.ontariobreastfeeds.ca (English and French).



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COMMENTS FROM PARENTS AND THOSE WHO ARE BABY-FRIENDLY:

““

The hospital and the breastfeeding drop-ins were essential for us. Any time we were in crisis or had questions, we always found reassurance, and they would get us back on track. It was good to go in and find that our baby’s weight was normal and the challenges we were facing were normal.

(Father, Nick)

““

It’s important to receive factual information. I was told I would always have nipple pain because of my hair colour. Of course that wasn’t true.

(Mother, Melissa)

““

In hospital, they said it didn’t matter if the baby successfully breastfed 8-12 times per day, but that it was important that we tried. When we tried at home, he wasn’t latching well. The baby got really upset, and we got worried.

(Mother, Katie)

““

Telehealth Ontario told us to go the ER because of poor feeding. We went back to the same hospital where a doctor was really sympathetic. She provided a prescription for ointment and recommended a book “Breastfeeding Made Simple” – both proved to be very helpful. The doctor then called down a mother-baby nurse who helped our son get latched that night and then arranged for us to see a lactation consultant at the hospital later that day.

(Anonymous)

““

We were lucky that our hospital had a breastfeeding drop-in. It made for a smooth transition home and helped overcome some early breastfeeding challenges.

(Mother, Katie)

““

I think it’s very important that breastfeeding support be provided to the couple. One of the best pieces of advice that I ever received is that breastfeeding is a family decision. All members of the family must be in support of breastfeeding (and the work it entails) for the nursing to be effective. The mom and the partner need to feel empowered as both people have roles. (Yes, the mom has the boobs, but the partner can do so many things to help support the process, especially in the beginning when it can be so challenging.)

(Mother, Auramarina)

““

My major challenge was lack of control and feeling helpless as I was unable to feed the baby myself and take pressure off my wife, especially not being able to help with night feedings.

(Father, Nick)



We need to empower women by teaching them that breastfeeding is normal and natural (even though it may not feel like that). How do we do this? We need to start young, for example: children's books and children seeing breastfeeding mothers.

(Mother, Auramarina)



We have a loop of breastfeeding videos on our Breastfeeding Channel on the TV's in each of our patient rooms.

(Grand River, RN, IBCLC)



We had a pre-registration clinic that was run by a lactation consultant, but that was dissolved over a year ago. We now have a pre-registration package, which includes our "Learning to Breastfeed" booklet. This package is sent to physicians' offices. We also have a new website and several new videos to help in health teaching. We are also planning to trial a new prenatal open house once a month to provide an opportunity for antenatal clients to orientate themselves to the hospital and give them an opportunity to ask questions. We hope to have Public Health as well as staff from our Women's and Infants program running this session.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)

ENSURING STANDARDIZED INFORMED CONSENT:

Some health care providers are concerned about making a mother feel guilty if the hazards of formula are openly discussed. It is, however, important that mothers make informed decisions, just as they would for car-seat safety, smoking cessation, and epidurals. Formula feeding is not a close second option to breastfeeding nor does it end up being more convenient. Health care providers need to openly provide information on breastfeeding and the hazards of formula feeding, both in health care facilities and as a routine part of health promotion.

Consider the following strategies:

- Discuss the risks and cost of breastmilk substitutes.
- Provide an information booklet to mothers who have made an informed choice to formula feed *Infant Formula – What You Need to Know* available at www.beststart.org/cgi-bin/commerce.cgi?search=action&category=D00E&advanced=yes&sortkey=sku&sortorder=descending (Available in 18 languages).
- Review and stimulate conversation using, the Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding available at www.breastfeedingresourcesontario.ca/resource/informed-decision-making-having-meaningful-conversations-regarding-infant-feeding
- Consider a signed consent when formula is requested or given.



- Consider teaching time. Some nurses may find it time consuming to assist with breastfeeding but providing thorough formula education also takes time. From a maternal point of view, it may take a few weeks for breastfeeding to go smoothly and then it really becomes much simpler to breastfeed.
- Consider a formula cart as a teaching tool (which has been successful in one hospital). The hospital cart (kept out of sight) containing what would be needed to prepare formula at home is brought into rooms when patients ask for formula for non-medical reasons. The nurse reviews the different types of formula (powdered, concentrate, and ready-to-serve), the risks of formula and benefits of breastfeeding, and what is involved in preparing formula versus breastfeeding. Mothers at that hospital often change their minds.
- Consider a decanting station for formula so that a mother receives the amount of formula appropriate for her baby. The formula container received by the mother would then be free of company logos.
- Use cup or spoon feeding for supplementation wherever possible rather than a bottle.
- Role-play various situations/scenarios to help staff practice responses.

For more information see:

- *Support for Non-breastfeeding Mothers Checklist* in the Outcome Indicators, Appendix 2.3 and the *Prenatal Education Checklist* that also applies to inpatients, Appendix 3.
- The Ontario Public Health Association has an excellent document on informed decision at http://opha.on.ca/getmedia/85cf723b-6cc2-4a22-ac07-20f2e1ee46bb/2007-02_pp.aspx.
- Review and stimulate conversation by using the toolkit *Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding* available at www.breastfeedingresourcesontario.ca/resource/informed-decision-making-having-meaningful-conversations-regarding-infant-feeding



We give a Parent Information Sheet to all mothers when medical supplementation is needed. The information shows that we use formula as a medication to fix a problem and then go back to exclusive breastfeeding. We explain alternative methods of giving formula so supplementation will have the least impact on breastfeeding. For those choosing to give formula for non-medical reasons, the Parent Information Sheet shows them that supplementation is not required. This also covers nurses from liability if a baby has a negative reaction to formula. Even if the family still chooses to give formula, they may use one of the alternate feeding methods so it does not interfere with breastfeeding if they decide to stop supplementation.

(Grand River Hospital, RN, IBCLC)

DECREASING SUPPLEMENTATION RATES:

Below are a number of suggestions and techniques that can be adopted to support decreasing supplementation rates at your organization.

- At a central meeting place for nurses, post a weekly message related to breastfeeding e.g., “Did you know...?” Include a breastfeeding fact; something silly; switch it up and post a point of view, a quote from a parent, a compliment from a family, all related to breastfeeding.
- Consider how many times your organization could give a breastfeeding message to the public. Messages could be combined with folic acid discussions, prenatal visits, physical exams, ultrasound appointments.

- Breastfeeding messages can be displayed in various ways:
 - Posters in waiting and exam rooms and on other walls and doors.
 - Breastfeeding decals on entrance doors.
 - Pre-admission literature.
 - White boards in patient rooms.
 - Discharge packages.
 - Information television.
 - Fridge doors where breastmilk may be stored.
 - Unit doors.
- Post BORN data re supplementation rates or other related data at the nursing station.
- Post supplementation data for the public. Consider an interesting presentation format such as a thermometer that indicates change over time. Also post measures the staff are taking to decrease formula use, or positive ways staff are supporting mothers' feeding decisions.
- Post exclusive breastfeeding rates on a colourful bar graph for all to see. Write something encouraging with it like, "Together we are improving health."
- Involve staff in setting supplementation targets. Consider implementing quality information boards on the units showing tracked BFI indicators.
- Audit charts and discuss outcomes regarding appropriate and inappropriate use of supplementation. Be as encouraging as possible.
- Hold daily breastfeeding information sessions for inpatients to provide them with breastfeeding basics. It is also an opportunity to enhance staff knowledge and skills and could be used as a "train-the-trainer" model.
- Discuss strategies with mothers who express concern about milk supply or are extremely tired. Strategy discussions enable families and nurses to problem solve together.
- Enforce visiting hours so families may focus better on getting to know their baby and establishing breastfeeding.
- Look at funding sources to support additional strategies to reach vulnerable populations.



We post our BFI stats regularly in our hallways for anyone to see as part of our hospital quality of care display.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)



We have a Parent Information Sheet for formula supplementation. It is not a comparison but states why exclusive breastfeeding is important, medical reasons for supplementation, why a baby should only be supplemented if medically indicated and how the formula should be given if needed. It ends with, "Returning to exclusive breastfeeding as soon as possible will help you and your baby have a positive breastfeeding experience." It is given to every parent where formula is used (either medically or non-medically indicated). Often parents decide not to supplement if there was no medical reason.

(Grand River Hospital, RN, IBCLC)



We have permanent display boards in all our patient-care areas of the Women's and Children's Program as part of a corporate initiative to highlight the highest quality of care. In our program, we ensure that one of the quality indicators is always related to improving exclusive breastfeeding in hospital (e.g., number of women taught hand expression, number of babies transferred skin-to-skin to mother-baby unit, number of babies where colostrum and skin-to-skin were successful in elevating newborns blood sugar, etc.). We huddle daily at the display board with all staff and self-report our stats for the day. We track our progress using green (attained our goal for the day) or red (missed our goal). The display boards can be seen by staff and families and serve as powerful reminders that stimulate conversation and enhance accountability to provide the best care for our families.

(Trillium Health Partners, Manager)

EMBRACING THE FORMULA FEEDING FAMILY:

Critics of BFI have commented on the emphasis on breastfeeding. However, BFI embraces the formula feeding family and encourages practices that benefit all families, regardless of their infant feeding methods. These include: Prenatal education, skin-to-skin, rooming-in, cue-based feeding and support post-discharge.

