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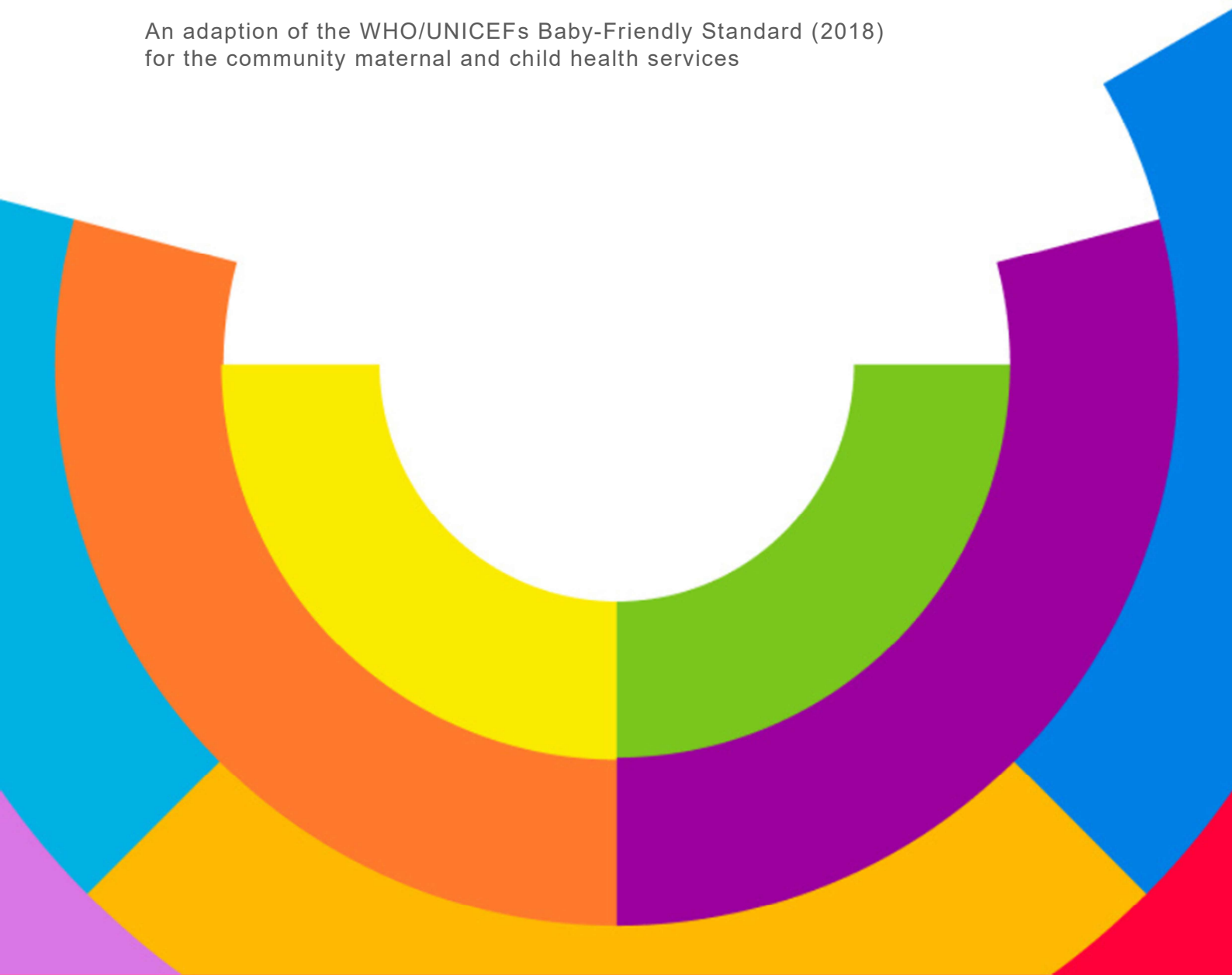
Guidance for the Baby-Friendly Community Health services

An adaption of the WHO/UNICEFs Baby-Friendly Standard (2018)
for the community maternal and child health services



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Innholdsfortegnelse

JA PreventNCD

Guidance for the Baby-Friendly Community Health services

An adaption of the WHO/UNICEFs Baby-Friendly Standard (2018) for the community maternal and child health services

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Guidance for the Baby-Friendly Community Health services

This guide is intended for health professionals and explains the process of becoming designated as a Baby-Friendly Community Health service (BFCHs). The Norwegian Baby-Friendly Community Health service is an adaption for the community maternal and child health services of the WHO/UNICEF (2018) Implementation guidance for the Baby-Friendly Hospital Initiative (BFHI). The Norwegian BFCHs was recognized as a Best Practice for the prevention of non-communicable diseases by the EU Commission in 2022.

In Norway, if you want your community health service to receive the Baby-Friendly designation, you can contact the Norwegian directorate of health, the institution being responsible for guiding the process and designation (external designation body). In other Countries, you can contact the national designation body.

