Helsedirektoratet
Norwegian Directorate of Health

Guidance for the Baby-Friendly Community Health Services

An adaption of the WHO/ Unicef Baby-Friendly Standard for the community maternal and child health services in Norway.

Foreword

This guide is intended for health professionals and explains the process of becoming designated as a Baby-Friendly Community Health Service. In Norway, if you want your community health service to receive the Baby-Friendly designation, you can contact the institution responsible for guiding the process and designation.

The Baby-Friendly Community Health Services Best Practice aligns with this Joint Action, emphasizing a strong trans-sectoral and multidisciplinary approach. The Multidisciplinary Group will be mainly in charge for the implementation of the Best Practice. The Reference Group will involve stakeholders from various sectors and at various levels with responsibilities for supporting infant and young children, mothers, fathers, and families. 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”. For further information please contact

- Norway team
- Italy team

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Chapter 1

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 Baby-Friendly Standard is recommended by the health authorities for maternity units, neonatal intensive care units and for the community 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 actual provision of antenatal and childcare, and make sure you include all the relevant stakeholders in the health sector as well as other relevant sectors.

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 of becoming a Baby-Friendly Community Health Service:

The process toward designation consists of seven stages and typically lasts for 1.5 years.

JA-PreventNCD >> 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 can also be considered.

Flowchart for Baby-friendly Child Health services

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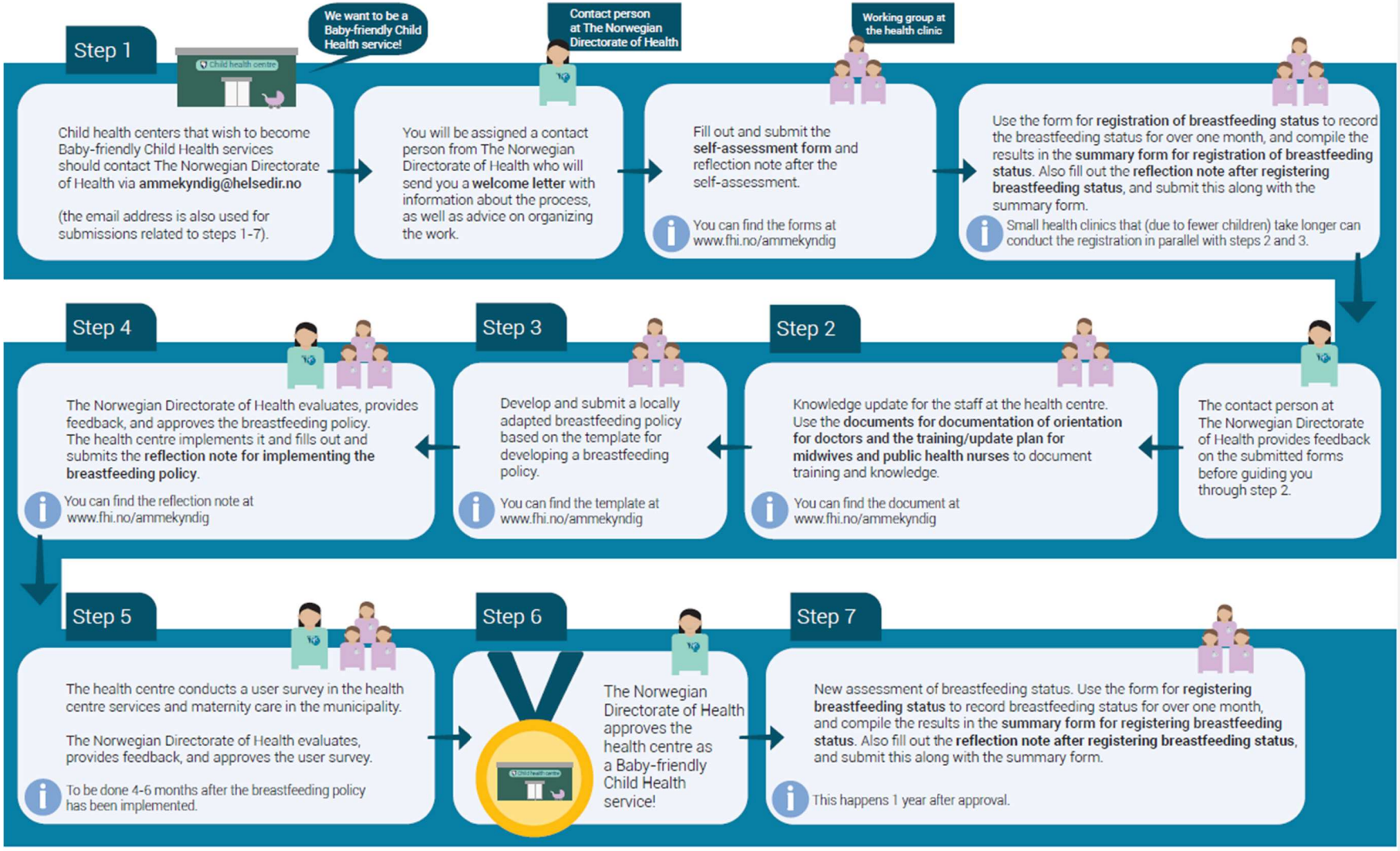