Other strategies for supporting the formula feeding family entail:

- Find the balance between an honest process of informing and supporting mothers. Do not force people to breastfeed.
- Develop guidelines on how to support families that choose to use formula. Guidelines should include an opportunity for breastfeeding education and discussion.
- Provide information on appropriate feeding volumes, information on paced bottle feeding, and education about alternative feeding methods to families. Tailor the information to each family and individual circumstance.
- The BFI Strategy for Ontario has developed a toolkit *Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding* available at www.breastfeedingresourceontario.ca/resource/informed-decision-making-having-meaningful-conversations-regarding-infant-feeding. The following recommendations are covered in this document:
 - Ensure that teaching is provided on: Safe and hygienic preparation; storage and use of formula; and the health hazards of inappropriate preparation and storage. Written and verbal instructions should be given.
 - Ensure that written materials on feeding formula are: current, clear, separate from breastfeeding information, and free of any promotional material that is not in compliance with the Code. Information should be provided on an individual basis and not in a group setting.
 - Before they leave the hospital or birthing centre, ensure that mothers and family members who will prepare and give formula are shown how to do so safely. Health care professionals who work in the community can ensure that this information has been understood and is being followed.
- The BFI Strategy for Ontario developed a resource: *Infant Formula – What You Need to Know* at www.beststart.org/cgi-bin/commerce.cgi?search=action&category=D00E&advanced=yes&sortkey=sku&sortorder=descending (Available in 18 languages).



COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



Coach your staff regarding how they should counsel women/families that have chosen to formula feed. Our staff struggled with not wanting clients to feel guilty. Role-playing helped to develop speaking points staff can live with and that feel natural for them.

(Community Health Centre, Manager)



We chose to get rid of all formula in the centre. A crisis worker, who was on the BFI committee, developed a document for when to give formula. Over time, demand for formula was decreasing. The formula on hand was reaching expiration date. The crisis worker made a plan with a pharmacy to honour vouchers issued by the centre, and the pharmacy would get paid later. Vouchers were given based on an assessment inclusive of financial need.

(Community Health Centre, RN, IBCLC)



We used an INFACCT document to discuss the hazards of formula.

(Community Health Centre, BFI lead)



Audit your practice prior to making any change and then audit again. Presenting this data regularly to the staff is important to help them feel engaged and aware that their care is making a difference.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)



We are presently doing a patient audit to ask our mothers how we can better support them to prevent supplementation. We are asking mothers who intend/ed to breastfeed, why they asked for supplementation, etc. Hopefully we can improve our practices to better support this population and decrease the supplementation here.

(Grand River Hospital, RN, IBCLC)

CHANGING CULTURE

Education of health professionals will contribute greatly to practice change. Education will lead to proper implementation of policies, improved documentation, intentional conversation, and continuous efforts and determination to sustain Best Practice. With practice change, the culture will eventually change. Research shows that culture change takes a number of years. Consistent messaging with repetition is essential for successful culture change. Leaders must expect to continue long-term breastfeeding education, as well as to broaden education to other stakeholders and the public.

AFFECT CHANGE WITH PRENATAL BREASTFEEDING CLASSES:

An effective way to promote and support a breastfeeding culture is by providing prenatal breastfeeding education.

- Have a breastfeeding mother come to class and share some stories. Consider inviting her partner. Pre-screening class guests would be wise.
- Take a self-efficacy approach. Build confidence.
- Use online breastfeeding videos to stimulate conversation (e.g., www.youtube.com/user/babyfriendlynl which features Newfoundland celebrities).
- Consider involving parents and grandparents, particularly in a multi-cultural setting.
- See more ideas on the *Prenatal Education Checklist* in the Outcome Indicators, Appendix 3.



The prenatal courses could perhaps focus more on how to get support from partners/friends/other family members. Also, I think that if all women went to see a lactation consultant the day after their baby was born this could help things.

(Mother, Auramarina)

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY:



Families are often far more influential than healthcare professionals so it's important to get families on board and educate them. For our prenatal classes, parents brought family members, especially for the breastfeeding component. They could bring more than one if they wished. The room was often multi-cultural and multi-generational. Amongst other topics, we went around the room and talked about what foods you should and should not eat resulting in interesting conversation.

(Somerset West Community Health Centre, former BFI lead)



I visited a centre where they ran a prenatal class and a breastfeeding drop-in at the same place. During the nutrition break, they open the divider which helped expectant mothers see breastfeeding in action. It could really be done!

(Somerset West Community Health Centre, former BFI lead)



Early on in our journey, in consultation with BCC, we were helped to realize that changing the culture is the biggest challenge. At many early meetings, I shared:

- Journal articles on BFI.
- Information on why BFI and the 10 Steps and WHO Code compliance were important to making things better for our families at TEGH.
- Information on the WHO Code from INFACT Canada. (There wasn't much published in those days; however, every little bit helped to shed more light.)

(Toronto East General Hospital, RN, IBCLC)



Changing culture. Talk it up! Show the research. Show the benefits to staff (e.g., skin-to-skin helps babies learn to breastfeed sooner so it is less work for staff!). There are a lot of hands-on materials for staff to use to support their practice. We developed a toolkit for staff to utilize when working with latching and non-latching newborns in the first 24 hours. This helped to empower and support our staff.

(Grand River Hospital, RN, IBCLC)



Start with:

- Inexpensive changes like skin-to-skin and hand expression that can have a big impact on patient satisfaction and breastfeeding outcomes.
- Auditing your practice.
- Presenting positive case scenarios from your unit, which make great learning tools.
- Involving staff in implementing their ideas toward making positive change.

Remember:

- Celebrate all the small achievements and keep a positive attitude.
- This is a big undertaking that starts with baby steps.

(St. Joseph's Healthcare, Hamilton, RN, IBCLC)



Review! Review! Review! Having a lactation consultant on the floor to go over situations with staff and give them support made a huge difference in their level of confidence. Once the staff started to feel confident, the lactation consultant could start stepping back. Yesterday, a nurse came to me with a question: Does she need to consult me for a referral? The baby is > 24 hours with a 6.6% weight loss, somewhat sleepy, and not latching well. I asked the typical assessment questions: Can mom hand-express, is the baby skin-to-skin, are there any other medical concerns, etc. In the end, the nurse said, “So really everything is normal and fine. We just need to give the baby a little more time to figure this out.” **RIGHT ON!** This nurse just needed a sounding board and reassurance that all was well. This builds confidence. Next time, she can do the same for her colleague/s in a similar situation. You don’t get this kind of support or interaction from an online course. After five years breastfeeding has become our culture.

(Grand River Hospital, RN, IBCLC)



- There’s changing a culture and there’s meeting a requirement and they are two different things. Face-to-face is an irreplaceable opportunity to ask questions and bring in everyday questions. It’s not the same motivation online.
- We used a mix of three strategies: pre-reading, in-house teaching, and an external facilitator.
- To shift a culture, constant and varied messaging is needed and frequent review of the information.
- Be gentle, be patient, and be persistent.

(Anonymous)



At Grand River Hospital, people attended a three-day course. The nurses’ time was not paid, but the hospital paid for the course. Having nurses face-to-face helped so much more than an online course to change the culture. Staff complete an online course every three years, and we pay for someone to come in to do a refresher. Staff voluntarily came in for refreshers, and we had over 100 people last time.

(Grand River Hospital, RN, IBCLC)

LESSONS LEARNED TO SUPPORT CULTURE CHANGE

Consider these lessons learned by others:

- Multiple interventions from multiple places are needed with frequent reminders.
- Remember the overarching item for your work plan is not just educating but changing attitudes, which will change the culture.
- Involve all types of staff members in decisions and policy development (e.g., consider anaesthetists when developing the skin-to-skin protocol as this involves the operating room).
- Consider multi-disciplinary opportunities for learning, working on case studies, and problem solving. For those based in hospitals, consider MORE^{OB} as a multi-disciplinary and effective model.

- If teaching nurses and other medical staff together cannot be planned, try to coordinate educational sessions close together. If there is a big lag in time, change will not occur.
- At an early stage, consider strategies to decrease supplementation rates.
- Staff need constant messaging. This needs to be planned in advance and implemented.
- Evaluate work being done.
- Make sure to have the support of senior management and that resources are allocated (human and otherwise).
- It's all in the name! We spent considerable time educating staff that it is **Baby-Friendly** and not **breast-friendly**.
- Use the expertise of other people who have been through the process.
- Time passes quickly. Keep revisiting the work plan, priorities, and time line. Everything takes longer than you expect. Stay committed because it can be done.
- Go everywhere in the hospital where a mother and baby may go. (This could include the operating room, labs, outpatient units, emergency, psychiatry, and the cafeteria.) Educate staff in each area about BFI and what this means to their area.



CHECKPOINT

At this point, your facility is well on its way to meet the BFI requirements and implement the 10 Steps. You will have completed a few items on your checklist:

- Reviewed and updated all prenatal education and office practices of providers to be compliant with BFI and the WHO Code.
- Revised information and material provided to women and their families to reflect the importance and value of breastfeeding, including, your website's prenatal and postnatal information.
- Revised all patient education materials, used in-hospital and related community services, so that these materials reflect BFI principles.
- Considered harmonizing in-hospital and community resources.
- Ensured mothers are using responsive, cue-based feeding and that no artificial nipples or soothers are provided to families.
- Revised practices in the immediate post-birth period to support skin-to-skin contact and initiation of breastfeeding within one hour.
- Ensured practices are in place to ensure 24-hour rooming-in and minimal separation of mother and infant.
- Ensured practices are in place to support and sustain breastfeeding or breastmilk feeding, even when mother and baby are separated due to medical necessity.
- Established collaborative strategies to support women post discharge.
- Established a mechanism to gather patient feedback.

You Are Well On Your Way To Pre-Assessment!