The Baby-Friendly Community Health services Best Practice aligns with this Joint Action, emphasizing a strong trans-sectoral and multidisciplinary approach. To underscore the effort to overcome siloed perspectives and integrate healthcare services into their respective communities, the Task has been named Baby-Friendly Community & Health Services.

For the purpose of the implementation of the Best Practice in the context of the Joint Action PreventNCD, this guidance provides suggestions for transferability and adaptation to the different contexts, considering that these are the minimum requirement for being designated as “Baby-Friendly Community Health service”.

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Task 6.5 participating countries:

Italy, Spain, Ukraine, Slovenia, Lithuania, Greece, Norway

Introduction

In 1991, WHO and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) with the Ten Steps to Successful Breastfeeding. In 2018, an updated Implementation Guidance for the Baby-Friendly Standard was published, based on a careful examination of the evidence for each of the Ten Steps.

As mothers are often discharged from hospital shortly after delivery, before breastfeeding is fully established, the Norwegian Baby-Friendly Community Health service was set up as an adaptation of the Baby-Friendly Hospital Initiative for integration into routine antenatal and child health services at the community level. The Baby-Friendly Community Health services, is a quality standard for breastfeeding support, formulated as Six steps. In a large, pragmatic trial in Norway, the Baby-Friendly Community Health services increased exclusive breastfeeding until 6 months. The program was evaluated as a Best Practice for the prevention of cancers and other non-communicable diseases by the European Commission in 2022.

In Norway, the WHO/UNICEFs Baby-Friendly Standard is recommended by health authorities for:

- Maternity units
- Neonatal intensive care units
- Community antenatal and child health services

The community maternal and child health services in Norway

Pregnant women can choose to receive antenatal care from a midwife at the maternal and child health center or from their general practitioner. Children between 0-4 years old are offered 14 regular preventive health and development consultations by a public health nurse, whereas physicians are responsible for medical examinations at four of these consultations.

JA-PreventNCD >> In the process of transferring the Best Practice to your implementing context, consider the current provision of antenatal and childcare, identify the reference health service and make sure you include all the relevant stakeholders and that the program is recognized and supported by the municipality's leadership.

Deliverable objectives

Specific objective of the Task is to implement the Best Practice (BP) “Baby-friendly community Health services” and pilot action in new settings, as a contribution to reducing the incidence of cancer and other NCDs later in life, starting from the first 1000 days of life (pregnancy to 0-2 yrs), with a focus on social and health inequalities.

Deliverable description

Guidance for implementation of the Best Practice, the Baby-Friendly Community Health services (English version, to be adapted by implementing partners) (Means of verification: guidance released to implementing partner: Version 1 released to implementing partners in October 2024.)

How to become a Baby-Friendly Community Health Service?

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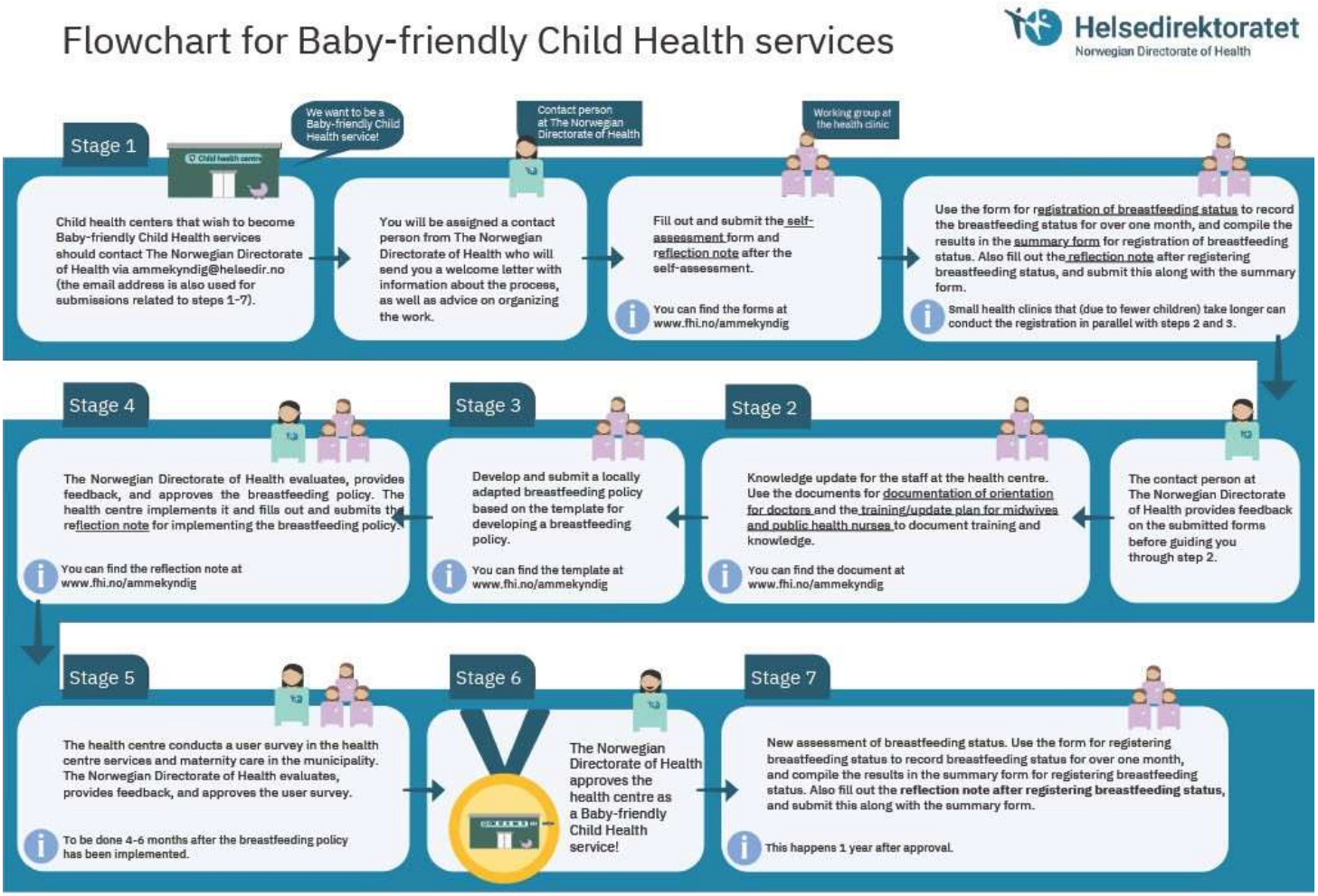
Chapter 1. How to become a Baby-Friendly Community Health service?