Stage 1. Self-assessment questionnaire and mapping of breastfeeding prevalence

Self-assessment: Staff in the community maternal and child health center fill out a self-assessment form (Appendix forthcoming) 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 forthcoming) 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 designation unit 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 prevalence: During a one-month period, the community maternal and child health center should document and assess the breastfeeding status of all infants during their 5-month and 1-year check-ups using a designated form. 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. This assessment is carried out concurrently with the ongoing efforts towards becoming a Baby-Friendly Community Health Service.

JA-PreventNCD >> Where feasible, please explore the option of recruiting a larger cohort of children, ideally encompassing the entire population or a probability sample.

In the designated form (Appendix forthcoming) the reasons for a child not being breastfed or for being partially breastfed should also be specified. The reasons may include factors such as past negative breastfeeding experiences, breast surgeries, maternal work, or study commitments, as well as breastfeeding difficulties like perceived low milk supply, or mastitis. Summarize the breastfeeding prevalence in the breastfeeding status summary form. (Appendix forthcoming)

Public health nurses and midwives should collaboratively generate a reflective note (Appendix forthcoming) after recording breastfeeding status. The reflective note should include reasons for premature breastfeeding cessation or reasons for partial breastfeeding and should explore factors influencing breastfeeding prevalence in the municipality. By jointly examining the situation, healthcare professionals can identify whether these factors can be influenced by the community maternal and child health center or relates to the routines at the hospital, for example.

JA-PreventNCD >> The Forms in the appendix can be adapted to the different contexts.

The breastfeeding status summary form and the reflective note are submitted digitally to the contact person at the designation unit for feedback.

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 in new employees and substitute staff. Within 3 months, the competency 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. The community maternal and child health services should have policies in place to ensure that the staff always stays updated and has access to new knowledge about breastfeeding.

Please find proposal for how theoretical and practical training and updates can be conducted:
Training/update plan for midwives and public health nurses (Appendix)

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

Physicians providing services to pregnant women, mothers, and babies are expected to have competencies 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 to 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*. 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 next chapter) 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.

JA-PreventNCD >> Some countries may have adapted the 2018 Guidance (link) to their communities and may have additional steps in their programs.

JA-PreventNCD >> After mapping the context and the stakeholders, you are expected to promote trans-sectoral and multidisciplinary and multistakeholder collaboration: A Multidisciplinary Group will be mainly in charge for the implementation of the Best Practice. The Reference Group will involve stakeholders from various sectors and at various levels with responsibilities for supporting infant and young children, mothers, fathers, and families, not involving just the healthcare sector. All the Municipalities of implementation should be involved. In some contexts, representation from government at local level (including health and nutrition, financing, education and social services), academia, professional organizations, NGOs and community-based organizations are part of the working group. This is essential for the policy definition, implementation and sustainability.

The community maternal and child health center receives a template 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 designation unit.

The designating unit 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 forthcoming), which is sent to the contact person at the designating unit, via the same email address as above.

Stage 5. User survey

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

- *Information on user surveys in the antenatal care and child health services at the community level*: (Appendix)

The community maternal and child health center receives information leaflets with a link/QR code to user surveys, which is distributed to pregnant women (Appendix) and parents of six-weeks old infants (Appendix).

The designation unit summarizes and evaluates the results of the user surveys.

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

Final designation as a Baby-Friendly Community Health Service is based on the approval of the written infant feeding policy and the results of the user survey.