CHAPTER 7



THE JOURNEY TO DESIGNATION: THE END

- **Pre-assessment: A two-part process**
 - Document review
 - Pre-assessment site visit
- **External assessment**
 - Baby-Friendly designation
- **Celebrating success**

PRE-ASSESSMENT: A TWO-PART PROCESS

There are two parts to a pre-assessment; a document review (the binders) and a site visit. When the facility is ready to engage in the formal assessment process, a facility contact-person (designated by the facility), contacts the BFI Ontario Assessment Committee, following which the BCC Assessment Committee is alerted. A pre-assessment contract is drawn up, and a BCC-certified BFI lead assessor is assigned to the facility by the BCC Assessment Committee. The lead assessor works with a facility contact-person to settle the contract and works with the facility contact-person moving forward. All documents must meet criteria before the site visit occurs.

For details on the end steps, refer to the *BFI Assessment Process and Costs: A Description of the Baby-Friendly Journey* at www.breastfeedingcanada.ca/documents/BCC-Process-and-Cost-doc-July%202017.pdf (English and French).

DOCUMENT REVIEW:

For the document review, three binders must be prepared each containing the following documents:

- Cover letter.
- Self-appraisal.
- Breastfeeding policy (in various formats).
- A record of staff orientation to the policy and other education.
- Staff education details.
- Prenatal education materials.
- Postpartum education materials.
- Collected data.

Two of these binders are submitted to the BCC assessors (identified in the contract), and one is retained by the facility. Following review by two assessors, the lead assessor will provide a written report to the BCC Assessment Committee, and the facility and BFI Ontario Assessment Committee receive copies within six weeks of receipt of the documents.



PRE-ASSESSMENT SITE VISIT:

The pre-assessment site visit is an intensive abbreviated evaluation, including detailed discussions with staff and clients, and observation of practices within the facility. It takes one or more days depending on the facility. Within one month of the site visit, a written report with recommendations and feedback is provided to the facility.



For us, not all changes were in place, but issues were identified and a plan was made to address them. To prepare, we created mock assessments where champions went to various teams and offices to do practice questions with staff to help them prepare. We created two sets of cards (with accompanying posters) called, “Are you ready?” These included information on the BFI contact people, questions about BFI, the Code, and other major concepts. The accompanying posters prompted questions. These efforts focused on staff working with families.

(Toronto Public Health, RN, Health Promoter)



In preparation for the assessors, go through the BFI Outcomes Indicator check list and make sure work is either completed or well in progress. Check that all staff have their required education (breastfeeding course or equivalent) and make “quick check lists” for staff and physicians. These serve as review sheets that are short and to the point.

(Grand River Hospital, RN, IBCLC)

After successful completion of the pre-assessment document review and site visit, a Certificate of Completion will be awarded by BCC on the recommendation of the lead assessor. This certificate is valid for one year.

Should the lead assessor recommend additional work, an action plan with time-lines to address gaps needs to be submitted within 90 days of receiving the pre-assessment report. BFI Ontario may provide information and assistance in formulating a plan to make the needed changes. The lead assessor will continue to support the facility in implementing the action plan, and will make a recommendation to the BCC Assessment Committee for an external assessment once the changes have been implemented. BFI Ontario will provide information and assistance in formulating a plan to make needed changes, and they in turn will make a recommendation for an external assessment once the changes have been implemented. At this point the journey to BFI designation is almost at the end!



The bulk of our time was spent on:

- **Developing our resource binder.**
- **Ensuring training compliance.**
- **Working on fact sheets.**
- **Preparing for pre-assessment and external assessment visits (communicating with staff, coordinating schedules, and organizing visits to drop-ins).**
- **Developing the Infant Feeding Surveillance System.**

(Public Health Unit)

EXTERNAL ASSESSMENT

The external assessment is a site visit lasting two to four days (depending on the size of the facility). The external assessment team will consist of a BCC-certified BFI lead assessor, and one or more certified assessors, assigned by the BCC Assessment Committee in collaboration with BFI Ontario. Where possible, the lead assessor (who was responsible for the pre-assessment) will be on the team. Assessor candidates, from one or more provinces, may be invited by BCC to join the team at no cost to the facility.

The facility contact-person has various duties. These duties include, informing administrators and staff in advance of the visit, advising that staff and mothers will be randomly selected for interviews, securing office space for the assessment team, and remain available to the team for the duration of the assessment.

On the last day, the assessment team will discuss highlights of their findings and present recommendations to facility representatives.



For the external assessment, we made another set of cards and posters that were titled, “We are ready!” One version had more details for our Healthy Families staff, and a second version had less detail and was sent electronically to everyone. The posters were sent to offices to remind people to use their cards.

(Toronto Public Health, RN, Health Promoter)

BABY-FRIENDLY DESIGNATION:

BCC receives the external assessment team’s recommendations regarding the external assessment. A written report will be provided within a month to the facility and BFI Ontario.

Where the facility meets all the BFI criteria, the Baby-Friendly designation is awarded by BCC. The designation is valid for five years from the time of external assessment. Congratulations!

If some criteria require additional work, a **Certificate of Commitment** is awarded and is valid for one year following the external assessment. As with a Certificate of Completion, after pre-assessment, an action plan to meet the missing criteria must be submitted to the BCC Assessment Committee within 90 days of receiving the external assessment report. The lead assessor and BFI Ontario may provide information and support in formulating a plan.

Once changes have been implemented, a return external assessment may occur. A second assessment requires an additional contract and the associated expenses.

Once all the criteria have been met, it is time to celebrate!



After achieving Baby-Friendly designation, we created another poster to say, “We were ready!” and announced the designation at all sites.

(Toronto Public Health, RN, Health Promoter)

CELEBRATING SUCCESS

Designation as a Baby-Friendly hospital, birthing centre, or community health service is a formal recognition by WHO and UNICEF, and is awarded by BCC as the national BFI authority in conjunction with BFI Ontario. The designation recognizes that global criteria and the BFI Outcome Indicators have been met. This is a significant achievement that should be celebrated both internally and with the community.

The facility:

- Provides staff with feedback from the External Assessment Report.
- Liaises with the media to notify the public.
- Arranges a date for the BCC presentation of the BFI award.

Considerations for planning the award presentation:

- Invite representatives from community partners, key stakeholders, physicians, and politicians.
- Invite representatives from aboriginal health centres, birthing centres, community health centres, Family Health Teams, hospitals, public health units.
- Invite breastfeeding mothers and their families, breastfeeding peer-support groups, pre-natal classes.
- Invite local and regional media (from a variety of platforms).
- Prepare speeches and remember to thank everyone who helped achieve BFI designation.
- Serve refreshments.

Splash your success on your website and information that goes to the public, especially to new and expectant parents.

**You Have Worked Hard For Your Success
Congratulations On This Prestigious Designation**



CHAPTER 8



MAINTAINING BFI DESIGNATION

- Requirements
- Lessons learned
- Comments from those who are Baby-Friendly

REQUIREMENTS

BFI designation is valid for five years from the time of the external assessment. Maintain designation by meeting the following requirements:

- Facilities are required to continue self-monitoring reports.
- Breastfeeding statistics are to be reported annually to BFI Ontario.
- A BFI Interim Report is submitted to BCC and BFI Ontario every two years. (The BFI Interim Report is available on the BFI Ontario website at www.bfiontario.ca/wp-content/uploads/2012/10/Interim-reportKV-1.docx).
- The facility's breastfeeding or infant feeding policy must be reviewed every two years.
- Re-assessment every five years involves a subsequent contract and additional costs to the facility.
- To help facilities sustain their BFI progress and Baby-Friendly designation review the *BFI Sustainability Tool* at www.tegh.on.ca/bins/doc.aspx?id=21744 (English and French).

LESSONS LEARNED

Consider the lessons learned in order to maintain and enhance BFI:

- Include BFI training at appropriate levels (e.g., new staff and volunteers).
- Provide new staff with BFI training within six months of hire.
- Follow a check-list for the development of new resources (examples found in Appendix 7).
- Keep the binder/s up to date.
- Consider breastfeeding teaching at almost every meeting.
- Ensure that people continue to hear about BFI as a way to solidify practice and culture changes.
- Make use of resources shared by others such as those available in Appendix 7.
- Provide annual education refresher – new information and techniques.
- Report data monthly to program staff.
- Follow-up on changes in indicators.
- Continue to extend partnerships with other community health organizations to sustain BFI.
- Continue to build awareness of BFI throughout your organization.

COMMENTS FROM THOSE WHO ARE BABY-FRIENDLY



During staff orientation, we provide ALL new employees with our breastfeeding policy and a short explanation of what being a BFI hospital means for GRH. Breastfeeding – anytime, anywhere!

(Grand River Hospital, RN, IBCLC)



For our BFI maintenance, we have an annual work plan which is reviewed.

(Centretown Community Health Centre, RN, IBCLC)



When we achieved our BFI designation, the assessors provided us with recommendations for improvement. Along with the required ongoing targets, we made the assessors' recommendations part of our Quality Council's annual goals and objectives. Our Quality Council meets monthly and oversees all the practices of the unit. This kept the targets "on the radar" so practices would not slip.

(Grand River Hospital, RN, IBCLC)



We developed new binders for our re-designation divided into the 10 Steps.

(Somerset West Community Health Centre, RN, IBCLC)



We include breastfeeding information in our annual, mandatory staff education day. We frequently monitor concerns through patient/staff audits to assess if there are any ongoing issues. The concerns are addressed through in-services done for the staff throughout the year. Having one lead (or a couple of people), who monitors patient/staff concerns, is vital in ensuring practices are maintained; otherwise, it is easy to lose the focus.

(Grand River Hospital, RN, IBCLC)



We go back to the 10 Steps on a regular basis and assess how we are doing, how we can do better, and what could be changed/added.

(Somerset West Community Health Centre, RN, IBCLC)



One of the biggest tasks of BFI maintenance for us was our ongoing documentation review. We collected all documents (policies, etc.) as we made changes. I can't stress enough how important it is to do this on an ongoing basis. Have a binder in one location and continue to add documents as they are updated. Keep it up.