Health professionals interested in initiating the process for their community maternal and health center to attain Baby-Friendly designation should contact the institution responsible for guiding the process and designation. They will be assigned a contact person who will offer support throughout the designation process. The process toward designation consists of seven stages and typically lasts for 1.5 years. Flowchart for Baby-Friendly Community Health Services



JA-PreventNCD >> Due to the different implementing criteria of the Baby-Friendly Community Health services in the Task 6.5 participating countries, the process could last more than 1.5 years. Ideally, within the context of the JA, the designation as a BFHs should be achieved by the end of the project. However, intermediate levels of implementation towards significant objectives will also be considered.

Stage 1. Self-assessment questionnaire and mapping of breastfeeding status

Self-assessment: Staff in the community maternal and child health center fill out a self-assessment form [appendix] to evaluate existing knowledge, routines, and policies related to breastfeeding support. This assessment helps identify areas that need improvement for the health service to achieve designation as a Baby-Friendly Community Health service

After completing the self-assessment, staff members are required to write a brief reflective note [appendix] summarizing their thoughts on the service's competence and policies regarding breastfeeding support. This note should also detail any identified challenges. The self-assessment form and reflective note are then sent to the assigned contact person at the external designating body for feedback, including any cooperation agreements between the community maternity and child health center and hospitals regarding pregnancy, childbirth, and postnatal care services.

Mapping of breastfeeding status: In Norway, during a one-month period, the community maternal and child health center should document and assess the infant feeding status of all infants during their 5-month and 1-year check-ups using infant feeding registration form [appendix]. A minimum of 20 infants should be assessed in each age group. In smaller municipalities unable to reach 20 children in each age category within a month, the assessment will continue until this number is achieved.

In the Norwegian Best Practice, the infant feeding registration form should also document reasons why a child is not breastfed or is only partially breastfed. This data helps identify key factors influencing breastfeeding rates and informs targeted improvements in breastfeeding support.

This assessment is carried out concurrently with the ongoing efforts towards becoming a Baby-Friendly Community Health service.

Summarize the breastfeeding prevalence in the Breastfeeding status summary form [appendix]

Public health nurses and midwives should collaboratively create a Reflective note [appendix]

This reflective note should: Identify reasons for early breastfeeding cessation or partial breastfeeding and explore factors influencing breastfeeding prevalence in the municipality.

By jointly examining the findings, healthcare professionals can determine whether these factors can be addressed within the community maternal and child health service or if they are related to hospital routines, for example.

Both the Breastfeeding status summary form and the Reflective note should be submitted to the contact person at the external designating body for feedback.

JA-PreventNCD >>

- *The forms in the appendix can be adapted to different contexts*

Stage 2. Ensure that staff have sufficient knowledge, competency and skills to support breastfeeding

All healthcare professionals providing breastfeeding support should have the necessary knowledge, competence, and skills to support breastfeeding. The required competencies should be tailored to the individual staff member's responsibilities. The competencies necessary for offering breastfeeding support according to the Baby-Friendly Standard should be assessed and necessary training should be completed. The health services should develop a plan for competency verification and training of its employees, based on the WHO/UNICEF's framework of competencies necessary for implementing the Baby-Friendly Standard. Community maternal and child health services should have procedures in place to ensure that staff remain up to date and have access to the latest knowledge on breastfeeding. For new employees and substitute staff, competencies should be assessed and necessary training completed within three months of employment.

