Healthy Babies, Healthy Families: Postpartum and Postnatal Guidelines

Second Edition
January 2020

nova scotia health authority

Reproductive Care Program of Nova Scotia

IWK Health Centre

Contents

Introduction

"Childbirth is a milestone, an exciting time when the family grows and a new generation begins. It is also a period of significant child development — a time of great vulnerability but also of great opportunity to benefit from healthy nurturing." [1]

Pregnancy, birth and the transition to parenting are profound but natural family events. From preconception throughout the prenatal, intrapartum and postpartum periods, information and advice is available from countless sources. Childbearing persons and their partners and families use this information to inform choices and decisions regarding self-care and the care of their infants. These decisions are shaped by the support they receive and the care options made available to them, in the context of what they determine to be 'right' or 'best' for themselves and their families.

This second edition of *Healthy Babies, Healthy Families: Postpartum and Postnatal Guidelines* has been developed for health care providers, health care organizations and the health authorities they work within. It includes resources and references for those working directly and indirectly with childbearing families and their infants.

"The major purposes of postpartum and postnatal care are to maintain and promote health … and to foster an environment that offers help and support to the extended family and community for a wide range of related health and social needs. These needs can involve physical and mental health as well as social and cultural issues that can affect health and well-being. Also, new parents need support for parenting and its responsibilities." [2]

Assumptions and Guiding Principles

The postpartum and postnatal guidelines were developed through a series of literature reviews and extensive consultations and collaboration with health care professionals, leaders and senior administrators. The document includes a series of **Assumptions** for the use of the guidelines and five **Guiding Principles.** The **Guidelines** are organized within four interrelated focus areas for action in postpartum/postnatal services.

Assumptions

The guidelines are presented based on the following assumptions:

- The recommended guidelines are targeted to generally healthy childbearing persons and their infants.
- Guidelines should not override the exercise of professional judgment by the health care provider.
- The guidelines support continuous quality improvement and as such these guidelines must regularly be revisited, reviewed, revised and updated to integrate new evidence and practice recommendations.
- Postpartum/postnatal contact/support/assessment services must be available seven days a week, from a variety of sources, and use a number of strategies such as home visits, discharge clinics, hospitals, telephone contact and parent helplines. The approach and type of support should be based on the assessed need, as identified by the parent and the health care provider, and the services available in their area.
- Identifying and addressing health inequities is critical to improving health outcomes for all parents, babies and families. This is reflected throughout the guidelines.[3]

Guiding Principles

Five guiding principles direct and support policies, guidelines and practices. Key factors supporting each principle are outlined below.

Principle 1: Collaboration

Working together effectively facilitates continuous and comprehensive care/support for childbearing families, utilizing the individual and shared knowledge and skills of many individuals and teams.

- Childbearing families are supported by services that are developed and implemented collaboratively, with team members providing services within their scope of practice, minimizing duplication and identifying and addressing gaps to provide a seamless continuum of care.
- Effective and respectful communication strategies exist between health care professionals, health care organizations and families.

Principle 2: Competent Work Force

Ongoing professional development for all health care providers supports safe, ethical and evidence-informed practice, which contributes to better health outcomes for childbearing families, infants and their communities.

- Professional development is accessible and relevant to all health care providers.
- Health care providers recognize their professional obligation to ensure competence in practice and to self-identify professional development needs.
- Professional development includes a cultural competence approach, which addresses cultural differences, cultural humility, sensitivity, sharing knowledge of cultures and building communication skills.[4]
- Health care providers caring for childbearing families engage in sensitive and ethical conversations related to informed choices for care, using gender-inclusive language and trauma-informed approaches and promoting cultural safety.[4–7]

Principle 3: Family-Centred

The Canadian National Family-Centred Maternity and Newborn Care Guidelines define family-centred care as: "(a) complex, multidimensional dynamic process of providing safe, skilled and individualized care. It responds to the physical, emotional, psycho-social and spiritual needs of the woman, the newborn and the family."[8] Cultural competency and trauma-informed approaches, which complement family-centred care, are integrated by health care providers and supported through health care organizational practices.

- A family-centred approach respects the central role of the family and upholds the importance of family members as active and informed caregivers and decision makers concerning their health care.[9–10]
- Relationships between childbearing persons and their families and health care providers are based on information sharing, mutual respect and trust.
- Health care providers demonstrate cultural competence by being sensitive and responsive to cultural and spiritual beliefs, practices, lifestyle, linguistic differences, structural and historical inequities and life experiences.[4, 11–16]
- Health care providers promote cultural safety for childbearing families by respectfully engaging with individuals, families and communities to ensure access to equitable care and trust in care. *Cultural safety is an outcome; the only person who can determine if services are culturally safe is the person receiving them*.[4, 17–18]
- Health care providers demonstrate an understanding of trauma-informed approaches and integrate key principles into their practice, including safety and trustworthiness; opportunities for choice and collaboration; recognition of cultural, historical and gender issues, and use of strengths-based approaches that foster empowerment.[6]
- Health care organizations commit to developing individual and organizational knowledge about trauma and its impact on all aspects of health. Services must be perceived as safe and nurturing and support effective relationships, self-efficacy and hope.[19]
- The attitudes and language of health care providers have an impact on the family's experience of care.[8]
- A family-centred approach respects reproductive rights.[8]
- Individual and family strengths, including the family's support network, are explored and recognized as primary resources for meeting each family's needs and goals.

- The health care environments support childbearing persons, infants, partners and their chosen family supports in being together for healthy postpartum/postnatal development, privacy, fulfilling personal needs, and gaining feelings of competence as parents and caregivers.[9, 20–21]

Principle 4: Baby-Friendly Initiative (BFI)

The Baby-Friendly Initiative (BFI) is a global campaign of WHO and UNICEF to protect, support and promote breastfeeding. BFI helps to improve breastfeeding outcomes for mothers and babies by improving their quality of care. The term 'baby-friendly' was selected because it is inclusive of all babies, regardless of how they are fed.

Given the health, social and economic advantages that breastfeeding confers on mothers, children and society in general; breastfeeding is a critical population health initiative.[22–23] The BFI has been shown to positively impact breastfeeding outcomes. There is a dose-response relationship between exposure to BFI-based interventions and the likelihood of improved breastfeeding outcomes.[24]

- Facilities demonstrate progress towards implementation of the *BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services* through an ongoing self-assessment and external assessment by the Breastfeeding Committee for Canada.[24–26]
- Health care providers are familiar with the BFI 10 Steps and the WHO Code.
- Health care providers inform childbearing families of the key success factors for breastfeeding, including the importance of skin-to-skin contact, exclusivity of breastfeeding, sustained breastfeeding and the impact of non-medically indicated supplementation.[23, 25]
- Childbearing families who make an informed decision to feed their babies breast milk substitutes (infant formula) are supported and guided to choose an option that is acceptable, feasible, affordable, sustainable and safe.[27]
- Breastfeeding support is effective and predictable. It is provided by skilled health care providers and/or trained volunteers who offer ongoing access including scheduled visits with families, or services that allow families to drop in when support is needed.[28]

Principle 5: Strengths-Based

All parents and families deserve to be recognized for the things they are doing well. This acknowledgement and positive reinforcement can help build their confidence and skills to help their child and family thrive.

- Parents and families are recognized and supported as advocates and leaders in the health and well-being of their infants and their families.
- Parents and families are supported and provided with knowledge and skills related to parenting, growth and development.
- Health care providers understand the impact of physical, social, emotional and spiritual environments on the capacity building and self-efficacy of families, and adopt a strengths-based approach.
- Families and health care providers collaborate to promote healthy infant and child development.[29–31]

Guideline Areas

Guidelines are developed to describe the level of quality or attainment required to align with evidence and best practices. The guidelines provided here describe a preferred approach and recommendations to guide action and decision making.

The postpartum and postnatal guidelines are organized into four key areas for action:

- Reducing Health Inequities
- Promoting and Supporting Healthy Infant Development
- Promoting and Supporting Parent Postpartum Physical and Emotional Well-Being
- Supporting Healthy Transitions and Follow-Up

Objectives are outlined for each guideline area, with specific guideline activities following.

Reducing Health Inequities

"A health care system — even the best health care system in the world — will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair." [1]

Health inequities are health differences between population groups that are related to the structural and social determinants of health. Key structural and social determinants of health in Canada include: colonialism, racism, gender, disability, housing, early life, income and income distribution, education, employment and working conditions, social exclusion, food insecurity, social safety nets, health services, unemployment and job security.[1-2] Each of these determinants of health has been shown to have strong effects on the health of Canadians, including maternal and child health.