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

The community maternal and child health center conducts a new assessment of breastfeeding prevalence, using the same method as at the beginning. When the registration is completed, midwives and public health nurses jointly create a reflective note with considerations about breastfeeding prevalence in the municipality.

The breastfeeding registration form, breastfeeding status summary form, and the reflective note are sent to the designating unit.

JA-PreventNCD >> Each country will need to identify the stakeholders responsible for the designation and reflective process, based on their roles in care during the First 1000 Days. This might involve all or part of the multisector designated reference group. In any case, the multisector designated working group must participate in various stages of the process.

Chapter 2

The Baby Friendly Standard: Six steps for a Baby Friendly community health service

Chapter 2

Six steps for a Baby-Friendly community health service

JA-PreventNCD >> The BFCH in some implementing countries might provide more than six steps. For the purpose of 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 WHO International Code of Marketing of Breast-milk Substitutes 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 WHO 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 WHO Code places a clear responsibility on health services and the professionals who work there not to promote breast-milk substitutes, feeding bottles or teats, and products covered by the Code. 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.

Criteria:

- The community maternal and child health center has an infant feeding policy describing how they comply with the WHO 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.
- Health professionals are not targeted/involved in training that is sponsored by formula or baby food Companies.

JA-PreventNCD >> In the WHO BFHI Guidance (2018) all infant formula, feeding bottles and teats are mentioned as products covered by the WHO Code.

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, WHO 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 encouraged/requires to record clinical practices related to breastfeeding in its own data-management systems, such as in medical records, or through user surveys and breastfeeding prevalence assessments.

Recommended Indicators:

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

JA-PreventNCD >> Which indicators are under discussion>

Step 2: Ensure that staff have sufficient knowledge, competency, 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.
However, 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 training, e-learning courses, and self-study. In addition, supervised clinical practice is necessary.

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 and skills obtained.

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.

JA-PreventNCD >> For the purpose of the JA, we might consider including the new WHO competence assessment toolkit (to be released in the next months).

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/partner 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, on-demand 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 center 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 benefits of breastfeeding for both mother and child.
- national 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.
- recognition of feeding cues.
- the use of pacifiers and bottles.

Additional Criteria:

- At least 80% of pregnant women who received antenatal care at the health center/facility report having received counselling on breastfeeding.
- At least 80% of pregnant women who received antenatal care at the health center/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 pacifier.

JA-PreventNCD >> *If your country has not national guidelines on infant nutrition and the risks of giving infant formula without medical indication, please refer to the Implementation guidance: protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018. Furthermore, all relevant professionals should collaborate in developing a protocol for antenatal discussion on breastfeeding (see bullet points).*

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 continue breastfeeding. The maternity ward should 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, in continuity with antenatal community care, were available.

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 health center 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 BFCI, please consider to provide a clear pathway, to be developed in a participatory approach, with all the relevant stakeholders involved in the babies and the family care.

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. Feeding on demand 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.

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 should be offered additional assistance with breastfeeding positioning and attachment. 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 on-demand breastfeeding, following the baby's cues and self-regulation. Regardless of whether the baby is breastfed or not, mothers 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, which are crucial to:
  - stimulate milk production.
  - ensure the baby receives enough milk, and that the mother knows how to assess this.
  - prevent sore nipples.
- How to handle engorgement
- Training in hand expression/pumping to increase or maintain milk production.
- How to store expressed milk.
- How to recognize and respond to their infants' cues for feeding

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 frequent weight checks until the mother's milk production is established, and the baby has a good, steady weight gain. The health center 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 national guidelines (Appendix).

The breastfeeding status should be assessed at all the baby's check-ups until weaning. 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.

Criteria:

- 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 how they assess that the baby latches effectively and transfer milk.
- 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 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 whithin 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).

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. 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, and breastfeeding should continue for at least the first year.
Staff at community health services should have knowledge about maternal and child factors that could potentially hinder exclusive breastfeeding or breastfeeding.

Pregnant women, 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:
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.

Mothers who are partially breastfeeding or providing supplements, should receive support and counselling to ensure that the infant receives appropriate nutrition. When using infant formula, the health services should provide guidance on the correct preparation and the use of bottles and pacifiers.