As for the competency verification, the *WHO/UNICEF Baby-Friendly Community competence verification toolkit* (release expected autumn 2025) may be helpful.

Please find proposal for how theoretical and practical training and updates can be conducted:

Each staff member should document their completed training using either the provided form or their municipality's training platform, with oversight from the manager.

Training/update plan for healthcare professionals providing breastfeeding support [appendix]

Physicians providing services to pregnant women, mothers, and babies are expected to have knowledge, competence, and skills in relevant aspects of breastfeeding support. They should be informed about the infant feeding policy and resources related to medical breast complications. For a detailed outline of what physicians in the community health services should be aware of, see: Documentation of information for physicians [appendix]

Stage 3. Development of a local infant feeding policy

The Baby-Friendly Standard for maternity and newborn services is based on the *Ten Steps to Successful Breastfeeding (2018)*. The Baby-Friendly Community Health services is an adaptation of this standard, designed for integration into routine antenatal and childcare services at the community level. It outlines Six steps (see below) that collectively constitute a quality standard for breastfeeding support. The purpose of the local infant feeding policy is to ensure quality and consistency in all breastfeeding support for pregnant and breastfeeding mothers.

In the Norwegian Best Practice, the community maternal and child health center receives a template (word document) for the infant feeding policy, which should be adapted to local conditions to specifically describe the implementation of the Six steps. The health service establishes a working group responsible for the local adaptation of the policy, involving and informing all relevant healthcare professionals throughout the process. Those responsible for developing the policy should outline responsibilities and local breastfeeding support routines in the template.

Stage 4. External evaluation and approval of the infant feeding policy

The infant feeding policy, including attachments such as collaboration agreements with hospitals and locally produced documents, is submitted to the contact person at the external designation body.

The external designating body evaluates and approves the local infant feeding policy. Before implementing the approved policy, the working group describes how this is intended to be carried out in their own reflective note [appendix], which is sent to the contact person at the external designating body.

Stage 5. User survey

Four to six months after the policy has been implemented, user surveys should be conducted.

The community maternal and child health services receive information leaflets from the external designation body, containing a link or QR code to user surveys. These are distributed to pregnant women and mothers of six-week-old infants

Information about user surveys in the community maternal and child health services [appendix]

Information letter – user survey for pregnant women [appendix]

Information letter - user survey for mothers [appendix]

Responses are collected through Microsoft Forms.

📌 User survey on breastfeeding counselling in antenatal care (Microsoft Forms)

📌 User survey on breastfeeding counselling in the child health care (Microsoft Forms)

Once completed, the external designation body summarizes and evaluates the results of the user surveys and provides a report to the community health services. The designation body has a procedure for evaluating both user surveys. The indicators are assessed against minimum threshold values, which must be met to achieve designation. The WHO/UNICEF Implementation guidance for the BFHI suggests 80 % target that could be applied to each step.

User survey evaluation and scoring thresholds - for external designating body [appendix]

Stage 6. Approval as a Baby-Friendly Community Health service

Final designation as a Baby-Friendly Community Health service is granted by the external designation body, based on the approval of the written infant feeding policy and the results of the user surveys.

Stage 7. New assessment of breastfeeding prevalence one year after designation

The community maternal and child health center, one year after designation, conducts a new mapping of breastfeeding status, using the same method as at the beginning. When the registration is completed, healthcare professionals providing breastfeeding support jointly create a reflective note with considerations about breastfeeding prevalence in the municipality.

The Breastfeeding status summary form [appendix], and the Reflective note [appendix] are sent to the external designating body.

The Baby-Friendly Standard: Six steps for a Baby-Friendly Community Health Service

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Chapter 2. The Baby-Friendly Standard: Six steps for a Baby-Friendly Community Health service

The Baby-Friendly Community Health services is a quality standard for breastfeeding support, structured into Six steps. These steps are based on the WHO/UNICEFs Ten Steps to Successful Breastfeeding (2018) from the Baby-Friendly Hospital Initiative (BFHI, 2018) and adapted for community health services.

JA-PreventNCD >> The BFCH in some implementing countries might provide more than six steps. For the JA, please make sure that this set of six steps and the criteria are included.

Step 1a: Comply fully with the WHO International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions.

Rationale:

The World Health Assembly (WHA) has called upon health professionals and health-care systems to comply with the International Code of Marketing of Breast-milk Substitutes (Henceforth referred to as "the Code") and subsequent relevant WHA resolutions, in order to protect families and themselves from commercial pressures.

Health professionals need protection from commercial influences that could affect their professional activities and judgment.