Objectives:

- To increase understanding of how parental and infant health is affected by the structural and social determinants of health and of resulting health inequities
- To improve communication, collaboration and coordination across the health system and with external partners, to address the structural and social determinants of health and reduce health inequities
- To understand and address the barriers and gaps that prevent access to programs and services

Guidelines:

- Health care providers will document information that reflects medical and social determinants of health using standardized tools (e.g., Healthy Beginnings Screening Tool, Rourke Baby Record).
- Health care organizations will plan and set priorities related to services and programs for childbearing families and infants based on the needs identified through the analysis of population health (ideally community-level) data, with a focus on health inequities.
- Health care providers will assess and consider the structural and social determinants of health when working with postpartum families; in particular, trauma, racism, colonialism, gender, sexual orientation, social safety nets, health services, adequate housing, food security, income, education and employment.[3–9]
- Health care providers will collaborate with other service providers to collectively identify and intervene to reduce health inequities including consideration of the unique needs and capacities of childbearing families and infants.
- Supports are in place in health care organizations to achieve healthy public policy objectives so that social, economic and physical environments enhance the health of childbearing families (e.g., breastfeeding, Baby-Friendly Initiative[10–15], healthy eating, physical activity, injury prevention, avoidance/reduction of substance use).
- Harm reduction strategies and approaches are used to minimize the health and social harms associated with addictions and substance use.
- Health care organizations and health care providers support province-wide, outcomes-based research that uses a diversity and inclusion lens and health equity lens to improve delivery of quality health service to childbearing families.[16]

Promoting and Supporting Healthy Infant Development

"When a caregiver consistently responds to an infant's needs, a trusting relationship and lifelong attachment develops. This sets the stage for the growing child to enter healthy relationships with other people throughout life and to appropriately experience and express a full range of emotions" [1]

The early years are pivotal in an infant/child's ability to learn and create, to love, to trust and to develop a strong sense of themselves. Parent/infant bonding and attachment, beginning in pregnancy and developing rapidly from the moment of birth, has a critical impact on all aspects of infant development. Healthy infant development requires nurturing and is influenced by the family's physical, social and emotional environments.[2]

Objectives:

- To ensure that infants are provided with appropriate and comprehensive care and support, enabling a safe transition from birth to continued responsive care by parents and family
- To provide parents and families with opportunities to meet their learning needs concerning healthy development and safety for their infants
- To provide parents and families with support and feedback in learning to be sensitive and responsive to infant cues, to promote secure attachment and social and emotional development of their infant
- To ensure that parents and families are engaged in discussions that support informed decision making, and include the benefits of exclusive breastfeeding and "the health outcomes for baby and mother related to a decision not to breastfeed"[3]

Guidelines:

- Health care providers will complete a comprehensive infant physical assessment, including red reflex to screen for abnormalities of the eye and Barlow/Ortolani test to screen for hip dysplasia; making appropriate and timely referrals and documenting results for the health care provider responsible for ongoing primary care:[4]
    - Within 24 hours of birth, in accordance with RCP Newborn admission/discharge records[5]
    - Within one week of birth, in accordance with the Rourke Baby Record; and at scheduled well-baby visits at intervals in accordance with the Rourke Baby Record.[6-7] For infants born in hospital, especially those discharged before 24 hours of age, scheduling an assessment 24–72 hours after discharge will facilitate assessment of on-going healthy transition, including successful feeding.[8]
- As part of a comprehensive assessment, health care providers will complete recommended screening tests, ensuring parents' awareness and support and documenting any situations where parents opt out of screening. Screening will be completed without separating infants and parents whenever possible:[9]
    - At 24–36 hours of age, screen for critical congenital heart disease (pulse oximetry screen).[10-11]
    - At 24–48 hours and no later than seven days of age, complete newborn screen (blood spot) for metabolic and genetic conditions included in the Maritime Newborn Screening Program panel.[12]
    - At 24–72 hours of age, and usually prior to discharge for those born in hospital, complete total serum bilirubin (TSB) screen.[13-15]
    - Before discharge, if possible (for those born in hospital), hearing screening is done by the Nova Scotia Hearing and Speech Centres (NSHSC). Note: If not done in hospital, NSHSC will organize hearing screening in the community, ideally within one month.
- As part of comprehensive care health care providers will complete recommended prophylaxis, ensuring parent(s)' awareness and support and documenting any situations where parents opt out of prophylaxis. Prophylaxis will be completed without separating infants and parents whenever possible:
    - Within six hours of birth, administer vitamin K.[16]
    - Within one hour of birth, administer antibiotic ophthalmic ointment, if appropriate.[17-18]

- Health care providers in all settings are vigilant for signs of poor feeding and other signs of illness (e.g., lethargy, temperature instability, jaundice, poor weight gain) and escalate concerns as appropriate.
- Health care organizations have a policy and protocols in place to ensure timely escalation of identified infant health issues.
- Health care providers will support parents to use strategies for analgesia during painful procedures such as heel lancing. Breastfeeding with skin-to-skin is the optimal strategy. For non-breastfed infants, skin-to-skin with non-nutritive sucking or sweet tasting solution is effective for term infants.[19-22]
- Health care providers will monitor infant growth using the WHO growth charts adapted for Canada.[23]
- Health care providers will support the growth and development needs of late preterm infants through particular attention to thermal environments, feeding abilities, weight monitoring using a growth chart appropriate for preterm infants and readiness for discharge.[24–27]
- Health care providers will follow evidence-informed practices regarding promoting skin-to-skin contact for infants and parents.[28–33]
- Health care providers will provide parents who have not made a final decision about infant feeding with information regarding infant feeding to support informed decision making.
- Health care providers will provide parents who choose to breastfeed with sensitive support for early, frequent and responsive feedings, assistance with position and latch, hand expression, exclusive breastfeeding unless supplements are medically indicated, and the use of effective techniques for comfort and milk transfer. Individualized feeding plans will build upon standardized breastfeeding/feeding assessments.[34–39]
- Health care providers will acknowledge and support the key role of partners or other family members as part of the breastfeeding team and offer early individualized information, encouragement and support.[40–41]
- Health care providers will provide parents and caregivers who made an informed decision to use infant formula with support for responsive and safe feeding techniques, feeding plans, appropriate volumes for age, safe formula preparation and storage.[42]
- Health care providers will collaborate with families to make specific plans for ongoing assessment of indicators of infant well-being, including how to access an appropriate primary care provider.[43–45]

- Health care organizations and health care providers will ensure that help with breastfeeding concerns will be available in the early postpartum period and, for those born in hospital, within 24 hours of discharge. Parents should be made aware of available community resources for breastfeeding support and how to access at least one contact for breastfeeding support that is available outside of office hours.[46-47]
- Health care organizations and health care providers will collaborate to develop and maintain a list of key contacts and resources within the network or zone, with particular attention to supports for breastfeeding. Regular review of the list is recommended, annually at minimum, to ensure the information is kept current.
- Health care organizations' and health care providers' practices will support parent/infant attachment and family relationship development including but not limited to
    - Providing information and coaching/modeling regarding
        - Identifying infant states and cues and developing sensitive responses
        - Practicing responsive infant feeding and effective infant soothing strategies
        - Understanding patterns of infant crying and coping strategies
        - Promoting attachment, growth and early language development[48-53]
    - Providing information on the relationship between early experiences in infancy and brain development[54-57]
- Health care organizations' and health care providers' practices will support parent learning regarding health promotion/illness prevention and infant safety by reviewing individual and family learning needs and providing information, and systematically documenting the learning activities.[58] Key discussion points include but are not limited to
    - Evidence-informed infant feeding decisions[55, 59-63]
    - Safe use and risk of feeding bottles, teats and pacifiers[42]
    - Safe infant sleep
    - Car seat safety
    - Strategies for safely coping with infant crying[50, 64-74]
    - Responses to infant illness, injury prevention and immunization based on NS guidelines[4, 75-77]

- Health care organizations have protocols and practices that support the documentation of comprehensive care, including recommended screening, and communication with the responsible primary care provider.[4] For some families, communication may be with several providers who work collaboratively.

Key Online Forms for Infant/Family Assessment

Newborn Admission and Discharge—Primary Care Provider (RCP)
http://rcp.nshealth.ca/chartforms/newborn-admission-discharge

Newborn Growth Charts (RCP)
http://rcp.nshealth.ca/chartforms/newborn-growth-charts

Newborn Assessment—Nursing (RCP)
http://rcp.nshealth.ca/sites/default/files/chartforms/chartform09.pdf

Daily Breastfeeding Record (RCP)
http://rcp.nshealth.ca/sites/default/files/chartforms/chartform06_201702.pdf

Breastfeeding Assessment and Discharge (RCP)
http://rcp.nshealth.ca/chartforms/breastfeeding-assessment-discharge

NS Rourke Baby Record. Includes infant assessment, growth chart and immunization record.
http://rcp.nshealth.ca/chartforms/nova-scotia-rourke-baby-record

WHO Growth Charts for Canada
http://www.rourkebabyrecord.ca/growth_charts

Promoting and Supporting Parent Postpartum Physical and Emotional Well-Being

"Good beginnings make a positive difference in the world, so it is worth our while to provide the best possible care for mothers and babies throughout this extraordinarily influential part of life." [1]

Healthy physical, emotional and relationship adjustment to pregnancy and birth has a positive influence on parenting confidence, satisfaction and ultimately on healthy infant development. Healthy parent/infant attachment, psychosocial adjustment, and seamless transition to home/self-care and community are enhanced by physiological stability at discharge from hospital. Postpartum physical, emotional and spiritual well-being is impacted by the family's physical, social and emotional environments.