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

Criteria:

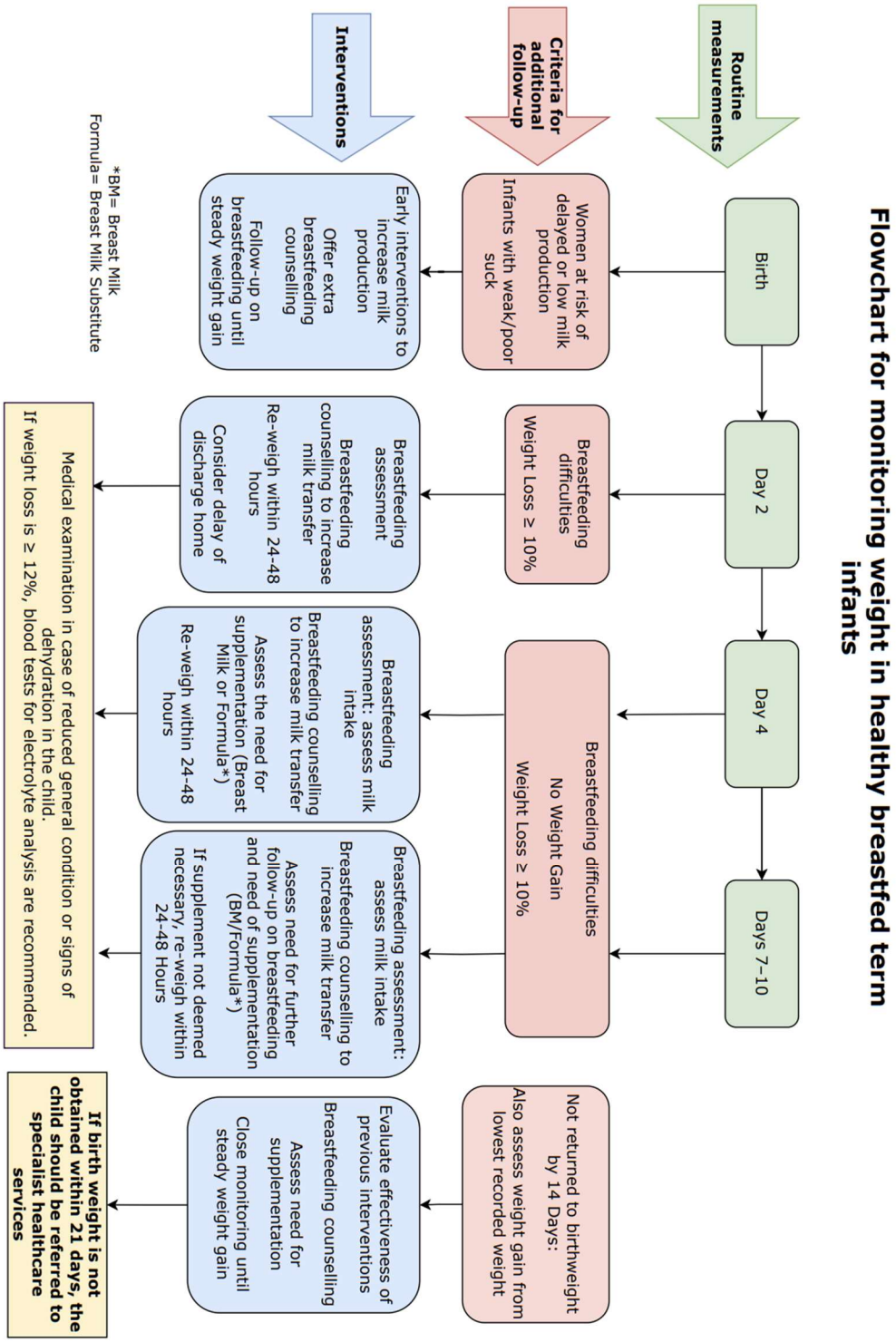
- At least 80% of mothers should know the recommendation on exclusive and any breastfeeding.

- 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 transectoral approach. If mother/father support groups are not available, please consider to promote them within the community.

Appendix

Flowchart for monitoring weight in healthy breastfed term infants



Welcome letter with information about the process

Helsedirektoratet
Norwegian Directorate of Health

Thank you for your interest in having your maternal and child health centre designated as a Baby-Friendly Community Health Service!

To get an overview of the process, you should familiarize yourself **with the guide for Baby-Friendly Community Health Centre** and all the steps in the process. How long it will take varies, but one should expect to spend about 1.5 years.