(Grand River Hospital, RN, IBCLC)



"Stay on top of it." It is easy for things to slip under the carpet. Obstetrics is a constantly changing area, as is most of health care. We need to be vigilant to keep this on the forefront and not let it slip away.

(Grand River Hospital, RN, IBCLC)

CHAPTER 9



CHALLENGES AND SUGGESTIONS

- **Formula contracts**
- **Time and financial resources**
- **Human resources**
- **Data collection**
- **Staff education**
- **Family feeding decisions**
- **Organizational settings**
- **Skin-to-skin in the operating room**

At times, achieving BFI designation may feel rather overwhelming. There can be many challenges on the journey to becoming Baby-Friendly. However, you will find that challenges are eventually surmountable with skilled problem solving. Facilities may need to get creative, think outside the box, and celebrate all forward momentum (even baby steps).

The tables that follow outline challenges or barriers that some facilities have faced. For each difficulty, an idea, tool, or supporting resource has been suggested that may be helpful in finding a solution. Many of these problems and solutions were responses from an informal survey of Ontario hospitals.

FORMULA CONTRACTS

Hospitals usually have a contract with one or more formula companies. In many cases, the formula company supplies the hospital with free formula and also pays the organization extra money to offset costs of staff education or programs. In some hospitals, breastfeeding clinics are funded through formula companies. Many community health services keep formula on hand for mothers in case a formula-feeding mother has run out of financial resources to purchase formula.

Both above-mentioned practices are a clear violation of the WHO Code and often present a conflict of interest. Ethical standards of each professional discipline will support decisions to decline all sponsorships and gifts (in any form) from formula companies.

Hospitals and community health services wishing to become Baby-Friendly must pay a fair price for formula and any other breastmilk substitutes; this includes feeding equipment (such as bottles and nipples), medically-indicated formula or related products, i.e., specialty formula or breastmilk fortifiers. (Practice Outcome Indicators, Appendix 11.1.)

Many facilities have policy governing transactions with vendors and donors to support ethical practices.

CHALLENGES OF IMPLEMENTING BFI

How can an organization realistically adjust their budget to compensate for lost revenue from a formula contract?

RESOURCES

There is less need for formula as BFI encourages lower supplementation rates.

Budget savings are realized with lower rates of mother and infant illness.

Supplementing with mother's breastmilk or donor breastmilk ensures the baby remains exclusively breastfed, and reduces the need for formula.

continues

CHALLENGES OF IMPLEMENTING BFI	RESOURCES
<p>Financial costs to purchase formula seem prohibitive to some organizations.</p>	<p>As hand-expression and effective breastfeeding increase, the need for formula decreases.</p> <p>Some hospitals decant formula into smaller amounts. This provides the double advantage of presenting a learning opportunity for families and staff members:</p> <ul style="list-style-type: none"> • They visualize a newborn's need for appropriately-small volume feeds. • There is less cost to the hospital as a single 120 ml bottle of formula can now be used for more than one feeding.
<p>There are significant costs related to formula and formula supplements for the NICU. Some organizations also rely on the financial incentives that the formula companies provide to fund other education initiatives like MORE^{OB}.</p>	<p>Initially, costs occur; however, the long-term cost savings result in fewer readmissions, fewer emergency room visits, healthier mothers, and healthier babies.</p> <p>Whenever possible expressed breastmilk should be used for supplementing.</p>
<p>“If we were to purchase our formula, not advertise a formula product in any way and not receive any product for free, would we be able to receive an unconditional education grant from the formula company to fund education initiatives like MORE^{OB}?”</p>	<p>Using money from companies whose products are covered by the Code to fund education is an ethical conflict as well as a Code violation. Securing funds for staff education is usually more a matter of setting priorities.</p> <p>Anything free from companies, whose products are covered by the WHO Code, goes against the WHO Code and would be unethical. Remember, from the point-of-view of industry, it is all about marketing! Research has demonstrated that marketing in this manner is effective as it implies health care provider endorsement.</p> <p>Details regarding the WHO Code compliance are available through INFAC^T Canada or the International Code Documentation Centre www.ibfan.org/ibfan-penang/99</p> <p>In Ontario, formula is provided to infants of HIV-infected mothers through the Teresa Group. This meets the AFASS (acceptable, feasible, affordable, sustainable, and safe) criteria found at www.teresagroup.ca.</p>
<p>What can facilities do that are getting close to BFI designation, but are only part-way through a five-year formula contract?</p>	<p>If a facility is still mid-contract but has otherwise been implementing the 10 Steps, complies with the WHO Code, and is getting close to BFI designation, they need to discuss this with the BFI Assessor.</p> <p>At-cost formula contracts may be broken.</p> <p>Some formula contracts in group buying programs are negotiated to allow for a BFI transition within the time of the contract. If your hospital is ready for the transition, you should have this checked by your purchasing department.</p> <p>It is important to include someone from your purchasing department on your BFI committee as they can be helpful in ensuring your hospital is not agreeing to practices/free materials that are in violation of the WHO Code.</p>

TIME AND FINANCIAL RESOURCES

Hospitals and community health services often experience competing priorities and may be in the midst of several major projects. Meanwhile, there is a significant investment involved in becoming Baby-Friendly. This is especially true on the original journey to designation. In addition, there are significant costs involved in the various contracts related to BFI assessments and resource development.

Once hospitals are Baby-Friendly and continue to maintain the required standards, the investment required decreases and cost savings are realized as new practices become routine and health outcomes improve.

CHALLENGES OF IMPLEMENTING BFI

RESOURCES

The organizational capacity to integrate a hospital-wide project is limited.

Include Best Practice implementation on the agenda of existing working groups and committees.

There are opportunities to network with stakeholders and build capacity for engaging in the BFI journey from:

- BFI Ontario networks and teleconferences.
- BFI Strategy monthly webinars.
- Regional maternal newborn/child networks or LHIN-based networks.
- Local public health units.
- BFI monthly webinars and workshops.

Try not to re-invent what has already been developed. Many agencies that have started the journey may have suggestions and tools to share.

There may be limited availability of resources, both time and monetary, to initiate teaching and develop program elements.

Staff can perform a self-appraisal of their learning needs. Based on the results, appropriate education and methods of delivery can be explored. (In-house options such as breastfeeding cafes are not costly.)

Explore available electronic learning-tools. Investigate other educational opportunities, including the WHO 20-hour course. Partial lists are available in Appendix 5.

Workshops based on the BFI 20-Hour Toolkit developed by the BFI Strategy for Ontario at www.bfistrategy@tehn.ca

Explore available *BFI 20-Hour Toolkit* workshops (regional or train-the-trainer). Contact TEGH at www.bfistrategy@tehn.ca

Consider access to personal funding from sources such as the Late Career Nurse Initiative found at www.health.gov.on.ca/en/pro/programs/hhrsd/nursingsecretariat/latecareernurse.aspx

The Nursing Education Initiative Grant Program found at <http://rmao.ca/education-funding/nei>

Some facilities include certain educational requirements as a condition of hiring new staff.

continues

CHALLENGES OF IMPLEMENTING BFI	RESOURCES
<p>There are often competing priorities for implementing policies and programs.</p>	<p>In the case of one facility: “We are working to prioritize initiatives within the organization. At present, a committee has been formed and we are working on developing a detailed work plan”.</p> <p>Many programs are evidence-based and therefore complement one another (e.g., implementing Mother-Baby Dyad Care will help to meet skin-to-skin requirements for BFI).</p> <p>Local solutions may be found as in the case of one facility: “Working with the Maternal Newborn Child and Youth Network (MNCYN) provides an opportunity for hospitals in our region to learn from each other and draw on resources that may be shared, i.e., education tools”.</p>
<p>Currently, senior leadership has not committed to allocating time and financial resources to assist in actively working towards BFI.</p>	<p>Grand River successfully completed the BFI re-assessment in December 2013. They reported that the key to successful implementation of BFI is the support of leadership, from senior administrators to program leadership, which then flows to the front line of care providers. They further stated that leadership support resulted in financial support for this process, both essential to success.</p> <p>If needed, use information from this toolkit and other resources to educate senior leadership.</p> <p>“The BFI Strategy team is working to engage hospital and LHIN CEOs in this initiative.”</p>
<p>It takes time to develop policy and procedures.</p>	<p>Use and adapt policy and procedures developed by others. See Appendix 7 for sample policies and adapt them for your facility.</p> <p>Facilities that are BFI designated are often keen to help others. Use these people-resources.</p> <p>Network through BFI Ontario.</p>

HUMAN RESOURCES

In an age of fiscal restraint, it may be difficult to imagine how to move forward. It may be helpful to keep in mind that Baby-Friendly is about Best Practice. In the process, staff become better equipped to support mothers and their infants, and satisfaction for patients and clients is increased.

CHALLENGES OF IMPLEMENTING BFI

Human resources are limited because other projects such as MORE^{OB} and Mother-Baby Dyad Care may seem to drain available resources.

There may be a lack of expertise. Some hospitals have identified they need an IBCLC or more lactation consultants, or a dedicated project coordinator.

RESOURCES

Use resources available from the Best Start Resource Centre website and their BFI Clearing house called *Breastfeeding Resources Ontario* at www.breastfeedingresourcesontario.ca (English and French).

Share successes and tools from other BFI designated organizations.

BFI Ontario frequently adds new resources and tools to their website, including in the Members Area section.

Build on techniques and Best Practices from other initiatives. Build BFI capacity from existing educational initiatives.

Some facilities have had employees just “squeeze” the BFI needs into the regular day, or had a slightly lighter load to be able to work on BFI.