Objectives:

- To provide appropriate and comprehensive assessment, care and support to promote healthy physical and emotional adaptation in the postpartum period
- To promote healthy adaptation to parenthood through provision of informational and instrumental support for parent-infant attachment, provision of infant care, and healthy adjustments in family and community relationships

Guidelines:

- Health care providers will complete an initial comprehensive postpartum assessment during the first 24 hours following birth and collaborate with the family to develop a plan for ongoing care and promoting postpartum well-being,[2–6] including making referrals as appropriate, regarding
    - Physiological health
    - Pain management
    - Emotional health
    - Life circumstances
    - Learning needs

- Health care providers will complete a comprehensive psychosocial assessment using a trauma-informed approach, beginning in the prenatal period and continuing into the postpartum period, making appropriate and timely referrals. The assessment includes but is not limited to
    - Psychosocial, emotional and mental health factors
    - Family factors (e.g., social support, relationships, stressful life events, intergenerational trauma, healthy eating, food security, physical activity)
    - Alcohol, tobacco and substance use[7–11]
    - Intimate partner/family violence[12–13]
    - Female genital mutilation/cutting
    - Preventative health practices (e.g., cervical screening, breast screening, immunizations)[14]
- Health care providers will follow the "Guideline for Perinatal Antibody Screening and Rho(D) immune globulin (WinRho®SDF) Administration."[15]
- Health care providers in all settings are vigilant for signs of illness (e.g., significant blood loss, signs of infection, hypertension, significant emotional or mental health concerns) and escalate concerns as appropriate.
- Health care organizations will have a policy and protocols in place to identify health issues that require escalation.
- Health care providers will complete a comprehensive postpartum assessment at 6–8 weeks postpartum and collaborate with the family to establish transfers for ongoing care by other primary care providers as needed.[3, 5, 16–17]
- At the 6–8 week postpartum assessment health care providers will assess for the resolution of any pregnancy-related complications, review chronic health conditions and the need for any medication adjustments, and order any follow-up laboratory testing, including but not limited to
    - Oral Glucose Tolerance Test for women who had gestational diabetes[18]
    - Cardiovascular risk assessment screening for women who had preeclampsia[19]

- Health care providers will assist the parents and family in coping with postpartum transitions by responding to health concerns and fostering confidence. Consistent information, collaboration and providing positive feedback promote growth for new families. Key discussion points include but are not limited to the following (prenatal introduction of the starred topics is often helpful)
    - Desire for review or debrief of birth events[3, 20]
    - Confidence in, and goals for, infant feeding*[21, 22]
    - Breast care
    - Care after cesarean birth[23-27]
    - Perineal and pelvic floor care[28]
    - Recognition and seeking care for physical illness, e.g., infection, excessive bleeding, deep vein thrombosis[25–27]
    - Recognition of and seeking care for postpartum anxiety and/or depression*[16–17]
    - Post-birth sexual health and contraception[29–36]
    - Preparing for adjustments in relationships with partners, older children and other family members*[37]
    - The impact of practices such as female genital mutilation/ cutting.*
    - Over-the-counter medications and use of medications while breastfeeding[38–40]
    - Nutrition[41-42]
    - Physical activity[43-44]
    - Healthy weight[45-47]
    - Importance of managing fatigue*[48–49]
- All new families will be offered postpartum screening, in particular to identify family mental health concerns. For example, assessing for the risk of, or presence of, postpartum depression using a standardized screening tool such as the Edinburgh Postnatal Depression Scale.[16–17] Recommended screening times are at 2 to 6–8 weeks after birth, repeated at four months after birth; with referrals made as appropriate.[50–52]

- Universal postpartum screening is conducted using the Healthy Beginnings screening tool to identify families with risk factors known to negatively impact healthy child development. Families with risk factors that are identified are offered a home assessment with subsequent follow-up based on family needs and goals.
- Health care providers will inform parents of the recommended adult immunizations, based on the Nova Scotia immunization schedule for adults.[53-54]
- Health care organizations will have protocols and practices that support the documentation of comprehensive care, including recommended screening, and communication with the responsible primary care provider.[2]

Supporting Healthy Transitions and Follow-Up

"The first few postpartum weeks are one of the most neglected areas of family-centred care. Preparation for parenthood is rare, either in schools or during pregnancy, even though this is the one career that most people will undertake during their lives. … Few first-time parents truly conceive of the enormous physical and emotional demands made by a new baby on the family." [1]

Pregnancy, birth and the discharge of the parent and infant from hospital to home may be viewed as periods of potential vulnerability when health care providers can have a profound impact on parental and infant well-being. Anticipatory guidance during antepartum and postpartum care, follow-up and successful transition to the community are key to promoting healthy new beginnings for the family. The ability of parents and infants to adapt positively will depend on multiple factors including the social determinants of health and care needs of the families and their infants, access to personal and community-based supports and the quality and availability of health services.

Objectives:

- To support the healthy integration of a new infant/infants into the family
- To support a seamless continuum of care from community to hospital and back to community
- To facilitate linkages to community services and supports for families, and especially families experiencing challenges
- To improve communication and coordination among health care providers and families

Guidelines:

- An individualized, family-centered and local approach to postpartum and newborn care precludes the establishment of strict guidelines for the timing and nature of follow-up contacts with health care providers. However, the work of international, national and local stakeholders promotes the following priorities and timelines for assessing and supporting postpartum and newborn transitions while considering the postpartum parent and newborn as a unit:[2–5]

- Development of a postpartum and postnatal plan that identifies how and when to contact and access services and supports for follow-up or concerns post-discharge, including how to access designated primary care providers. The plan will be based on collaboration and problem solving with the family.[6]
- Sharing the postpartum and postnatal plan with identified health care providers within 24–48 hours after discharge/transition to new health care providers.
- Postpartum and newborn care contacts are recommended to assess parental and newborn well-being: within a week **after birth**, in the baby's second week of life if warranted, one month, and 6–8 weeks following birth (see Rourke Baby Record for a comprehensive list of well-baby visits).[2, 7] For infants born in hospital, especially those discharged before 24 hours of age, scheduling the first infant assessment 24–72 hours after discharge will facilitate assessment of on-going healthy transition, including successful feeding.[8]

- Health care organizations will make postpartum/postnatal support services available and accessible seven days a week to families through a coordinated network of appropriate services and health care providers, including the capacity to assess the parent and/or infant face-to-face as required and the ability to provide interpretation services as needed.[9-10]
- Health care providers will ensure that information is provided to families on how to access emergency services, community supports, peer support and resources (e.g., 911, 811, 211; for breastfeeding help, La Leche League phone numbers for various locations can be found at https://www.lllc.ca/get-help).
- Health care organizations and health care providers will ensure that effective communication processes are in place for key transitions/milestones to ensure continuity of care and support for the postpartum parent and infant. This is of particular importance for families with complex needs.
    - Communication must include a discharge assessment and summary that contains birth and discharge weight and infant feeding plan.[11-12]
    - Additional communication may include areas of strength and concern related to
        - Infant feeding
        - Healthy infant development
        - Parent postpartum physical and mental well-being
        - Challenging life circumstances

    - A copy of this information is provided to the parent(s), utilizing interpretation services as needed.
- Health care organizations and health care providers will collaborate with families to ensure that follow-up plans promote continuity in management of care, and consistent supportive information, utilizing interpretation services as required.[4, 13–14]

Links to Learning Resources to Share with Families with Infants

Infant Feeding

Support for New Parents (NSHA)
http://www.nshealth.ca/i-have-baby

Infant and Parent Care

Loving Care E-Books (NSHA)
http://www.nshealth.ca/i-have-baby

Family Teaching Videos (links to YouTube videos created by IWK staff)
http://www.iwk.nshealth.ca/women-and-newborns-health

Maternal and Child Services in the Nova Scotia Health Authority (links to a variety of services)
http://www.nshealth.ca/maternal-child-health

Rourke Baby Record: Resources for Parents
http://www.rourkebabyrecord.ca/parents

Child Safety Link
http://childsafetylink.ca/

Safe Sleep for Your Baby (PHAC)
https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/safe-sleep/safe-sleep-your-baby-brochure.html

Postpartum sexual concerns — a series of short evidence-based films about sexual and relationship satisfaction of new parents. Page also has postpartum sexuality links for parents.
http://postbabyhankypanky.com/