Compliance with the Code is important for healthcare services providing support to mothers, infants, and young children, since the promotion of breast-milk substitutes is one of the largest undermining factors of breastfeeding.

Implementation:

The Code lays out clear responsibilities of health services to not promote breast-milk substitutes, feeding bottles or teats. Breastmilk substitutes, feeding bottles, and teats should be procured through regular purchasing procedures. Healthcare professionals working with mothers and newborns should not engage in any form of marketing, use product names, or allow breastmilk substitutes or equipment bearing the manufacturer's name to be displayed or distributed. Professional meetings for healthcare personnel should not be sponsored by the baby food industry, and the baby food industry should not participate in parenting education. It is

recommended that health professionals are not involved in training sponsored by the baby food companies.

Criteria:

- The community maternal and child health center has an infant feeding policy describing how they comply with the Code.
- The community maternal and child health centers premises are not used for marketing, presentation, and advertising of these products or for the distribution of materials from the producers and distributors.
- Health professionals should not be offered or accept free samples of these products or gifts from the producers and distributors.
- Health professionals do not distribute free samples of breastmilk substitutes, feeding bottles, or teats.

Step 1b: Have a written infant feeding policy that is routinely communicated to staff and parents

Rationale:

Policies are important to ensure that parents receive evidence-based guidance and that the staff provides consistent information.

Implementation:

All healthcare staff who care for pregnant women, mothers and children should be familiar with the infant feeding policy and follow it in their practice. The infant feeding policy should explain how the Six Steps for breastfeeding support are implemented in the community maternal and health service, ensuring that mothers/partners receive consistent and evidence-based breastfeeding support that is not influenced by individual opinions.

The policy should also ensure that non-breastfeeding mothers receive the counselling and support they need to safely feed their infants.

Physicians who conduct examinations of infants in the community health services, the municipal medical officer and other general practitioners in the municipality should be informed about the infant feeding policy.

Criteria:

- The community maternal and child health center has a written infant feeding policy that explains how the clinical steps (steps 3-6) are implemented, the Code implementation, and competency assessment.
- All documents related to breastfeeding and infant feeding are in accordance with the Baby-Friendly Standard and current evidence-based guidelines.

Step 1c: Establish ongoing monitoring of compliance with the Baby-Friendly Standard in the community health services data-management systems

Rationale:

The community health maternal and child health service is required to record clinical practices related to breastfeeding in its own data-management systems, such as in patiens records, or through user surveys and breastfeeding prevalence assessments.

Implementation

Recording of information on the breastfeeding indicators should be reviewed for progress at least annually.

Recommended Indicators:

- Exclusive breastfeeding at the 5-month check-up
- Breastfeeding at 1 year

JA-PreventNCD >> The specific age of assessing exclusive breastfeeding for six months and breastfeeding at the age of 1 year, may be adapted to the timing of consultations in implementing countries.

Step 2: Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding

Rationale:

Timely and appropriate care for breastfeeding mothers can only be accomplished if staff have the knowledge, competence, and skills to carry it out. Staff cannot be expected to implement a practice or counsel a mother/father/caregiver on a topic for which they have received no training.

Implementation:

In general, the responsibility for building this capacity resides with the national pre-service education system.

All staff who help mothers with infant feeding should have their competencies in implementing the Baby-Friendly Standard assessed. This assessment also includes the ability to support mothers who do not breastfeed. It is important to focus not on a specific curriculum, but on the knowledge, attitudes and skills obtained.

If staff capacity is insufficient, internal training must be conducted, or arrangements should be made for the staff to receive training through courses or other means. BreastFEEDucation (LINK) is an e-learning course on breastfeeding counselling that covers the theoretical knowledge needed for staff at a Baby-Friendly Community Health service.

Health professionals should be allocated time to complete the competencies verification assessment and, subsequentially, the training, e-learning courses, and self-study. In addition, supervised clinical practice is necessary.

The manager is responsible for ensuring that there is a plan for competency verification and training in place, which also includes a description of how the staff stays updated.

In practical training, a system can be established where one works alongside a colleague in a counselling situation and, for example, demonstrates how to counsel mothers on hand expression or conduct a breastfeeding assessment, possibly using a breastfeeding assessment form. Practical training may also be done through internships at hospitals.

Newly employed staff should have completed competency verification and training within three months of employment. Staff should document their completion of knowledge updates. Training should be tailored to each staff member's area of responsibility.

The plan for competency verification and training should also specify how ongoing knowledge updates will take place. Staff should have received training/ updates on breastfeeding support within the last two years.

Indicator: A plan for competency verification and training is included in the infant feeding policy.

Step 3: Discuss the importance and management of breastfeeding with pregnant women and their families

Rationale:

All pregnant women must have basic information about breastfeeding, in order to make an informed decision. Pregnancy is a key time to inform future mothers/fathers/partners about the importance of breastfeeding, and what they can do to initiate breastfeeding successfully. Pregnant women also need to be informed that birth practices have a significant impact on the establishment of breastfeeding.