Some facilities give staff dedicated time. This is more likely to happen when senior management is on board.

In the case of one facility: “In our facility, an application for an RNAO leadership fellowship is being submitted with the spring intake. The RN undertaking this fellowship will implement BFI at our facility and develop the educational tools to support the implementation. Upon completion of the fellowship, our clinical educator will assume facilitating the ongoing education for our staff, midwives, and physicians”.

There are Ontario-wide BFI networks accessible by email and teleconference wherein requests may be sent and helpful responses given.

The BFI Strategy microsite on the Michael Garron Hospital website can also be used to reach out for assistance or coaching with a particular issue.

Identify someone with an interest in BFI who could be encouraged to learn about breastfeeding and BFI. They can be tasked with sharing this information with staff.

Identify a breastfeeding champion, this could be a nurse or perhaps a dietician, then find a physician champion and grow from there.

Consider applying for RNAO education funding for developing expertise in staff leaders.

DATA COLLECTION

Data is an objective method of identifying breastfeeding outcomes in your facility or community, and in turn being able to measure progress.

Epidemiology specialists will likely need to be involved at a community level. How families will be recruited for follow-up data collection will need to be decided. In community health centres and hospitals, data collection tools may need to be altered to capture required data.

CHALLENGES OF IMPLEMENTING BFI

Low birth numbers may appear to skew breastfeeding initiation rates.

For example, if there are only four births in a month and one mother makes an informed decision to formula feed, then our breastfeeding rates appear low at only 75%.

Current data collection with BORN does not capture maternal intent to do combination feeding.

Data may not be accurate due to incomplete documentation.

RESOURCES

Data needs to be collected over time, and then one month of low numbers will have less impact. The assessors will be reviewing breastfeeding trends over time.

Medically-indicated supplementation needs to be clearly documented as this can be factored into the calculation of an adjusted breastfeeding rate (BORN data).

BORN is working with BCC to ensure BORN data reflects BFI requirements.

As part of your work with BFI practice changes, you need to be setting expectations on changes to documentation to capture the practice changes. For example, documenting the time each baby spends skin-to-skin, informed decision discussions, and the reasons for supplementation that are medically indicated are all important to ensure that your BORN data is accurate. The BFI strategy will be using BORN data to track the impact of the BFI work across the province. The data will be reported broadly and used for further planning of initiatives to support BFI implementation.

STAFF EDUCATION

It is recommended that staff who provide direct care have more breastfeeding educational hours (i.e., at least 20 hours) when compared with those who provide indirect care and need awareness.

It is important that families receive more standardized messages concerning infant feeding. This will happen with adequate educational endeavors.

Staff education on selected topics may need to be repeated during your BFI journey to ensure that you have full uptake of the information regarding a practice change.

CHALLENGES OF IMPLEMENTING BFI

RESOURCES

There may be a lack of clarity concerning meeting the 20-hour education recommendation.

Look at examples in the toolkit and PCMCH's *Breastfeeding Curriculum Outline and Educational Resources* document at www.pcmch.on.ca/health-care-providers/maternity-care/pcmch-strategies-and-initiatives/breastfeeding-services-and-supports/

Work with BFI Ontario for clarity concerning meeting the 20-hour education recommendation and how that will be calculated.

The number of hours of education is a recommendation, not a requirement. The number of hours of education does not guarantee knowledge-transfer and implementation.

The assessment process reveals staff knowledge and more importantly, the breastfeeding outcomes for mothers and babies.

Funding for developing educational material and for staff to participate may not be available.

Use *BFI 20-Hour Toolkit* for ready-to-use course content and materials.

Many other education tools have been developed that meet BFI criteria, and are available at no cost. Educational options for direct-care providers and for others who require greater breastfeeding awareness are available in Appendix 5.

Use educational resources for self-directed learning. To create change, combine self-learning packages with in-person educational sessions. These sessions will allow for dialogue, which enhances learning, addresses attitude, and results in a cultural shift.

A staff person with an interest in breastfeeding can present breastfeeding scenarios and lead other initiatives, providing facilitation and learning with colleagues. At each staff meeting, present an educational breastfeeding component.

In the case of one hospital:

- “A trainer was paid to present the WHO 20-Hour course. Staff attended the free course on their own time. This “win-win” situation provided free education for staff at minimal expense for the hospital.”
- “The sessions were available for a fee to other organizations and professionals. This offset some of the course expenses.”

Request shared tools and resources developed by hospitals in Canada that achieved designation.

continues

CHALLENGES OF IMPLEMENTING BFI	RESOURCES
<p>Funding for developing educational material and for staff to participate may not be available.</p>	<p>Use medical rounds to introduce change components gradually and discuss what this involves. This allows you to pace the changes to your staff and physicians' comfort level. Medical rounds also provide a larger interdisciplinary forum for discussing the meaning of the change and identifying areas you may have overlooked in your planning.</p> <p>Assess assimilation of education into practice (e.g., with chart audits) and report on these at daily "huddles" or similar settings.</p>
<p>Maintaining educational requirements can be challenging for all maternal newborn and child clinicians. This is especially true for rotating staff and students.</p>	<p>The initial education is most difficult to achieve. Following that, BFI training can be completed during orientation or within six months of beginning a job.</p> <p>Once a facility is Baby-Friendly, continue breastfeeding in-services, educating, reminding, and auditing.</p> <p>Invite internal and external speakers, and encourage attendance at webinars.</p> <p>Be sure to include education to "nights only" staff.</p> <p>Online modules about BFI can be worked into orientation programs for students. Ensure the modules capture the key aspects of your policy and BFI practices.</p> <p>Students can be responsible for presenting the latest research on BFI during rounds.</p> <p>Encourage staff to attend refresher education sessions.</p>
<p>Consistency of commitment and practices between different healthcare providers is lacking.</p>	<p>Breastfeeding education is never "done." Education and dialogue will need to be ongoing, long after designation.</p> <p>Continue open communication with all colleagues.</p> <p>Use the BFI committee and champions to streamline practices.</p> <p>Present the evidence to improve consistent practices.</p>
<p>"Some facilities are concerned about "buy-in" from staff and physicians. It can be a challenge to determine the best method/s of capturing the attention of the physician group and how best to provide education. There is resistance from nurses, paediatricians, and clinicians within the community to change entrenched practices. The practice of relying on supplementation for fear hypoglycemia may present a challenge."</p>	<p>Meet with key representatives of each group to problem solve together. This could help to "win over" some people, and they in turn may become breastfeeding champions.</p> <p>Emphasize that this is Best Practice.</p> <p>Use evidence-based resources and protocols from the Academy of Breastfeeding Medicine www.bfmed.org.</p> <p>In the case of one hospital: "We have been organizing and providing education on CPS hypoglycemia guidelines. We have standing orders for normal newborns that follow our BFI standard-of-care".</p>

continues

CHALLENGES OF IMPLEMENTING BFI

There may be a nursing-staff perception that supporting breastfeeding is more time consuming than formula feeding.

Currently, some hospitals are focused on the MORE^{OB} program.

RESOURCES

It takes time to change perception and learn new skills before they become habit. It takes time for the attitudes of health care professionals to change and believe that breastfeeding really works. After knowledge and belief are assimilated, staff can more easily and concretely support breastfeeding.

Consider a “formula cart” as a teaching tool (mentioned in Chapter Six).

MORE^{OB} supports the development of team and practice changes to evidence based care.

Use the MORE^{OB} principles of interdisciplinary training and working together to problem solve when considering how to approach breastfeeding education.

Integrate BFI practice changes into your MORE^{OB} workshop series.

FAMILY FEEDING DECISIONS

The Baby-Friendly Initiative is all about helping families make an informed feeding decision. (That is why it is not called the “Breastfeeding Initiative.”) Cultures shift slowly, and that may be seen in the decisions parents make.

Even prior to pregnancy, infant feeding decisions begin to be made. Arguably, tomorrow’s parents should begin to be informed about infant feeding decisions from a young age. Health care professionals continue to have influence at every stage.

CHALLENGES OF IMPLEMENTING BFI

RESOURCES

In some cases, there is little to no infant feeding education prior to giving birth and virtually none prior to pregnancy.

Use the Best Start Resource Centre BFI patient education available from their website. Provide these to your physicians, and to patients during tours and hospital registration processes. Breastfeeding education should begin with conception planning and folic acid discussions. This would involve the offices of family physicians, obstetricians, nurse practitioners, midwives, and hospital clinics. Ask yourself what influence your facility could have on early breastfeeding education.

Remember to partner with your local public health units; they may already be doing this work.

Think about patient education materials in all areas of your centre, e.g., ultrasound clinics, labs, restrooms. Consider where the general public receives educational messages, e.g., cafeteria, lobbies, and waiting rooms.

Prenatal hospital admission information should include breastfeeding education and information about BFI.

Review websites from Baby-Friendly designated facilities for ideas. Breastfeeding campaigns in the community could further provide a consistent breastfeeding message.

Parents may decide not to breastfeed or to supplement with formula.

Ensure an informed decision has been facilitated and charted. Review the BFI Strategy for Ontario resource called *Informed Decision Making: Having Meaningful Conversations Regarding Infant Feeding* at www.breastfeedingresourcesontario.ca/resource/informed-decision-making-having-meaningful-conversations-regarding-infant-feeding

Many mothers who intend to use formula change their mind when they receive appropriate information. Ensure mothers are making informed choices.

In the case of one hospital:

“We have developed a signed consent for non-medical formula supplementation, and we have seen a decrease in use of formula.”

In discharge planning, ensure patients know exactly where they can get help in the following 24 - 48 hours.

Connect pregnant and postpartum mothers with peer support.