Nova Scotia 211
http://ns.211.ca/

Welcoming and Celebrating Sexual Orientation and Gender Diversity in Families: From Preconception to Preschool (Best Start Resource Centre)
https://www.beststart.org/resources/howto/pdf/LGBTQ_Resource_fnl_online.pdf

Immunization

Routine Immunization Schedules for Children, Youth & Adults
https://novascotia.ca/dhw/CDPC/documents/Routine-Immunization-Schedules-for-Children-Youth-Adults.pdf

Resources for families in other languages

Public Health Agency of Canada – Maternal Child Health
http://rcp.nshealth.ca/sites/default/files/resources-reports/Arabic%20Maternal%20and%20Child%20Health%20%20Publications%20List%20April%202017.pdf

Canadian Paediatric Society – Care for Kids New to Canada
https://www.kidsnewtocanada.ca/care/parent-info

Appendix A: References

Introduction

1. Vanier Institute of the Family. (2017). *In context: Understanding maternity care in Canada*. Retrieved from http://vanierinstitute.ca/context-understanding-maternity-care-canada/

2. World Health Organization. (2010). *WHO technical consultation on postpartum and postnatal care*. Retrieved from www.who.int/making_pregnancy_safer/documents/WHO_MPS_10_03/en/index.html

Assumptions and Guiding Principles

3. Nova Scotia Department of Health and Wellness. (2016). *Improving social determinants of health and reducing health inequities in Nova Scotia*.

Guiding Principles

Principle 2: Competent Work Force

4. Nova Scotia Health Authority, & Izaak Walton Killam Health Centre. (2017). *Provincial diversity and inclusion framework*. Available via intranet to all NSHA and IWK health care providers.

5. Nova Scotia Health Ethics Network. (n.d.). *Nova Scotia health ethics network*. Retrieved from www.nshen.ca/

6. Nova Scotia Health Authority, Izaak Walton Killam Health Centre, & Nova Scotia Department of Health and Wellness. (2015). *Trauma-informed approaches: An introduction and discussion guide for health and social service providers*. Retrieved from https://novascotia.ca/dhw/addictions/documents/TIP_Discussion_Guide_1.pdf

7. Nova Scotia Health Authority, Izaak Walton Killam Health Centre, & Nova Scotia Department of Health and Wellness. (n.d.). *Your experiences matter*. Retrieved from www.yourexperiencesmatter.com/resources/

Principle 3: Family-Centred

8. Public Health Agency of Canada. (2017). Family-centred maternity and newborn care in Canada: Underlying philosophy and principles. In *Family-centred maternity and newborn care: National guidelines*. Retrieved from www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-1.html

9. Chalmers, B. (2017). *Family-centred perinatal care: Improving pregnancy, birth and postpartum care*. Cambridge, UK: Cambridge University Press.

10. Accreditation Canada. (2015). *Client- and family-centred care in the Qmentum program*. Retrieved from www.cfhi-fcass.ca/sf-docs/default-source/patient-engagement/accredication-canada.pdf

11. Canadian Association of Perinatal and Women's Health Nurses. (2017). *Position statement on cultural safety/humility*. Retrieved from www.capwhn.ca/uploads/documents//CAPWHN_Position_Statement_on_Cultural_Safety_Humility.pdf

12. Etowa, J., & Adongo, L. (2007). Cultural competence: Beyond culturally sensitive care for childbearing black women. *Journal of the Association for Research in Mothering, 9*(2), 73–85. Retrieved from https://jarm.journals.yorku.ca/index.php/jarm/article/download/13801/12854

13. Kinsman Dean, R. A. (2010). Cultural competence: Nursing in a multicultural society. *Nursing for Women's Health, 14*(1), 50–59. Retrieved from https://doi.org/10.1111/j.1751-486X.2010.01507.x

14. Yee, J., Apale, A. N., & Deleary, M. (2011). Sexual and reproductive health, rights and realities and access to services for First Nations, Inuit and Métis in Canada**.** *Journal of Obstetrics and Gynaecology Canada, 33*(6), 633–637. http://dx.doi.org/10.1016/S1701-2163(16)34914-3

15. Rossi, A. L., & Lopez, E. J. (2017). Contextualizing competence: Language and LGBT-based competency in health care. *Journal of Homosexuality, 64*(10), 1330–1349. https://doi.org/10.1080/00918369.2017.1321361

16. *Structural competency*. (n.d.). Retrieved from https://structuralcompetency.org/

17. First Nations Health Authority. (2017). *Cultural humility.* Retrieved from www.fnha.ca/wellness/cultural-humility

18. Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health, 5*(2), 6–41. https://doi.org/10.3138/ijih.v5i2.28981

19. Nova Scotia Health Authority, Izaak Walton Killam Health Centre, & Nova Scotia Department of Health and Wellness. (2015). *Trauma-informed practice at the agency, interagency and leadership levels*. Retrieved from https://novascotia.ca/dhw/addictions/documents/TIP_Discussion_Guide_4.pdf

20. Gaboury, J., Capaday, S., Somers, J., & Purden, M. (2017). Effect of the postpartum hospital environment on the attainment of mothers' and fathers' goals. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(1), 40–50. http://dx.doi.org/10.1016/j.jogn.2016.08.008

21. Ontario Provincial Council for Maternal and Child Health. (2011). *Final report: Maternal newborn advisory committee mother-baby dyad work group*. Retrieved from www.pcmch.on.ca/wp-content/uploads/2015/07/MBDC_Report_2011FEB06.pdf

Principle 4: Baby-Friendly Initiative

22. Breastfeeding Committee for Canada. (2014). *Baby-friendly initiative documents*. Retrieved from http://breastfeedingcanada.ca/bfi.aspx

23. Public Health Agency of Canada. (2018). Breastfeeding. In *Family-centred maternity and newborn care: National guidelines*. Retrieved from www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-6.html

24. World Health Organization. (2018). *Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: The revised baby-friendly hospital initiative*. Retrieved from www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf

25. Breastfeeding Committee for Canada. (2017). *The BFI 10 steps and WHO code outcome indicators for hospitals and community health services*. Retrieved from http://breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

26. Nova Scotia Department of Health and Wellness. (2012). *The baby-friendly initiative: A quality improvement primer.* Retrieved from http://rcp.nshealth.ca/sites/default/files/resources-reports/Baby%20Friendly_WEB_Rev%20Nov%2012.pdf

27. Ontario Public Health Association. (2014). *Informed decision-making & infant feeding: Position paper*. Retrieved from www.opha.on.ca/getmedia/9f1864f4-66e1-4a4e-8064-a547bdd45a59/Informed-Decision-Making-Infant-Feeding-OPHA-Position-Paper.pdf.aspx

28. McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., … MacGillivray, S. (2017). Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database of Systematic Reviews, 2*. doi:10.1002/14651858.CD001141.pub5

Principle 5: Strengths-Based

29. Nova Scotia Department of Education and Early Childhood Development. (2018). *Building connections: An early years framework for Nova Scotia*. Retrieved from www.ednet.ns.ca/earlyyears/index.shtml

30. Reproductive Care Program of Nova Scotia. (2017). *Adapting the 2017 Rourke well baby record for use in Nova Scotia*. Retrieved from http://rcp.nshealth.ca/chartforms/nova-scotia-rourke-baby-record

31. Rourke, L., Leduc, D., & Rourke, J. (2017). *Rourke baby record: Evidence-based infant/child health maintenance guide*. Retrieved from www.rourkebabyrecord.ca/

Guideline Areas

Reducing Health Inequities

1. Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Retrieved from www.thecanadianfacts.org/

2. Raphael, D. (2009). *Social determinants of health: Canadian perspectives* (2nd ed.) Toronto: Canadian Scholars' Press.