Start with:

The first thing you need to do is to create a working group consisting of the manager, midwife and public health nurse in the municipality. Then you can start with these three tasks:

1. Self-assessment

The working group must jointly complete a **self-assessment form** of the service. Then you should write a **reflection note** about the self-assessment.

2. Assessment of breastfeeding status

All public health nurses must register breastfeeding status by continuously filling in their own **form for registering breastfeeding status** for all children attending 5-month and 1-year check-ups throughout a whole month. If the municipality is small, you must expect to spend some more time, as we want a minimum of 20 children in each age group.

Make sure that everyone who fills out the form has a common understanding of the breastfeeding indicators, so that the registration is as precise as possible (see definitions in the form for registration of breastfeeding status).

After the breastfeeding registration has been completed, public health nurses and midwives must jointly write a **reflection note**. The note must contain considerations about the reasons for early cessation of breastfeeding or for partial breastfeeding, and factors they think affects breastfeeding in their municipality.

When the registration is completed, you compile the data in **the summary form for recording breastfeeding status.**

Helsedirektoratet
Norwegian Directorate of Health

How to submit form and notes?

Submit forms and notes digitally – using the "Submit form" button at the bottom of the forms, and/or as an attachment in emails to ammekyndig@helsedir.no.

What happens after forms are submitted?

After we have received forms and notes from you, you will receive formal feedback on both self-evaluation, breastfeeding registration and reflection notes.

You will then be guided through the next step, which is updating/training of the staff and development of the municipality's infant feeding policy (according to the criteria for Baby-Friendly Community Health Service).

The sender of this letter is your supervisor and contact person at the designating unit. Feel free to contact us if you have any questions or requests for input and advice along the way.

Good luck!

Best wishes,

.....
contact person

Plan for training/update for midwifes and public health nurses.

Helsedirektoratet
Norwegian Directorate of Health

Plan for training/update for midwives and public health nurses

All health professionals who help mothers with infant feeding should have their competencies in implementing the Six steps for the Baby-Friendly Community Health Services assessed. This assessment also includes the ability to guide and support mothers who do not breastfeed. Newly employed staff should have completed competency verification and training within three months of employment.

Theoretical knowledge

- ❑ **Conduct BreastfeEducation,** including discussing case reports with colleagues.

Employees should be familiar with the following literature:

- ❑ Breastfeeding – a handbook for health professionals 2021.
- ❑ National professional guidelines for postnatal care 2014
- ❑ National Guidelines for Infant Nutrition 2016
- ❑ National guidelines for child health centres and the school health service
- ❑ National professional guidelines for pregnancy care
- ❑ WHO International Code of Marketing of Breastmilk Substitutes
- ❑ Lancet breastfeeding series (on health effects)
- ❑ Medical breast complications when breastfeeding
- ❑ Relis.no og Legemiddelhandboka.no

Employees must be familiar with films and websites about breastfeeding

- ❑ All about infant food (Helsenorge.no)
- ❑ Website on breastfeeding and breast milk
- ❑ Mother-to-mothers support group
- ❑ Global Health Media
- ❑ Breast is best

Employees must be familiar with relevant courses and in-service training in breastfeeding counselling

Practical knowledge (suggestions for practical training)

- ❑ Colleague-supervised breastfeeding counselling.
- ❑ Perform breastfeeding observations using the form for *structured breastfeeding observation*
- ❑ Using *The Breastfeeding Assessment Form*
- ❑ Colleague-supervised counselling on hand expression
- ❑ Colleague-supervised counselling on cup feeding
- ❑ Colleague-supervised counselling on the use of breast pumps, SNS and breast shields
- ❑ Hospital internship, if possible

Documentation of information provided to physicians.

Helsedirektoratet
Norwegian Directorate of Health

Documentation of information provided to physicians

This form can be used to document that physicians who work at the community child health center are informed about breastfeeding and the Baby- Friendly Community Health Services.