Know that there are many determinants that influence a family and not all mothers will decide to exclusively breastfeed.

Patients may have already decided to use combination feeding prior to delivery. The public may be poorly informed of the risks of formula.

BFI insists on informing mothers about the risks of formula. Each facility may present this differently, but it is imperative to ensure that each client/patient has been given thorough and factual information to enable them to make an informed decision. Mothers who have decided to combination feed, may be more easily influenced to breastfeed exclusively.

continues

CHALLENGES OF IMPLEMENTING BFI	RESOURCES
<p>High rates of soother use.</p>	<p>Provide education for staff and families concerning soothers. With time, education, role modeling and support this practice will change.</p> <p>Remove soother availability on the postpartum unit.</p> <p>Soothers are sometimes medically indicated for special-needs babies. Ensure babies moving from the NICU to the postpartum unit do not bring soothers with them.</p>
<p>In other areas, there are high proportions of women who say they want to combination feed due to cultural reasons.</p>	<p>Mothers from populations with lower breastfeeding rates can successfully breastfeed if provided with effective strategies such as culturally and socially appropriate peer support and education.</p> <p>Develop a breastfeeding peer-support program and encourage developing connections during pregnancy. There are many models of breastfeeding peer support provided by public health units, the Canadian Prenatal Nutrition Program (CPNP), and La Leche League. The idea is to link new mothers with breastfeeding mothers, in order to provide encouragement and support.</p>
<p>In some geographical areas, there are high rates of substance use in women (i.e., approximately 18% substance use rate in pregnancy). In some areas, there are high rates of Neonatal Abstinence Syndrome (NAS) (also called Neonatal Adaptation Syndrome).</p>	<p>Not all substance use is a contraindication to breastfeeding.</p> <p>Learn more about substance use and NAS through educational avenues and network to find out how others are managing substance use and NAS.</p> <p>Keep a mother and her baby together as much as possible. If separation is needed, assist the mother to protect and increase her milk supply. Give the expressed breastmilk to the infant. If possible, provide skin-to-skin care; it is calming to both mother and baby.</p> <p>In the case of one hospital:</p> <p>“Opioid use is now at 28%. There has been success in using morphine-tapering for babies who may suffer from NAS. We are doing a morphine-tapering program because:</p> <ul style="list-style-type: none"> • Methadone is not an option in our community. • Mothers can stay in their own communities. <p>The goal is that by the time they give birth, mothers will be on the lowest dose of morphine possible, if not off it completely”.</p> <p>A report from the health centre states, “We are winning the war on NAS.” The incidence of NAS has dropped by half, and the severity has been reduced as well. Therefore, few pharmacological interventions are required after birth. Additionally, mothers are receiving counselling on their opioid use, and often mom and baby go home free from substance-use effects.</p> <p>See <i>Neonatal Abstinence Syndrome Clinical Practice Guidelines</i> for Ontario on the PCMCH website at www.pcmch.on.ca.</p>
<p>Availability of resources to support patient, family and staff education.</p>	<p>Liaise with other institutions to adapt resources.</p>
<p>Educational resources are required in multiple languages to support our current patient population.</p>	<p>Send a request through the BFI Ontario membership network for translated materials.</p> <p>See the Best Start Resource Centre for breastfeeding patient-education materials in multiple languages.</p> <p>Contact your local public health units for potential translated materials.</p> <p>If translations are not available consider applying for grants.</p>

ORGANIZATIONAL SETTINGS

Every facility has its own set of challenges. Although each situation is unique, there are also commonalities. Around the world, tens of thousands of facilities have become Baby-Friendly (many in resource-poor areas). It can be done.

CHALLENGES OF IMPLEMENTING BFI

In small rural settings, there are unique challenges.

(Small annual birth rates, e.g., 35-40 births per annum; minimal staff available to work on policy/program development; no designated clinical educator; nurses required to work in all areas of the hospital with numerous related educational obligations; current involvement in the MORE^{OB} program).

Large hospitals have many units and departments with large numbers of staff. The cost of education can seem prohibitive.

RESOURCES

Adapt breastfeeding policies and checklists from other institutions.

Use the BFI Ontario membership email network for direct answers or requests for tools for your situation.

Enlist volunteer help. Breastfeeding mothers may be enlisted for many tasks, e.g., binder development, gathering information, and peer support.

Buddy with another small hospital to meet milestones and help each other. Divide and exchange some of the work. Consider collaborating on education. Consider some motivating, friendly competitions.

Find out which staff have a passion for advancing BFI and empower them.

Work on incorporating principles of the MORE^{OB} model when working on breastfeeding, such as learning as interdisciplinary groups and problem solving together.

Start small. Start with what you have support for. Progress will occur.

Find champions in key areas and build momentum from there.

Focus on the maternal newborn and child areas first so that staff from these units can assist with obtaining support from other areas.

Educate in as many and varied ways as possible.

Have mini-contests to encourage the staff to participate in education on their own time. You could also use a competition or challenge other hospital departments to identify how they can support BFI.

Keep track of the education each nurse has completed.

continues

CHALLENGES OF IMPLEMENTING BFI

Hospitals with a large paediatric population experience multifaceted challenges.

(Infants who are admitted with medical challenges and mother not present; oral feeding may be contraindicated; lack of accessibility of an adequate supply of breast pumps and rental equipment; rooming-in may not be possible in all units (NICU, CCU); and space restrictions may exist for storage of expressed breast milk (EBM).

Challenges can occur when organizations with two and three sites or satellite locations find themselves at different places in the BFI journey.

RESOURCES

Include education to establish including breastmilk as part of the transfer protocol. If mother-infant separation must occur, have the mother express milk and send it with the baby.

Teach mothers hand expression. It is simple, free, with practice it can work really well, and it is part of BFI! Mothers can do this at the bedside and at home. Mothers get more milk by hand expressing than pumping in the first 24 - 48 hours.

It is vitally important that the first feeds are breastmilk for intestinal health, immunity, and well-being.

Spoon, cup, and syringe feeding are all options to explore.

Encourage mothers to stay at the bedside of NICU, SCN, and CCU as much as possible. Encourage mothers to provide the baby's care. This frees up nursing time and empowers mothers.

Accommodate parents as they are the baby's caregivers and decision-makers.

Research is supportive of skin-to-skin for sick infants.

Use a small section of a fridge that is already present. Label EBM well and have policies addressing the use of EBM.

Pacifiers for NICU babies are accepted and medically indicated but not for healthy babies.

In the case of one hospital:

“With the new breastmilk bank, there are more opportunities to provide human donor milk for special needs or premature infants.”

Be creative with implementing policy change, e.g., loan a champion from one site to another or have staff attend another site's staff meeting for education, networking, and discussion.

Have mini-competitions and joint incentives.

Use technology for enhancing teaching and sharing. Use the Ontario Telehealth Network (OTN) to link into rounds at other sites.

SKIN-TO-SKIN IN THE OPERATING ROOM

Throughout the hospital or birthing centre stay, it is important for the mother-baby dyad to practice skin-to-skin as much as possible. The newborn instinctually learns how to breastfeed. The value of skin-to-skin has been well researched and should start immediately after birth. Amongst other benefits, vital signs stabilize more quickly immediately after birth when infants are placed on their mothers' chests. This is equally important in the operating room. For many facilities, this will mean a change in practice.

CHALLENGES OF IMPLEMENTING BFI

In the operating room, surgeons, anaesthetists, and staff struggle with facilitating mother-baby dyad skin-to-skin immediately after C-section.

When a C-section is performed, the length of time for skin-to-skin is either minimal or absent.

RESOURCES

Include the anaesthetists on the BFI committee.

Show physician and nursing staff the skin-to-skin research. Problem solve together.

Do a site visit or teleconference with another hospital that has implemented skin-to-skin.

If mothers are unable, her partner can hold baby skin-to-skin. Babies will have the physiological benefits of skin-to-skin and many dads enjoy this bonding experience. They also are quick to return a rooting baby to the mother.

Implementing skin-to-skin policy involves the whole birthing team. Following a C-section, skin-to-skin can be a challenge to implement, but it is possible!

The Mother-Baby Dyad Care Implementation Toolkit from PCMCH may also be helpful.



APPENDICES, RESOURCES, LINKS, REFERENCES

- **Appendix 1: What Everyone Should Know about Breastfeeding**
- **Appendix 2: Key documents for BFI**
- **Appendix 3: Key supports for BFI**
- **Appendix 4: Key organizations and groups**
- **Appendix 5: Online courses, face-to-face courses, and breastfeeding videos**
- **Appendix 6: Additional online resources: Videos and others**
- **Appendix 7: Resources shared in this toolkit**
- **Appendix 8: Websites referred to in the toolkit**
- **References**

APPENDIX 1

WHAT EVERYONE SHOULD KNOW ABOUT BREASTFEEDING*

- 1 Breastmilk alone is the only food and drink an infant needs for the first six months. No other food or drink, not even water, is usually needed during this period.
- 2 Newborn babies should be kept close to their mothers and begin breastfeeding within one hour of birth.
- 3 Frequent breastfeeding causes more milk to be produced. Almost every mother can breastfeed successfully.
- 4 Breastfeeding helps protect babies and young children against dangerous illnesses. It also creates a special bond between mother and child.
- 5 Bottle feeding can lead to illness and death. If a woman cannot breastfeed her infant, the baby should be fed breastmilk or a breastmilk substitute from an ordinary clean cup.
- 6 From the age of 6 months, babies need a variety of additional foods, but breastfeeding should continue through the child's second year and beyond.
- 7 A woman employed away from her home can continue to breastfeed her child if she breastfeeds as often as possible when she is with the infant.
- 8 Exclusive breastfeeding can give a woman more than 98% protection against pregnancy for six months after giving birth – but only if her menstrual periods have not resumed, if her baby breastfeeds frequently day and night, and if the baby is not given any other food or drinks, or a pacifier or dummy.
- 9 There is a risk that a woman living with HIV may pass the virus on to her infant through breastfeeding, especially when breastfeeding is not exclusive. Women who are infected should be counselled by a trained health worker on the benefits and risks of all infant feeding options and supported in carrying out their infant feeding decision.
- 10 All women have the right to an environment that protects, promotes and supports breastfeeding, including the right to protection from commercial pressures to artificially feed their babies. The International Code of Marketing of Breast-Milk Substitutes aims to provide the necessary protection by prohibiting the promotion of all breastmilk substitutes, feeding bottles and teats.