3. Benoit, C., Stengel, C., Phillips, R., Zadoroznyj, M., & Berry, S. (2012). Privatisation & marketisation of post-birth care: The hidden costs for new mothers. *International Journal for Equity in Health*, *11*(61), 1–9. https://doi.org/10.1186/1475-9276-11-61

4. Goldberg, L., Aston, M., Burrow, S., & Searle, J. (2017). *Relationships and rural health practices: The experiences of LGBQ+ women and their perinatal care providers*. Retrieved from http://qrbnsandbeyond.ca/finalreport

5. Higginbottom, G. M., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews, 4*(13), 1–30. https://doi.org/10.1186/2046-4053-4-13

6. Stewart, D. E., Vigod, S. N., MacMillan, H. L., Chandra, P. S., Han, A., Rondon, M. B., … Riazantseva, E. (2017). Current reports on perinatal intimate partner violence. *Current Psychiatry Reports, 19* (Article 26). https://doi.org/10.1007/s11920-017-0778-6

7. Winn, A., Hetherington, E., & Tough, S. (2017). Systematic review of immigrant women's experience with perinatal care in North America. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(5), 764–775. https://doi.org/1.0.1016/j.jogn.2017.05.002

8. *Structural competency*. (n.d.). Retrieved from https://structuralcompetency.org

9. National Collaborating Centre for Determinants of Health. (2017). *Let's talk: Racism and health equity.* Retrieved from https://nccdh.ca/resources/entry/lets-talk-racism-and-health-equity

10. Breastfeeding Committee for Canada. (2014). *Baby-friendly initiative documents.* Retrieved from http://www.breastfeedingcanada.ca/

11. Breastfeeding Committee for Canada. (2017). *The BFI 10 steps and WHO code outcome indicators for hospitals and community health services*. Retrieved from http://www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

12. Brown, C. R. L., Dodds, L., Attenborough, A., Bryanton, J., Elliott Rose, A., Flowerdew, G., … Semenic, S. (2013). Rates and determinants of exclusive breastfeeding in first 6 months among women in Nova Scotia: A population-based cohort study. *Canadian Medical Association Journal Open, 1*(1), E9–E17. doi:10.9778/cmajo.20120011

13. Chalmers, B. (2013). Breastfeeding unfriendly in Canada? *Canadian Medical Association Journal, 185*(5) 375–376. doi:10.1503/cmaj.121309

14. Newhook, J. T., Newhook, L. A., Midodzi, W. K., Goodridge, J. M., Burrage, L., Gill, N., … Twells, L. (2017). Poverty and breastfeeding: Comparing determinants of early breastfeeding cessation incidence in socioeconomically marginalized and privileged populations in the FiNaL study. *Health Equity, 1*(1), 96–102. doi:10.1089/heq.2016.0028

15. Orr, S., Dachner, N., Frank, L., & Tarasuk, V. (2018). Relation between household food insecurity and breastfeeding in Canada. *Canadian Medical Association Journal, 190*(11), 312–319. https://doi.org/10.1503/cmaj.170880

16. Nova Scotia Health Authority, & Izaak Walton Killam Health Centre. (2017). *Provincial diversity and inclusion framework*. Available via intranet to all NSHA and IWK health care providers.

Promoting and Supporting Healthy Infant Development

1. Steinfeld, M. B. (2017). *The importance of infant bonding*. Retrieved from www.ucdmc.ucdavis.edu/medicalcenter/healthtips/20100114_infant-bonding.html

2. Lancet Series Executive Summary. (2016). *Advancing early childhood development: From science to scale*. Retrieved from www.who.int/maternal_child_adolescent/documents/ecd-lancet-exec-summary-en.pdf?ua=1

3. Public Health Agency of Canada. (2018). Breastfeeding. In *Family-centred maternity and newborn care: National guidelines*, 6–9. Retrieved from www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-6.html

4. Reproductive Care Program of Nova Scotia. (2017). *Adapting the 2017 Rourke well baby record for use in Nova Scotia*. Retrieved from http://rcp.nshealth.ca/chartforms/nova-scotia-rourke-baby-record

5. Reproductive Care Program of Nova Scotia. (2014). *Newborn admission and discharge-primary care provider form*. Retrieved from http://rcp.nshealth.ca/chartforms/newborn-admission-discharge

6. Riverin, B., Rourke, L., Leduc, D., & Rourke, J. (2015). Rourke baby record 2014. *Canadian Family Physician*, *61*, 941–955. Retrieved from www.cfp.ca/content/cfp/61/11/949.full.pdf

7. Rourke, L., Leduc, D., & Rourke, J. (2017). *Rourke baby record: Evidence-based infant/child health maintenance guide*. Retrieved from www.rourkebabyrecord.ca/

8. Lemyre, B., Jefferies, A. L., O'Flaherty, P., Canadian Paediatric Society, & Fetus and Newborn Committee. (2018). Facilitating discharge from hospital of the healthy term infant. *Paediatrics & Child Health*, *23*(8), 515–522.

9. Public Health Agency of Canada. (2018). Care during labour and birth *and* Breastfeeding. In *Family-Centred Maternity and Newborn Care: National Guidelines* (Chapters 4 and 6). Retrieved from https://www.canada.ca/en/public-health/services/maternity-newborn-care-guidelines.html

10. Narvey, M., Wong, K., Fournier, A., & Fetus and Newborn Committee. (2017). Pulse oximetry screening in newborns to enhance detection of critical congenital heart disease. *Paediatrics & Child Health, 22*(8), 494-498. Retrieved from https://www.cps.ca/en/documents/position/pulse-oximetry-screening

11. Reproductive Care Program of Nova Scotia. (2017). *Pulse oximetry screening in newborns*. Retrieved from http://rcp.nshealth.ca/clinical-practice-guidelines/pulse-oximetry-screening-newborns

12. Izaak Walton Killam Health Centre. (2017). *Maritime newborn screening program*. Retrieved from www.iwk.nshealth.ca/newbornscreening

13. Reproductive Care Program of Nova Scotia. (2010). *Timing of newborn screening specimen collection*. Retrieved from http://rcp.nshealth.ca/sites/default/files/clinical-practice-guidelines/Timing_of_Newborn_Specimen_Protocol_201004.pdf

14. Reproductive Care Program of Nova Scotia. (2015). *Routine bilirubin screening*. Retrieved from http://rcp.nshealth.ca/clinical-practice-guidelines/routine-bilirubin-screening

15. Barrington, K. J., Sankaran, K., Canadian Paediatric Society, & Fetus and Newborn Committee. (2007, reaffirmed 2018). *Position statement: Guidelines for detection, management and prevention of hyperbilirubinemia in term and late preterm newborn infants*. Retrieved from www.cps.ca/en/documents/position/hyperbilirubinemia-newborn

16. Ng, Eugene & Loewy, A. D., & Fetus and Newborn Committee. (2018). Guidelines for vitamin K prophylaxis in newborns. A joint statement of the Canadian Paediatric Society and the College of Family Physicians of Canada. *Paediatrics & Child Health*, *23*(6), 394–397.

17. Health Canada (2018). Drug product database: Access the database. (2018). Retrieved from: https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html. Cited in Perinatal Services BC. (2018). Perinatal Services BC guideline: Prevention and management of Ophthalmia Neonatorum caused by *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. Retrieved from http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Newborn/PSBC%20Guideline%20Ophthalmia%20Neonatorum_WEB.pdf

18. American Academy of Pediatrics, Committee on Infectious Diseases. (2018). *Red book: 2018–2021 report of the committee on infectious diseases* (31st ed.). Kimberlin, D. W., Brady, M. T., Jackson, M. A., Long, S. S. (Eds.) Elk Grove Village, IL: American Academy of Pediatrics.

19. Benoit, B., Martin Misener, R., Latimer, M., & Campbell-Yeo, M. (2017). Breast-feeding analgesia in infants: An update on the current state of evidence. *Journal of Perinatal & Neonatal Nursing, 31*(2), 145–159. doi:10.1097/JPN.0000000000000253

20. Johnston, C., Campbell-Yeo, M., Disher, T., Benoit, B., Fernandes, A., Streiner, D., … Zee, R. (2017). Skin-to-skin care for procedural pain in neonates. *Cochrane Database of Systematic Reviews*, Issue 2, Article CD008435. doi: 10.1002/14651858.CD008435.pub3

21. Nova Scotia Health Authority, & Izaak Walton Killam Health Centre. (2018). *Skin to skin contact for healthy term infants.* Available via intranet to all NSHA and IWK health care providers.

22. Harrison, D., Larocque, C., Bueno, M., Stokes, Y., Turner, L., Hutton, B., & Stevens, B. (2017). Sweet solutions to reduce procedural pain in neonates: A meta-analysis. *Pediatrics, 139*(1). doi: 10.1542/peds.2016-0955

23. Dietitians of Canada. (2014). *WHO growth charts for Canada*. Retrieved from www.dietitians.ca/Dietitians-Views/Prenatal-and-Infant/WHO-Growth-Charts.aspx

24. Boies, E. G., Vaucher, Y. E., & Academy of Breastfeeding Medicine. (2016). ABM clinical protocol #10: Breastfeeding the late preterm (34–36 6/7 weeks gestation) and early term infants (37–38 6/7 weeks of gestation), second revision, 2016. *Breastfeeding Medicine, 11*(10), 494–500. https://doi.org/10.1089/bfm.2016.29031.egb

25. Radtke, J. (2011). The paradox of breastfeeding-associated morbidity among late preterm infants. *Journal of Obstetrical, Gynecologic & Neonatal Nursing, 40*(1), 9–24. https://doi.org/10.1111/j.1552-6909.2010.01211.x

26. Reproductive Care Program of Nova Scotia. (2016). *Newborn growth charts*. Retrieved from http://rcp.nshealth.ca/chartforms/newborn-growth-charts