Pregnant women and their families must be informed about the use and risks of using pacifiers and bottles before breastfeeding is established, so they can make an informed decision. While WHO's guidelines do not call for absolute avoidance of feeding bottles and pacifiers for term infants, there are a number of reasons for caution about their use, including hygiene, oral formation, and recognition of feeding cues.

Implementation:

Health centers providing antenatal care should counsel women and their families about the benefits and management of breastfeeding.

Information about breastfeeding should include the risks of using formula without a medical reason, practical skills such as positioning and attachment, responsive feeding, and recognizing feeding cues. Families should be informed about the importance of skin-to-skin contact and being with the baby 24 hours a day. Women also need to be informed about possible challenges they may encounter (such as engorgement and a perception of not producing enough milk), and how to address them.

Conversations on breastfeeding should begin at the first or second antenatal visit so that there is time to discuss any challenges. Early information is crucial, especially for women who may deliver prematurely.

Antenatal breastfeeding counselling must be tailored to the individual needs of the woman and her family, addressing any concerns they have. This counselling needs to be sensitively given and consider the social and cultural context of each family, the woman's knowledge, and any previous breastfeeding experiences. Printed or online information in a language mothers understand is one way to ensure that all relevant topics are covered, but they should not replace interpersonal counselling (one-on-one or in small groups). Information for pregnant women should be quality-assured and should not include advertisements for infant formula.

If there is a breastfeeding difficulty in the newborn period that necessitates the use of expressed breast milk or infant formula, various feeding methods like a cup, spoon, supplemental nursing system or bottle can be used. However, the physiology of suckling at the breast is different from

the physiology of suckling from a feeding bottle and teat. It is possible that the use of feeding bottles and teat could lead to breastfeeding difficulties, particularly if use is prolonged. If pacifier use reduces the number of times the baby stimulates the breast, this can lead to a reduction in milk production. Pacifier use may also make mothers miss the baby's early feeding cues. It's important for mothers to understand that crying is a late sign of hunger, and it can be more challenging to find a comfortable breastfeeding position and establish a good latch when the baby is hungry and crying.

The health service should have a protocol for the antenatal discussions on breastfeeding. Public health nurses and midwives should collaborate in developing this by reviewing breastfeeding registration data in order to identify the main breastfeeding challenges in the municipality, and possibilities of preventing them by antenatal counselling.

Providers of antenatal care should be familiar with the routines at the local maternity unit and inform the mother about what to expect after childbirth. If the pregnant woman has previously experienced breastfeeding difficulties, these should be assessed and potentially described in a letter accompanying the woman to the maternity unit. Special conditions and previous breastfeeding difficulties should be documented in the pregnant woman's health card. A plan should be developed in collaboration with the woman on how to prevent previous breastfeeding difficulties this time, and this should be documented in the antenatal health card.

Criteria:

The protocol for antenatal discussions of breastfeeding includes at a minimum:

- the importance of breastfeeding for both mother and child
- national/international guidelines on infant nutrition and the risks of giving infant formula without medical indication
- the importance of immediate and sustained skin-to-skin contact
- the importance of early initiation of breastfeeding and frequent stimulation for establishing a good milk production
- the importance of rooming-in
- basics of good positioning and attachment
- how to recognize the feeding cues
- counsel mothers on the use and risks of feeding bottles, teats and pacifiers

Threshold:

- At least 80% of pregnant women who received antenatal care at the health facility report having received counselling on breastfeeding.
- At least 80% of pregnant women who received antenatal care at the health facility are able to adequately describe what was discussed about two of the topics mentioned above.
- At least 80% of pregnant women should be able to confirm that they have received information about the risks of using a feeding bottle and teats.

Step 4: Establish a coordinated chain of support between antenatal care, maternity/neonatal units, and the community health services

Rationale:

Mothers need ongoing support to successfully establish and continue breastfeeding. Therefore, close cooperation between antenatal care, hospitals, and community child health services is essential. The maternity ward should continue to provide mothers with basic knowledge and skills for breastfeeding. Since milk production is usually not fully established by the time of hospital discharge, continuous support, and assistance for breastfeeding in the days and weeks after returning home is crucial.

Implementation:

One of the criteria for good postpartum care should be continuous, daily follow-up until breastfeeding is established and the baby has good, steady weight gain. This requires that mothers receive the necessary counselling and support for breastfeeding.

In Norway, the National Clinical Guidelines for Postnatal Care includes:

"(4.4) Regional health authorities and municipalities are obligated to develop collaboration agreements and a locally adapted plan for antenatal, childbirth, and postnatal care in the health region.

(4.5) When a mother and child return home after childbirth, the municipality, or the entity responsible for following up with the family should be notified by the maternity ward about their return.