* Based on Facts for Life, published by UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and the World Bank and retrieved from: www.breastfeedingcanada.ca/documents/Innocenti_Declaration_2005_English.pdf.

APPENDIX 2

KEY DOCUMENTS FOR BFI

From: BCC at www.breastfeedingcanada.ca/TheBCC.aspx and BFI Ontario at www.bfiontario.ca.

- The revised *BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services* (English and French)
- *BFI Assessment Process and Costs: A Description of the Baby-Friendly Journey* (English and French)
- *Calculation of Exclusive Breastfeeding Statistics: Hospitals & Birthing Centres*

APPENDIX 3

KEY SUPPORTS FOR BFI

- MGH is leading the provincial implementation for BFI. Use the MGH microsite at www.bfistrategy@tehn.ca for updates on release of new tools and strategies to assist with BFI, resources under development, upcoming webinars, coaching strategies, and to submit a request for assistance with a particular need.
- BCC and BFI Ontario websites to inform the BFI journey.
- A Members Area of the BFI Ontario website allows for access to shared resources not available in the public domain. These have been developed by members and include policies, signage, and education modules.
- Province-wide teleconferences held four times per year for networking, resource, and information sharing. BFI Ontario members on the teleconference have expertise in various aspects of BFI implementation.
- There are three separate teleconference groups.
 - General BFI Ontario teleconferences.
 - BFI in Community Health Services group meets regularly via teleconference
 - BFI in Hospital networking group meets regularly via teleconference.
- BFI Ontario email distribution list where people may send queries for information and resources to members throughout the province.
- When a Certificate of Intent is issued to the facility, BFI Ontario will provide a BFI contact-person who also provides ongoing guidance.
- “Ask an Assessor” teleconferences are provided by BCC and/or provincial/territorial BFI groups. In Ontario these are provided through BFI Ontario.

APPENDIX 4

KEY ORGANIZATIONS AND GROUPS

Breastfeeding Committee for Canada provides:

- The Outcome Indicators and other key BFI documents.
- List of designated hospitals and community health services in Canada.
- BFI National Symposium presentations and virtual displays.
- The WHO Code in detail.
- *The Global Strategy for Infant and Young Child Feeding*.

www.breastfeedingcanada.ca

Baby-Friendly Initiative Ontario (formerly the Ontario Breastfeeding Committee) provides:

- BFI documents.
- Connection to email networks and BFI teleconferences.
- Additional shared resources.
- Information on educational opportunities.

www.bfontario.ca

Best Start Resource Centre provides:

- *Breastfeeding for the Health and Future of Our Nation*, to support Aboriginal women.
- *Breastfeeding Matters*, an important guide to breastfeeding for women and their families.
- *My Breastfeeding Guide*, to support women and their families.
- Additional resources for Ontario families and health care professionals.
- Some resources are provided in multiple languages.
- Breastfeeding Resources Ontario, a clearing house for breastfeeding and BFI resources.

www.beststart.org/resources/index.html

Health Canada provides information on:

- Breastfeeding.
- Vitamin D.
- Complementary foods.
- Growth monitoring.
- Breastmilk substitutes.

www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php

Provincial Council for Maternal and Child Health:

- Mother-Baby Dyad Care.
- Curriculum outline for personnel.

www.pcmch.on.ca/initiatives/breastfeeding-supports-and-services

APPENDIX 5

ONLINE COURSES, FACE-TO-FACE COURSES, AND BREASTFEEDING VIDEOS

COURSES FOR PERSONNEL PROVIDING DIRECT CARE	AUDIENCE	DESCRIPTION, COST
<p><i>BFI 20-Hour Toolkit</i> www.bfistrategy@tehn.ca</p> <p><i>Breastfeeding Resources Ontario</i> www.breastfeedingresourcesontario.ca</p>	Nurses and other health care professionals.	A 20-hour online course. No cost.
<p>International Breastfeeding Centre Lactation Medicine Program E-Learning Webinars live and recorded www.nbc.ca</p>	Professionals or parents	Lactation Medicine, e-Learning modules and Webinars. Fee based.
<p>Ontario Public Health Association <i>Breastfeeding Curriculum For Undergraduate Health Professionals, 2009</i> www.opha.on.ca/getmedia/1965ec98-46dd-4c00-83ae-0085a19b6239/BF_CurriculumforHSchool-May2009.aspx</p>	For faculty to use with students in medicine, nursing, nutrition, and other health professionals.	Eight modules that may be adapted for self-learning. Complete with teaching/learning strategies. No cost.
<p>Quintessence Foundation courses. <i>Breastfeeding: Making a Difference: Level 1</i> (direct contact), 20-hour WHO equivalent breastfeeding course. <i>Breastfeeding: Making a Difference: Level 2</i> (direct contact and specialist), more in-depth than Level 1. <i>Course for physicians and policy makers</i> (half day). www.babyfriendly.ca/courses.aspx</p>	For nurses and other health care professionals.	Included are the Practice Outcomes Indicators with the course notes. The focus is on clinical evaluation and implementing care plans to support successful outcomes. Courses are offered on a cost recovery basis.
<p>Registered Nurses' Association of Ontario <i>Breastfeeding eLearning</i> www.rnao.ca/search/content/elearning</p>	Nurses and other health care professionals.	The aim is to develop the knowledge, skills and attitude required to implement internationally recognized Best Practices in breastfeeding to create a Baby-Friendly environment based on the WHO 20-hour course. No cost.

continues

COURSES FOR PERSONNEL PROVIDING DIRECT CARE	AUDIENCE	DESCRIPTION, COST
<p>Registered Nurses' Association of Ontario <i>Breastfeeding: Fundamental Concepts: A Self-Learning Package</i> (English and French) www.rnao.ca/bpg/guidelines/resources/breastfeeding-fundamental-concepts-self-learning-package <i>Mother/Infant Self-Reflection Guide for Nurses and Clinical Case Studies</i> (English and French) www.rnao.ca/bpg/guidelines/resources/breastfeeding-educational-resources-mother-infant-selfreflection-guide-nurse</p>	<p>Nurses and other health care professionals.</p>	<p>May be used for pre-learning, 4-6 hours, before other BFI learning activities. Self-learning package to generally learn about policies, current evidence and clinical care related to breastfeeding. Self-reflection guide to illuminate attitudes and beliefs. No cost.</p>
<p>Toronto Public Health <i>Breastfeeding E-Learning Modules</i> www.toronto.ca/health www1.toronto.ca/wps/portal/contentonly?vgnextoid=46bdf87775c24410VgnVCM10000071d60f89RCRD&vgnextfmt=default</p>	<p>For health care professionals.</p>	<p>Foundational breastfeeding information based on Breastfeeding Protocols for Health Care Providers (2013), and guided by BFI principles. Twelve online modules, with quizzes, take 45-60 minutes each. No cost.</p>
<p>University of Manitoba <i>Multidisciplinary Online Breastfeeding Education</i> www.umanitoba.ca/faculties/medicine/units/obstetrics_gynecology/breastfeeding.html</p>	<p>For nurse, physicians and other health care professionals.</p>	<p>Three interactive modules, total of 3 hours. This educational program is an accredited group learning activity as defined by Maintenance of Certification Program of The Royal College of Physicians & Surgeons of Canada. The International Board of Lactation Consultant Examiners (IBCLE) has approved it for CERPs. No cost.</p>
<p>There are also many breastfeeding courses offered by various colleges throughout Ontario, i.e., Fanshawe College, Mohawk College, Humber College, George Brown College. Some have options of classroom teaching or self-study with mentoring by an instructor.</p>		

COURSES FOR PERSONNEL NEEDING AWARENESS	AUDIENCE	DESCRIPTION, COST
<p>Best Start Resource Centre <i>Healthy Mothers. Healthy Babies</i> <i>Breastfeeding Web Course</i> www.beststart.org/courses</p>	<p>For staff or volunteers working with prenatal women or new families.</p>	<p>Takes about 1 hour. Is divided into seven modules. No cost.</p>
<p>The International Institute of Human Lactation <i>BreastEd Lactation Studies Program</i> www.health-e-learning.com/courses/breasted</p>	<p>For those interested in a comprehensive study of lactation and breastfeeding.</p>	<p>Ten mini-courses are offered to prepare students for the International Board of Lactation Consultant Examiners (IBCLE) exam for professional qualifications as an IBCLC. Once enrolled, students have access to the course for 12 months. Cost \$1250 U.S.</p>
<p>UNICEF and World Health Organization. <i>Strengthening and sustaining the Baby-Friendly Hospital Initiative: A course for decision-makers</i> www.who.int/nutrition/publications/infant-feeding/bfhi_trainingcourse_s2/en/</p>	<p>To orient hospital decision-makers (directors, administrators, key managers) and policy-makers to BFI and its positive impacts to assist them in committing to promoting and sustaining “Baby-Friendly”.</p>	<p>There is a course guide and eight session plans with handouts and PowerPoint slides. Two alternative session plans and materials for use in settings with high HIV-prevalence have been included. No cost.</p>