27. Whyte, R., & Canadian Paediatric Society. (2017). *Safe discharge of the late preterm infant*. Retrieved from www.cps.ca/en/documents/position/safe-discharge-late-preterm-infant

28. Bigelow, A., & Gillis, D. (2010). *DVDs on mother-infant skin-to-skin contact*. Retrieved from http://people.stfx.ca/abigelow/dvds-mother-infant-skin-to-skin-contact.htm

29. Cleveland, L., Hill, C. M., Pulse, W. S., DiCiccio, H. D., Field, T., & White-Taut, R. (2017). Systematic review of skin to skin care for full term healthy newborns. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(6), 857–869. https://doi.org/10.1016/j.jogn.2017.08.005

30. Moore, E. R., Bergman, N., Anderson, G. C., & Medley, N. (2016). Early skin to skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews, 11*. doi:10.1002/14651858.CD003519.pub4

31. Nova Scotia Health Authority, & Izaak Walton Killam Health Centre. (2017). *A parent's guide to skin to skin contact*. Retrieved from www.iwk.nshealth.ca/sites/default/files/PL-1030-Final-Dec20-2017.pdf

32. Ontario Provincial Council for Maternal and Child Health. (2011). *Final report: Maternal newborn advisory committee mother-baby dyad work group*. Retrieved from www.pcmch.on.ca/wp-content/uploads/2015/07/MBDC_Report_2011FEB06.pdf

33. Shorey, S., He, H. G., & Morelius, E. (2016). Skin-to-skin contact by fathers and the impact on infant and paternal outcomes: An integrative review. *Midwifery, 40*, 207–217. doi:10.1016/j.midw.2016.07.007

34. Reproductive Care Program of Nova Scotia. (2017). *New breastfeeding user forms and user guide*. Retrieved from http://rcp.nshealth.ca/news/new-breastfeeding-forms-user-guide

35. Colson, S. (2010). What happens to breastfeeding when mothers lie back: Clinical applications of biological nurturing. *Clinical Lactation, 1*, 9–12. Retrieved from www.biologicalnurturing.com/assets/Colson%20CL%20Vol%201-1.pdf

36. Jones, E. (2011). The impact of exhaustion on step 6 of the baby friendly initiative. *British Journal of Midwifery, 19*(8), 483–488.

37. Kellams, A., Harrel, C., Omage, S., Gregory, C., Rosen-Carole, C., & Academy of Breastfeeding Medicine. (2017). ABM clinical protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. *Breastfeeding Medicine, 12*(4), 188–198. https://doi.org/10.1089/bfm.2017.29038.ajk

38. Robinson, B. A., & Hartrick Doane, G. (2017). Beyond the latch: A new approach to breastfeeding. *Nurse Education in Practice, 26,* 115–117. http://dx.doi.org/10.1016/j.nepr.2017.07.011

39. Schafer, R., & Genna, C. W. (2015). Physiologic breastfeeding: A contemporary approach to breastfeeding initiation. *Journal of Midwifery & Women's Health, 60*(5), 546–553. doi:10.1111/jmwh.12319

40. Abbass-Dick, J., Stern, S. B., Nelson, L. E., Watson, W., & Dennis C.-L. (2015). Co-parenting breastfeeding support and exclusive breastfeeding: A randomized controlled trial. *Pediatrics, 135*(1), 103–110. http://dx.doi.org/10.1542/peds.2014-1416

41. Rempel, L. A., & Rempel, J. K. (2011). The breastfeeding team: The role of involved fathers in the breastfeeding family. *Journal of Human Lactation, 27*(2), 115–121. https://doi.org/10.1177%2F0890334410390045

42. Nova Scotia Health Authority. (2015). *How to feed your baby with infant formula*. Retrieved from http://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/05115.pdf

43. NICE: National Institute for Health and Care Excellence. (2015). *Postnatal care up to 8 weeks after birth*. Retrieved from www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#planning-the-content-and-delivery-of-care

44. Reproductive Care Program of Nova Scotia. (2015). *RCP quality assessment review: Newborn transition from hospital to home 2010–2015*. Retrieved from http://rcp.nshealth.ca/publications/quality-assessment-review-newborn-transition-2010-2015

45. World Health Organization. (2014). *WHO recommendations on postnatal care of the mother and newborn*. Retrieved from http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf

46. Breastfeeding Committee for Canada. (2017). Step 5. In *The BFI 10 steps and WHO outcome indicators for hospitals and community health services*, 9. Retrieved from www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

47. Breastfeeding Committee for Canada. (2017). Step 10. In *The BFI 10 steps and WHO outcome indicators for hospitals and community health services*, 17. Retrieved from www.breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

48. DiSantis, K. I., Hodges, E. A., Johnson, S. L., & Fisher, J. O. (2011). The role of responsive feeding in overweight during infancy and toddlerhood: A systematic review. *International Journal of Obesity, 35*(4), 480–492. doi:10.1038/ijo.2011.3

49. Karl, D. (2004). Using principles of newborn behavioral state organization to facilitate breastfeeding. *MCN: The American Journal of Maternal Child Nursing, 29*(5), 292–298. http://dx.doi.org/10.1097/00005721-200409000-00006

50. National Centre on Shaken Baby Syndrome. (2016). *What is the period of purple crying?* Retrieved from http://purplecrying.info/what-is-the-period-of-purple-crying.php

51. Parent-Child Relationship Programs. (2018). *Keys to caregiving*. Retrieved from www.pcrprograms.org/

52. Ornstein, A. E., Fitzpatrick, E., Hatchette, J., Woolcott, C. G., & Dodds, L. (2016). The impact of an educational intervention on knowledge about infant crying and abusive head trauma. *Paediatrics & Child Health, 21*(2), 74–78. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC4807799/#

53. Reese, L. S., Heiden, E. O., Kim, K., & Yang, J. (2014). Evaluation of period of purple crying, an abusive head trauma prevention program. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 43*(6) 752–761. https://doi.org/10.1111/1552-6909.12495

54. Smith, P., & Forrester, R. (2017). Maternal time use and nurturing: Analysis of the association between breastfeeding practice and time spent interacting with baby. *Breastfeeding Medicine, 12*(5), 269–278. https://doi.org/10.1089/bfm.2016.0118

55. Parent Health Education Resource Working Group. (2019). *Loving care books*. Retrieved from www.nshealth.ca/i-have-baby

56. Caring for Kids. (2013). *Your baby's brain: How parents can support healthy development*. Retrieved from www.caringforkids.cps.ca/handouts/your_babys_brain

57. Zero-to-Three. (2018). *Brain development*. Retrieved from www.zerotothree.org/espanol/brain-development

58. Reproductive Care Program of Nova Scotia. (2012). *Record of parent teaching / mother baby flowsheet*. Retrieved from http://rcp.nshealth.ca/chartforms/record-parent-teaching-mother-baby-flowsheet

59. Benoit, B., Goldberg, L., & Campbell-Yeo, M. (2016). Infant feeding and maternal guilt: The application of a feminist phenomenological framework to guide clinician practices in breast feeding promotion. *Midwifery, 34*, 58–65. https://doi.org/10.1016/j.midw.2015.10.011

60. Canadian Paediatric Society. (2016). *Practice point: Nutrition for healthy term infants, birth to six months: An overview*. Retrieved from www.cps.ca/en/documents/position/nutrition-healthy-term-infants-overview

61. Health Canada, Canadian Paediatric Society, Dietitians of Canada, & Breastfeeding Committee for Canada. (2014). *Nutrition for healthy term infants: Recommendations from birth to six months*. Retrieved from www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php

62. Ontario Public Health Association. (2014). *Informed decision-making & infant feeding: Position paper*. Retrieved from www.opha.on.ca/getmedia/9f1864f4-66e1-4a4e-8064-a547bdd45a59/Informed-Decision-Making-Infant-Feeding-OPHA-Position-Paper.pdf.aspx

63. Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., … Rollins, N. C. (2016). Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect. *The Lancet, 387*(10017), 475–490. http://dx.doi.org/10.1016/S0140-6736(15)01024-7

64. Parent Health Education Resource Working Group. (2019). *Loving care: Birth to 6 months*. Retrieved from http://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/09045.pdf

65. Parent Health Education Resource Working Group. (2019). *Loving care: 6 to 12 months*. Retrieved from http://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/09046.pdf

66. Parent Health Education Resource Working Group. (2019). *Loving care: Parents and families*. Retrieved from http://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/09048.pdf

67. Best Start Resource Centre. (2017). *Sleep well, sleep safe: A booklet for parents of infants 0–12 months and for all who care for infants*. Retrieved from www.beststart.org/resources/hlthy_chld_dev/pdf/BSRC_Sleep_Well_resource_FNL_LR.pdf