(6.3) It is recommended that the Baby-Friendly Standard is the minimum standard for antenatal, childbirth, and maternity care, ensuring that women and newborns have access to healthcare professionals with sufficient competence in breastfeeding. It is suggested that a woman who wishes to breastfeed either remains in the maternity unit until breastfeeding is functioning satisfactorily and the child is nourished with breast milk, or that the maternity unit ensures that the woman will receive adequate support through home visits and consultations at the health center upon discharge."

The community maternal and child health service and maternity/neonatal units should collaborate on discharge procedures for mothers and their newborns. Upon receiving oral or written notification that the mother and child have returned home, the community health service should contact the mother within 48 hours on working days. Responsibility for contacting the mother should be clearly assigned. During the initial contact with the family, a checklist with questions to identify breastfeeding difficulties should be used. Additionally, the community health

service should inform mothers/parents about where to seek guidance outside of the health center's operating hours.

If necessary, the community health service should have a policy for collaborating with the mother’s and child’s general practitioner. This collaboration should occur with the mother’s consent.

Criteria:

- The community health service can document its collaboration with facilities offering maternity and newborn services for postnatal care, supported by a formal cooperation agreement.

JA-PreventNCD >> The continuity of care is highly relevant for the BFCH, please consider providing a clear pathway, to be developed in a participatory approach, with all the relevant stakeholders involved in the babies and the family care. During the definition of the pathway, please specify who will carry out continuous and daily post-partum follow up until breastfeeding is established and the baby has good, steady weight gain.

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

Rationale:

While breastfeeding is a natural human behavior, most mothers need practical help in learning how to breastfeed. Even experienced mothers can encounter new challenges. Ensuring that mothers are well-informed and providing them with the necessary support is crucial for building their confidence in breastfeeding.

Breastfeeding involves recognizing and responding to a baby's feeding cues indicating they are ready to nurse. Responsive feeding means there are no restrictions on the number or duration of feedings. Mothers should be advised to nurse when the baby shows feeding cues and as often as the baby wants to feed. Scheduled feedings, which means nursing by the clock, is not recommended for healthy infants. It's important for mothers to understand that crying is a late sign of hunger, and it can be more challenging to find a comfortable breastfeeding position and to establish a good latch when the baby is hungry and crying. Early adjustments to position and attachment can prevent breastfeeding problems. Frequent counselling and support help build maternal confidence.

Implementation:

Mothers should receive practical support that empowers them to establish and maintain breastfeeding and manage common breastfeeding difficulties. This includes providing emotional and motivational support, as well as offering information and counselling that enables them to establish successful breastfeeding. The first home visit is a key opportunity to discuss and assist the mother with any questions or issues related to breastfeeding and to strengthen her confidence in her ability to breastfeed.

First-time mothers and mothers with previous negative breastfeeding experiences may need extra support to prevent breastfeeding difficulties. Women who have had cesarean sections and overweight women may need extra practical support for breastfeeding. Babies born between weeks 34 and 36 + 6 days can usually be fully breastfed. They are, however, more vulnerable to jaundice, low blood sugar (hypoglycemia), and feeding difficulties than full-term babies. Therefore, more vigilance is required. Mothers of twins also need extra support, especially with breastfeeding positioning and attachment.

Mothers should be counselled in practicing responsive feeding, following the baby's cues and self-regulation. Regardless of whether the baby is breastfed or not, families should be guided in responding to the baby's feeding cues and the need for closeness and comfort.

Counselling of mothers should include the following topics:

- Demonstration of proper breastfeeding positions and attachment, essential for:
    - stimulating milk production
    - preventing sore nipples
    - ensuring the baby receives enough milk and helping the mother assess this
- Managing breast engorgement
- Techniques for hand expression and pumping to maintain or increase milk production
- Proper storage of expressed milk
- Recognizing and responding to infant feeding cues

Breastfeeding observation is necessary to ensure that the baby is capable of breastfeeding and is receiving breast milk (that milk transfer is occurring). Close follow-up is especially important during the first few weeks.

There should be weight checks until the mother's milk production is established, and the baby has a good, steady weight gain. The health service should have procedures for monitoring infants with insufficient weight gain in the hospital or after returning home, in accordance with the flowchart for Weight Follow-up for healthy full-term breastfed infants in the Norwegian national guidelines [appendix].

The breastfeeding status should be assessed at all the baby's check-ups until cessation of breastfeeding. Counselling should be provided tailored to the mother's needs and her knowledge about breastfeeding. If the mother has other children, the health center should discuss her previous breastfeeding experiences with her. The health center should have procedures for assessing whether mothers who do not wish to breastfeed have made an informed decision.

Threshold

- At least 80% of breastfeeding mothers of full-term infants should confirm that the staff offered breastfeeding counselling during the first home visit.
- At least 80% of breastfeeding mothers of full-term infants should be able to describe at least two signs of the effective baby latch and milk transfer.
- At least 80% of breastfeeding mothers of full-term infants should be able to describe at least two ways to stimulate milk production.