APPENDIX 6

ADDITIONAL ONLINE RESOURCES: VIDEOS AND OTHERS

ADDITIONAL VIDEO RESOURCES	AUDIENCE	DESCRIPTION, COST
Baby-Friendly Newfoundland www.youtube.com/user/babyfriendlynl	Professionals or parents	Series of breastfeeding videos using humour, comedians, mothers, and fathers. No cost.
<i>Breastfeeding. Bringing Baby to the Breast and Becoming Parents... Nursing Baby.</i> www.videoallaitement.org/english.html	Professionals or parents	A 22 minute video, available in English, French and Spanish. For purchase.
Dr. Suzanna Colson <i>Biological Nurturing: Laid back breastfeeding</i> www.biologicalnurturing.com/index.html Pinecrest-Queensway Community Health Centre www.youtube.com/watch?v=hRyHR6jkFDU	Professionals or parents	Dr. Colson teaches to follow a baby's cues and use a baby's natural instincts. Her information can help rethink how professionals work with babies. Many more biological nurturing videos are available online. No cost.
INFACT Canada <i>Breastfeeding: Making the Connection</i> https://www.infactcanada.ca/mall/bf-dvd.asp	Professionals or parents	A 35-minute video giving an overview of Best Practices to support breastfeeding and BFI. Multicultural population inclusive of young mothers. For purchase.
Dr. Jack Newman Video clips and handouts ibconline.ca/breastfeeding-videos-2	Professionals or parents	Short video clips addressing breastfeeding assessment and several challenges. No cost.
Region of Peel Public Health www.peelregion.ca/health/family-health/index.htm	Focused on parents but could be used with nurses for discussion and to "compare notes" with one another.	Short videos available in seven languages, covering positions, skin-to-skin and other common topics.

OTHER RESOURCES

Certificates of Intent and Participation
BFI Ontario at bfi@bfiontario.ca

The Ethics of Decision Making, a power point presentation by Kathy Venter
Members Area at www.bfiontario.ca

Best Practice Guideline and Health Education Fact Sheet
Breastfeeding Best Practice Guideline and Breastfeeding: The Best Start
www.rnao.ca/bpg/guidelines/breastfeeding-best-practice-guidelines-nurses
<http://pda.rnao.ca/content/health-education-fact-sheet-12>

APPENDIX 7

Resources in this appendix have been shared by organizations navigating the BFI journey and can be found at www.beststart.org/implementationtoolkit. They are divided by committee resources, teaching and evaluation resources, and client/patient-centered resources.

When using these, please acknowledge the facility (or person) from where the resource originated or obtain permission to use and adapt.

COMMITTEE RESOURCES

Breastfeeding pledge/policy to families-Poster

1. St. Joseph's Healthcare, Hamilton
2. Michael Garron Hospital (formerly known as Toronto East General Hospital)

Breastfeeding or infant feeding policies

3. Centretown CHC
4. Grand River Hospital
5. Somerset West CHC
6. Michael Garron Hospital

BFI work plans

7. Centretown Community Healthy Centre BFI work plan
8. Somerset West Community Health Centre work plan
9. St. Joseph's Healthcare, Hamilton BFI work plan
10. Timiskaming Health Unit Logic Model
11. Michael Garron Hospital Constant Vigilance checklist

BFI resource checklist

12. Ottawa Public Health
13. Toronto Public Health

Binder contents, Hospital

14. Michael Garron Hospital

External assessment

15. Toronto Public Health "We are ready" poster
16. Toronto Public Health "We are ready" questions and answers for staff working with breastfeeding families

Skin-to-skin

17. Sioux Lookout Meno Ya Win Health Centre policy for skin-to-skin care
18. Sioux Lookout Meno Ya Win Health Centre policy for skin-to-skin care in the operating room

TEACHING AND EVALUATION RESOURCES

Audit tool

19. Feeding and skin-to-skin: St. Joseph's Healthcare BFI Feeding Audit worksheet

Breastfeeding management tools

20. Breastfeeding management tools developed by Grand River Hospital (acknowledge Lisa Dawson RN, IBCLC)
 - a. for the latching newborn
 - b. for the non-latching newborn

Clinical observation

21. Clinical observation assignment for breastfeeding basics

Evaluation tool

22. Sample in-service evaluation

Hand expression

23. Toronto Public Health hand expression crossword
 - a. TPH Hand expression crossword blank
 - b. TPH Hand expression crossword with question
 - c. TPH Hand expression crossword with answers

Medical indications

24. Medical indications fill-in-the-blank activity sheet – Toronto Public Health
25. Medical indications to supplement word search – Toronto Public Health

CLIENT-CENTERED RESOURCES

Hand expression

26. Diagrams from Trillium Health Partners

Informed consent tool

27. Grand River Hospital parent information sheet
28. The Ottawa Hospital breastmilk information sheet

Skin-to-skin

29. Trillium Health Partners skin-to-skin posters, set of eight
 - a. Protection from infection – Adanna
 - b. Benefits of breastmilk – twins
 - c. Relaxation – Evan
 - d. Bonding – Cameron
 - e. Breastfeeding longer – Chloe
 - f. Breastfeeding longer – Evelyn
 - g. Breathing – Adanna
 - h. Warmth – Dominic and Danielle

APPENDIX 8

WEBSITES REFERRED TO IN THE TOOLKIT AND OTHER SUPPORTING WEBSITES

Academy of Breastfeeding Medicine

www.bfmed.org

Action in the workplace

www.ottawabreastfeeds.ca/index.php/en/resources/resources-for-teachers-businesses-employers-and-policy-makers

Baby-Friendly Initiative Ontario

www.bfontario.ca

Baby-Friendly Newfoundland and Labrador

www.youtube.com/user/babyfriendlynl

Best Start Resource Centre

www.beststart.org

www.beststart.org/resources/breastfeeding/index.html

Breastfeeding Committee for Canada

www.breastfeedingcanada.ca

www.breastfeedingcanada.ca/TheCode.aspx

Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)

www.capwhn.ca

Canadian Institute of Child Health (CICH)

www.cich.ca

Canadian College of Physicians

www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Final_04Infant_Feeding_Policy_Statement.pdf

Canadian Lactation Consultants Association (CLCA)

www.clca-accl.ca

Canadian Paediatric Society (CPS)

www.cps.ca

www.cps.ca/documents/position/baby-friendly-initiative-breastfeeding

www.cps.ca/documents/position/nutrition-healthy-term-infants-overview

www.cps.ca/documents/position/newborns-low-blood-glucose

Canadian Pharmaceutical Association (CPA) Breastfeeding resources

www.pharmacists.ca/index.cfm/education-practice-resources/patient-care/breastfeeding-resources/#Breast-feeding_Policy_Statements/Breastfeeding_Initiatives

Code Compliance

www.bfontario.ca/the-baby-friendly-initiative/protection/who-code-for-the-marketing-of-breastmilk-substitutes

Family-Centered Maternity and Newborn Care: National Guidelines (2000)

www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/fcm-smp/index-eng.php

Government of Ontario, *Healthy Kids Strategy*

www.health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf

Grand River Hospital Breastfeeding Policy
www.grhosp.on.ca/Childbirth

Growth charts for Canada
www.dietitians.ca/Secondary-Pages/Public/Who-Growth-Charts.aspx

Hale Publishing
www.ibreastfeeding.com

Health Canada (HC)
www.hc-sc.gc.ca

Health Canada, *Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months*
www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php
www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/pif-ppn-recommandations-eng.php

Health Force Ontario Late Career Nurse Initiative
www.healthforceontario.ca/en/Home/Employers/Late_Career_Nursing_Initiative

INFACT Canada
www.infactcanada.ca

International Lactation Consultants Association (ILCA)
www.ilca.org

Kangaroo Mother Care
www.skintoskincontact.com

LactMed: A National Library of Medicine Database on Drugs and Lactation
www.nlm.nih.gov/pubs/factsheets/lactmedfs.html

La Leche League International (LLLC)
www.lllc.ca

La Leche League International (LLLI)
www.lalecheleague.org

Marsha Walker, *Just One Bottle Won't Hurt, or Will It?*
www.health-e-learning.com/articles/JustOneBottle.pdf

Mother-Baby Dyad Care, Skin-to-skin care
www.pcmch.on.ca/initiatives/mother-baby-dyad-care

Motherisk
www.motherisk.org/women/index.jsp

Ontario Public Health Association
www.opha.on.ca

Ottawa Breastfeeds
www.ottawabreastfeeds.ca/index.php/en/resources/resources-for-teachers-businesses-employers-and-policy-makers

Public Health Agency of Canada: *Breastfeeding and Infant Nutrition* (2013)
www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/nutrition/index-eng.php

Public Health Ontario: *Addressing Obesity in Children & Youth*

www.publichealthontario.ca/en/BrowseByTopic/HealthPromotion/Pages/Addressing-Obesity-in-Children-and-Youth.aspx#.U0IaV1e8B6U

Provincial Council for Maternal and Child Health

www.pcmch.on.ca/health-care-providers/maternity-care/pcmch-strategies-and-initiatives/breastfeeding-services-and-supports/

Registered Nurses' Association of Ontario

www.rnao.ca

Registered Nurses' Association of Ontario: *Toolkit: Implementation of Best Practice Guidelines, Second Edition (2012)*

www.rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Skin-to-skin support for Kangaroo Mother Care

www.skintoskincontact.com

Teresa Group

www.teresagroup.ca

United Nations Children Fund (UNICEF)

www.unicef.org

www.unicef.org/programme/breastfeeding/innocenti.htm

World Alliance for BF Action (WABA)

www.waba.org.my

World Health Organization (WHO)

www.who.int

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