Physicians at the Baby-Friendly Community Health Service must document that they have read/know the following (tick off when completed)	*Date of completion*	*Sign*
Be familiar with the child health center's infant feeding policy		
Are informed about the course BreastfeEducation (no requirement to complete the course)		
Are informed about the website Breastfeeding and breast milk from the NIPH, and especially the pages on medical breast complications during breastfeeding: ✓ Pain in the breasts ✓ Breast engorgement, clogged milk ducts, mastitis/breast inflammation and abscess ✓ Milk production: increase, decrease and cessation ✓ Medications and breastfeeding ✓ Guide to diagnosis and treatment of tongue-tie Know the chapter in the Norwegian Gynecological Association's Guide to obstetrics, section on Breastfeeding/breast milk/mastitis and abscess Be familiar with www.relis.no and www.legemiddelhandboka.no for assessment of medication and breastfeeding		

Date:

child health center physician: ..... *Manager:.....*

Information about user surveys

Helsedirektoratet
Norwegian Directorate of Health

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

As part of the evaluation of the community maternal and child health service, user surveys must be conducted for both the antenatal care and the child health (if available).

Pregnant women who are in their 32nd week of pregnancy (and who have had 2 or more pregnancy check-ups with a midwife at the health centre) as well as mothers with 6-week-old infants, will be given an information letter with an electronic link/QR code to the user survey.

Requirements for the number of responses from the user survey:

- Health centres with more than 400 pregnant women/births per year: 20 responses
- Health centres with 50-400 pregnant women/births per year: 10 responses
- Health centres with fewer than 50 pregnant women/births per year: 5 responses

How to conduct the examination?

- We suggest that one person is appointed to be responsible for conducting the user survey.
- When you are ready to start the user survey, you will receive an email from us with an information letter to pregnant women and mothers that you can hand out.
- Those who distribute information letters should encourage the women to complete and submit the examination before they leave the child health centre (incomplete user surveys cannot be used and will therefore be deleted).
- Feel free to make a list that gives you an overview of the number of invited women and responses.
- When you have received enough responses, send an email to your contact person at the designating unit.
- The contact person reviews the answers and gives you feedback on the results, as well as suggestions for improving routines if needed. In some cases, it is necessary for the health centre to improve its routines before meeting the requirements to become a Baby-Friendly Community Health Service. If the designating unit makes suggestions for improvements, the child health centre will have time to work on the suggestions before a new user survey is conducted.

Good luck!

Kind regards

Designating unit

Information to pregnant women in their 32nd week

Helsedirektoratet

To Pregnant Women in their 32nd Week

The health station you attend is committed to providing the best possible support for breastfeeding. As part of this, they are working to become accredited as a Baby-Friendly Health Station. This means that the health station has the theoretical and practical knowledge required to offer high-quality breastfeeding guidance. The final approval for this accreditation is given by the Norwegian Directorate of Health.

As part of the process to become a Baby-Friendly Health Station, a user survey is being conducted. The health station is asking all pregnant women in their 32nd week of pregnancy (who have attended two or more prenatal check-ups with a midwife at the health station) to answer questions about the breastfeeding guidance provided by the health station. The aim is to find out whether pregnant women receive adequate information about breastfeeding during their prenatal check-ups at the health station.

We hope you can take a few minutes to complete the survey before you leave the health station today. It should take about 5 minutes to answer all the questions.

You can access the survey by following the link or using the QR code below:

[Insert link here]

or:

[Insert QR code here]

The survey is anonymous, and only the Norwegian Directorate of Health will have access to the responses. The health station will receive a summary report.

Thank you in advance for your participation!

Kind regards

The Norwegian Directorate of Health

Information to mothers with 6-week-old babies

Helsedirektoratet

To mothers with 6-week-old babies

The health station you attend is committed to providing the best possible support for breastfeeding. As part of this, they are working towards becoming accredited as a Baby-Friendly Health Station. This means that the health station has the theoretical and practical knowledge necessary to provide effective breastfeeding guidance. The Norwegian Directorate of Health is responsible for approving health stations that meet the criteria.

As part of the process to become a Baby-Friendly Health Station, user surveys are being conducted. The health station is asking all mothers with 6-week-old infants to answer questions regarding the station's breastfeeding support.

The aim of the survey is to gain insight into the type of follow-up you have received since being discharged from the hospital. It is also important for us to understand your experiences with the support and assistance provided, including both what has been helpful and areas where improvements can be made.

We hope you can take a few minutes to complete the survey before you leave the health station today. It should take about 5 minutes to answer all the questions.

You can access the user survey by following the link or using the QR code:

[Insert link here]

or:

[Insert QR code here]

The survey is anonymous, and only the Norwegian Directorate of Health will have access to the responses. The health station will receive a summary report.

Thank you in advance for your help!

Kind regards

The Norwegian Directorate of Health