- At least 80% of breastfeeding mothers of full-term infants should be able to describe and, if possible, perform hand expression.
- At least 80% of breastfeeding mothers should be able to describe at least two signs of feeding cues.
- At least 80% of mothers can confirm that they have received advice to breastfeed as often and as long as the baby desires.

JA-PreventNCD >> Although home visiting within the first two weeks of life is highly recommended, if your healthcare system does not provide it, make sure that at least the women who need extra support can have the opportunity of home visiting. All women should be contacted / supported in other ways (i.e. tele-support, or breastfeeding support services).

Step 6: Provide the support mothers need to enable them to breastfeed exclusively for about six months, with continued breastfeeding along with introducing appropriate complementary foods for up to 1 year of age or longer if mutually desired

Rationale:

The Norwegian Directorate of Health recommends exclusive breastfeeding for about six months, with continued breastfeeding along with introducing appropriate complementary foods for up to one year of age or longer. The World Health Organization and UNICEF recommend continued breastfeeding for up to two years of age or longer, as long as mother and baby's desire. All mothers should receive information about the nutritional and immunological qualities of breast milk.

Mothers should be supported and encouraged to be confident that infants with satisfactory growth and well-being do not need supplementation with infant formula or solid food before six months of age. The introduction of solid food should then occur gradually from the age of six months, and breastfeeding should continue for two years or beyond.

Staff at community health services should have knowledge about maternal and child factors that could potentially hinder exclusive breastfeeding or breastfeeding.

Parents and their families must be informed about the use and risks of using pacifiers and feeding bottles before breastfeeding is established, so they can make an informed decision. While WHO's guidelines do not call for absolute avoidance of feeding bottles and pacifiers for term infants, there are a number of reasons for caution about their use, including hygiene, oral formation, and recognition of feeding cues.

Implementation:

As recommended by the WHO BFHI Implementation Guidance (2018), mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated. Very few conditions of the infant or mother preclude the feeding of breast milk and necessitate the use of breast-milk substitutes. Mothers who intend to "mixed feed" (a combination of both breastfeeding and feeding with breast-milk substitutes) should be counselled on how to establish a milk supply and to ensure that the infant is able to suckle and transfer milk from the breast. Mothers who are feeding breast-milk substitutes, by necessity or by informed choice,

must be taught about safe preparation and storage of formula and how to respond adequately to their child's feeding cues.

If there is a breastfeeding difficulty or a medical indication for providing expressed breast milk or infant formula, various feeding methods like a cup, supplemental nursing system, or bottle can be used. However, the physiology of suckling at the breast is different from the physiology of suckling from a feeding bottle and teat. It is possible that the use of feeding bottles and teat could lead to breastfeeding difficulties, particularly if use is prolonged.

If pacifier use reduces the number of times the baby stimulates the breast, this can lead to a reduction in milk production. Pacifier use may also make mothers miss the baby's early feeding cues.

Parents should be informed about the rights to parents' leave and breastfeeding breaks and how to continue breastfeeding after returning to work.

Threshold:

- At least 80% of mothers should know the international recommendation on exclusive and any breastfeeding.
- At least 80% of mothers should be able to confirm that they have received information about the risks of using a feeding bottle and teats.

JA-PreventNCD >> It is highly recommended to provide the support to mothers/fathers/partners/caregivers, by recognizing, valuing, and networking all the resources of the community in a trans-sectoral approach. If mother/father support groups are not available, please consider promoting them within the community.

Appendix

All the necessary forms and documents required for the Baby-Friendly Community Health service (BFCHS) designation process are available online. Each form has a specific purpose and serves as a tool to document progress, assess compliance with the Six Steps, and ensure that local policies and practices align with BFCHS standards. All forms have been made available for download and printing on the Norwegian Directorate of Health's website [www.helsedirektoratet.no/bfchs]

If you have any questions regarding the forms, their purpose, or how to complete them, please contact the Norwegian Directorate of Health: ammekyndig@helsedir.no.

JA-PreventNCD>> Countries may adapt the forms to fit their national context and healthcare system. However, the wording and core content must always remain within the BFCHS standards to ensure consistency with international guidelines.

Documents available online:

Flowchart for BFCHS

Forms for Stage 1

Welcome letter to the community health service

Self-Assessment Form

Reflection note - self-assessment

Infant feeding registration form

Breastfeeding status summary form

Reflection note - registration of breastfeeding status

Forms for Stage 2

Plan for training and updating of healthcare professionals

Documentation of information provided to physicians

Forms for Stage 3

Template - Infant feeding policy (in progress)

Forms for Stage 4

Reflection note – implementation of the infant feeding policy

Forms for Stage 5

Information about user surveys in the community maternal and child health services

Information letter- user survey for mothers

Information letter- user survey for pregnant women

User survey evaluation and scoring thresholds – for the designating body