68. Campbell, R., & Phillips-Beck, W. (2017). *Sacred babies: Infant survival curriculum*. Retrieved from www.cps.ca/uploads/imich/B1.1_Sacred_Babies.pdf

69. Public Health Agency of Canada. (2014). *Safe sleep for your baby brochure*. Retrieved from www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/safe-sleep/safe-sleep-your-baby-brochure.html

70. Registered Nurses' Association of Ontario. (2014). *Working with families to promote safe sleep for infants 0–12 months of age.* Retrieved from http://rnao.ca/sites/rnao-ca/files/PromoteSafeSleepForInfant.pdf

71. Rourke, L. (2017). *Evidence summary: Safe sleeping environment*. Retrieved from www.rourkebabyrecord.ca/evidence

72. Caring for Kids. (2017). *Car seat safety*. Retrieved from www.caringforkids.cps.ca/handouts/car_seat_safety

73. Child Safety Link. (n.d.). *Child safety link*. Retrieved from http://childsafetylink.ca/

74. Barr, R. G., Barr, M., Rajabali, F., Humphreys, C., Pike, I., Brant, R., … Singhal, A. (2018). Eight-year outcome of implementation of abusive head trauma prevention. *Child Abuse & Neglect, 84,* 106–114. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/30077049

75. Canadian Paediatric Society. (2016). *A harmonized immunization schedule for Canada: A call for action*. Retrieved from www.cps.ca/en/documents/position/harmonized-immunization-schedule-Canada

76. Nova Scotia Department of Health and Wellness. (2019). *Routine immunization schedules for children, youth & adults*. Retrieved from https://novascotia.ca/dhw/CDPC/documents/Routine-Immunization-Schedules-for-Children-Youth-Adults.pdf

77. Public Health Agency of Canada. (2017). *A parent's guide to vaccination*. Retrieved from www.canada.ca/en/public-health/services/publications/healthy-living/parent-guide-vaccination.html

Promoting and Supporting Parent Postpartum Physical and Emotional Well-Being

1. Gaskin, I. M. (n.d.). *Ina Mae Gaskin quotes*. Retrieved from www.azquotes.com/author/37677-In

2. American College of Obstetricians and Gynecologists. (2016). Committee opinion no. 666: Optimizing postpartum care. *Obstetrics & Gynecology, 127*(6), e187–e192. doi:10.1097/AOG.0000000000001487

3. NICE: National Institute for Health and Care Excellence. (2015). *Postnatal care up to 8 weeks after birth: Maternal health*. Retrieved from www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#maternal-health

4. Reproductive Care Program of Nova Scotia. (2015). *RCP quality assessment review: Newborn transition from hospital to home 2010–2015*. Retrieved from http://rcp.nshealth.ca/publications/quality-assessment-review-newborn-transition-2010-2015

5. World Health Organization. (2013). *WHO recommendations on care of the mother and newborn*. Retrieved from http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf

6. Fahey, J. O., & Shenassa, E. (2013). Understanding and meeting the needs of women in the postpartum period: The perinatal maternal health promotion model. *Journal of Midwifery & Women's Health, 58*(6), 613–621. https://doi.org/10.1111/jmwh.12139

7. Haastrup, M. B., Pottegård, A., & Damkier, P. (2014). Alcohol and breastfeeding. *Basic & Clinical Pharmacology & Toxicology, 114*(2), 168–173. doi:10.1111/bcpt.12149

8. Koren, G. (2002). *Drinking alcohol while breastfeeding: Will it harm my baby?* Retrieved from www.motherisk.org/women/updatesDetail.jsp?content_id=347

9. Gilbert, N. L., Nelson, C. R. M., & Greaves, L. (2015) Smoking cessation during pregnancy and relapse after childbirth in Canada. *Journal of Obstetrics and Gynaecology Canada, 37*(1), 32–39. https://doi.org/10.1016/S1701-2163(15)30360-1

10. Mourh, J., & Rowe, H. (2017). Marijuana and breastfeeding: Applicability of the current literature to clinical practice. *Breastfeeding Medicine, 12*(10), 582–596. https://doi.org/10.1089/bfm.2017.0020

11. Ordean, A., Wong, S., & Graves, L. (2017). SOGC clinical practice guideline no. 349: Substance use in pregnancy. *Journal of Obstetrics and Gynaecology Canada, 39*(10), 922–937. https://doi.org/10.1016/j.jogc.2017.04.028

12. Women's College Hospital. (n.d.). *Responding to domestic violence in clinical settings*. Retrieved from www.dveducation.ca

13. Nova Scotia Advisory Council on the Status of Women. (2017). *Nova Scotia domestic violence resource centre*. Retrieved from www.nsdomesticviolence.ca/

14. Walker, L. O., Murphey, C. L., & Nichols, F. (2015). The broken thread of health promotion and disease prevention for women during the postpartum period. *The Journal of Perinatal Education, 24*(2), 81–92. http://doi.org/10.1891/1058-1243.24.2.81

15. Reproductive Care Program of Nova Scotia. (n.d.). *Rh program of Nova Scotia*. Retrieved from http://rcp.nshealth.ca/rh

16. BC Reproductive Mental Health Program, & Perinatal Services BC. (2014). *Best practice guidelines for mental health disorders in the perinatal period*. Retrieved from www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/MentalHealthDisordersGuideline.pdf

17. Perinatal Services BC. (2018). *Edinburgh postnatal depression scale*. Retrieved from www.perinatalservicesbc.ca/health-professionals/professional-resources/health-promo/edinburgh-postnatal-depression-scale-(epds)

18. Diabetes Care Program of Nova Scotia Working Group. (2014). Pregnancy and Diabetes Guidelines: Approaches to Practice. Retrieved from http://diabetescare.nshealth.ca/sites/default/files/files/Preg%26DMGuidelines2014.pdf

19. American College of Obstetricians and Gynecologists. (2016). Committee opinion no. 666: Optimizing postpartum care. *Obstetrics & Gynecology, 127*(6), e187–e192. doi:10.1097/AOG.0000000000001487

20. Mercer, R. T., & Walker, L. O. (2006). A review of nursing interventions to foster becoming a mother. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 35*(5), 568–582. https://doi.org/10.1111/j.1552-6909.2006.00080.x

21. Hinic, K. (2016). Predictors of breastfeeding confidence in the early postpartum period. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 45*(5), 649–660. http://dx.doi.org/10.1016/j.jogn.2016.04.010

22. Jonas, W., Atkinson, L., Steiner, M., Meaney, M. J., Wazana, A., & Fleming, A. S. (2015). Breastfeeding and maternal sensitivity predict early infant temperament. *Acta Paediatrica, 104*(7), 678–686. https://doi.org/10.1111/apa.12987

23. NICE: National Institute for Health and Care Excellence. (2017). *Cesarean section*. Retrieved from www.nice.org.uk/search?q=Cesarean+section

24. Johansson, M., Hildingsson, I., & Fenwick, J. (2013). Fathers want to stay close to their partner and new baby in the early postnatal period: The importance of being able to room in after a surgical birth. *Sexual & Reproductive Healthcare 4*(1), 35–36. http://dx.doi.org/10.1016/j.srhc.2012.11.002

25. Suplee, P. D., Kleppel, L., & Bingham, D. (2016). Discharge education on maternal morbidity and mortality provided by nurses to women in the postpartum period. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 45*(6), 894–904. http://dx.doi.org/10.1016/j.jogn.2016.07.006

26. Quinlan, J., & Murphy, N. (2015). Cesarean delivery: Counseling issues and complication management. *American Family Physician, 91*(3), 178–184. Retrieved from www.aafp.org/afp/2015/0201/p178.html

27. Association of Women's Health, Obstetric and Neonatal Nurses. (2016). *Post-birth warning signs: Postpartum discharge education checklist*. Retrieved from http://nwhjournal.org/cms/attachment/2075726627/2069832130/mmc1.pdf

28. Joanna Briggs Institute. (2011). The Joanna Briggs Institute best practice information sheet: The effectiveness of pelvic floor muscle exercises on urinary incontinence in women following childbirth. *Nursing and Health Science, 13*(3), 378–381. doi:10.1111/j.1442-2018.2011.00617.x

29. Rosen, N. O., Bailey, K., & Muise, A. (2017). Degree and direction of sexual desire discrepancy are linked to sexual and relationship satisfaction in couples transitioning to parenthood. *The Journal of Sex Research*, *55*(2), 1–12. https://doi.org/10.1080/00224499.2017.1321732

30. Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., … Whelan, A. M. (2015). Canadian contraception consensus (Part 1 of 4). *Journal of Obstetrics and Gynaecology Canada, 37*(10), 936–938. https://doi.org/10.1016/S1701-2163(16)30033-0

31. Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., … Whelan, A. M. (2015). Canadian contraception consensus (Part 2 of 4). *Journal of Obstetrics and Gynaecology Canada, 37*(11) 1033–1035. https://doi.org/10.1016/S1701-2163(16)30054-8

32. Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., … Whelan, A. M. (2016). Canadian contraception consensus (Part 3 of 4): Chapter 7 – Intrauterine contraception. *Journal of Obstetrics and Gynaecology Canada, 38*(2), 182–222. https://doi.org/10.1016/j.jogc.2015.12.002

33. Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., … Whelan, A. M. (2016). Canadian contraception consensus (Part 3 of 4): Chapter 8 – Progestin-only contraception. *Journal of Obstetrics and Gynaecology Canada, 38*(3), 279–300. https://doi.org/10.1016/j.jogc.2015.12.003

34. Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., … Whelan, A. M. (2017). Canadian contraception consensus (Part 4 of 4): Chapter 9: Combined hormonal contraception. *Journal of Obstetrics and Gynaecology Canada, 39*(4), 229–268.e5. https://doi.org/10.1016/j.jogc.2016.10.005

35. Society of Obstetricians and Gynaecologists of Canada. (2015). Canadian contraception consensus: Chapter 6: Permanent contraception. Journal of *Obstetrics and Gynaecology Canada, 37*(11), S25–S39. https://doi.org/10.1016/S1701-2163(16)39377-X

36. Heller, R., Cameron, S., Briggs, R., Forson, N., & Glasier, A. (2016). Postpartum contraception: A missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. *The Journal of Family Planning and Reproductive Health Care, 42*(2), 93. http://dx.doi.org.ezproxy.library.dal.ca/10.1136/jfprhc-2014-101165

37. Chapman, J. K., & Hart, S. L. (2017). The transition from mother-of-one to mother-of-two: Mothers' perceptions of themselves and their relationships with their firstborn children. *Infant Mental Health Journal, 38*(4), 475–485. https://doi.org/10.1002/imhj.21650

38. The Hospital for Sick Children. (n.d.). *Motherisk*. Retrieved from www.motherisk.org/

39. U.S. National Library of Medicine. (n.d.). *LactMed: Drugs and lactation database*. Retrieved from https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

40. Texas Tech University Health Sciences Center. (n.d.). *The infant risk center: For medication safety during pregnancy and lactation*. Retrieved from www.infantrisk.com/

41. Health Canada. (2010). Prenatal nutrition guidelines for health professionals – Background on Canada's Food Guide. Retrieved from: https://www.canada.ca/en/health-canada/services/publications/food-nutrition/prenatal-nutrition-guidelines-health-professionals-background-canada-food-guide-2009.html

42. O'Connor, D. L., Blake, J., Bell, R., Bowen, A., Callum, J., Fenton, S., … Cheung, A. (2016). Canadian consensus on female nutrition: Adolescence, reproduction, menopause, and beyond. *Journal of Obstetrics and Gynaecology Canada, 38*(6), 508-554.e18. Retrieved from https://www.jogc.com/article/S1701-2163(16)00042-6/abstract

43. Childers, C. (2016). Protecting the pelvic floor during pregnancy. *International Journal of Childbirth Education, 31*(4), 10–13.

44. Canadian Society for Exercise Physiology. (2019). 2019 Canadian guideline for physical activity throughout pregnancy. Retrieved from https://csepguidelines.ca/wp-content/uploads/2018/10/4208_CSEP_Pregnancy_Guidelines_En_P2A.pdf

45. Neville, C. E., McKinley, M. C., Holmes, V. A., Spence, D., & Woodside, J. V. (2014). The effectiveness of weight management interventions in breastfeeding women: A systematic review and critical evaluation. *Birth, 41*(3), 223–236. https://doi.org/10.1111/birt.12111

46. Polheber, A., & Feutz, K. (2017). Implementing an evidence-based outpatient program to reduce postpartum weight retention. *Nursing for Women's Health, 21*(4), 284–295. https://doi.org/10.1016/j.nwh.2017.06.008

47. Woolcott, C., Dodds, L., Ashley-Martin, J., & Piccinini-Vallis, H. (2016). Distribution of pregnancy-related weight measures. *Canadian Family Physician, 62*(7), e400–e406. Retrieved from www.cfp.ca/content/62/7/e400

48. Doering Runquist, J. J., Morin, K., & Stetzer, F. C. (2009). Severe fatigue and depressive symptoms in lower-income urban postpartum women. *Western Journal of Nursing Research, 31*(5). https://doi.org/10.1177%2F0193945909333890

49. Jones, E. (2011). The impact of exhaustion on step 6 of the baby friendly initiative. *British Journal of Midwifery, 19*(8), 483–488. doi:10.12968/bjom.2011.19.8.483

50. Bobo, W. V., & Yawn, B. P. (2014). Concise review for physicians and other clinicians: Postpartum depression. *Mayo Clinic Proceedings, 89*(6), 835–844. doi:10.1016/j.mayocp.2014.01.027

51. MacDonald, J., & Flynn, C. (2012). *Mothers' mental health toolkit* (2nd ed.). Retrieved from www.iwk.nshealth.ca/themes/iwkhc/downloads/mmh-toolkit.pdf

52. Sharma, V., & Sharma, P. (2012). Postpartum depression: Diagnostic and treatment issues. *Journal of Obstetrics and Gynaecology Canada, 34*(5), 436–442. Retrieved from https://www.jogc.com/article/S1701-2163(16)35240-9/pdf

53. Nova Scotia Department of Health and Wellness. (2017). *Nova Scotia immunization manual*. Retrieved from https://novascotia.ca/dhw/cdpc/documents/Immunization-Manual.pdf

54. Nova Scotia Department of Health and Wellness. (2019). *Routine immunization schedules for children, youth & adults.* Retrieved from https://novascotia.ca/dhw/CDPC/documents/Routine-Immunization-Schedules-for-Children-Youth-Adults.pdf

Supporting Healthy Transitions and Follow Up

1. Chalmers, B. (2017). *Family-centred perinatal care: Improving pregnancy, birth and postpartum care*. Cambridge, UK: Cambridge University Press.

2. American College of Obstetricians and Gynecologists. (2016). Committee opinion no. 666: Optimizing postpartum care. *Obstetrics & Gynecology, 127*(6), e187–e192. doi:10.1097/AOG.0000000000001487

3. Haran, C., van Driel, M., Mitchell, B., & Brodribb, W. (2014). Clinical guidelines for postpartum women and infants in primary care — A systematic review. *BMC Pregnancy and Childbirth, 14*(51). https://doi.org/10.1186/1471-2393-14-51

4. NICE: National Institute for Health and Care Excellence. (2015). *Postnatal care up to 8 weeks after birth: Maintaining infant health*. Retrieved from www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#planning-the-content-and-delivery-of-care

5. World Health Organization. (2013). *WHO recommendations on care of the mother and newborn*. Retrieved from http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf

6. Perinatal Services BC. (2011). *Obstetrics guideline 20: Postpartum nursing care pathway*. Retrieved from www.perinatalservicesbc.ca/health-professionals/professional-resources/pathways-toolkits/postpartum-nursing-care-pathway

7. Reproductive Care Program of Nova Scotia. (2017). *Adapting the 2017 Rourke well baby record for use in Nova Scotia*. Retrieved from: http://rcp.nshealth.ca/chartforms/nova-scotia-rourke-baby-record

8. Lemyre, B., Jefferies, A. L., O'Flaherty, P., Canadian Paediatric Society, & Fetus and Newborn Committee. (2018). Facilitating discharge from hospital of the healthy term infant. *Paediatrics & Child Health*, *23*(8), 515–522.

9. Breastfeeding Committee for Canada. (2017). *The BFI 10 steps and WHO code outcome indicators for hospitals and community health services*. Retrieved from http://breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

10. Reproductive Care Program of Nova Scotia. (2015). *RCP quality assessment review: Newborn transition from hospital to home 2010–2015*. Retrieved from http://rcp.nshealth.ca/publications/quality-assessment-review-newborn-transition-2010-2015

11. Reproductive Care Program of Nova Scotia. (2017). *Breastfeeding assessment and discharge*. Retrieved from http://rcp.nshealth.ca/chartforms/breastfeeding-assessment-discharge

12. Reproductive Care Program of Nova Scotia. (2014). *Newborn admission / discharge*. Retrieved from http://rcp.nshealth.ca/chartforms/newborn-admission-discharge

13. Barimani, M., & Vickstrom, A. (2015). Successful early postpartum support linked to continuity management, informational and relational continuity. *Midwifery, 31*(8), 811–817. https://doi.org/10.1016/j.midw.2015.04.009

14. Kurth, E., Krähenbühl, K., Eicher, M., Rodmann, S., Fölmli, L., Conzelmann, C., & Zemp, E. (2016). Safe start at home: What parents of newborns need after early discharge from hospital — A focus group study. *BMC Health Services Research, 16*(82), 1–14 https://doi.org/10.1186/s12913-016-1300-2