



Baby-Friendly Hospital Initiative Congress

October 24-26, 2016

World Health Organization Headquarters
Geneva, Switzerland

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Executive summary

More than 300 people attended the Baby-friendly Hospital Initiative (BFHI) Congress which took place from 24 to 26 October made up of over 130 government delegates, over 20 development partners (NGOs, international professional associations and donors) and a number of technical professionals from UNICEF and WHO country, regional and headquarter offices. These met to discuss and share successes as well as lessons learned from the implementation of the BFHI. They worked to help shape the operational guidance for future implementation of the Initiative.

High-level officials of WHO and UNICEF welcomed all participants and opened the Congress. The objectives of the BFHI Congress were then presented:

- Celebrate achievements in improving quality of care for breastfeeding mothers
- Examine the current status of the Baby-friendly Hospital Initiative
- Discuss new guidance on country implementation of the Ten Steps for Successful Breastfeeding
- Form or strengthen regional networks to improve country programmes for maternity facilities

Four mothers from Australia, Cameroon, Ecuador, and Switzerland shared their own personal experience, the kind of support they received and how this allowed them to feel confident to breastfeed. Representatives of six countries (Bolivia, China, Ireland, Kenya, Kuwait and USA) presented their case studies reflecting their journey in the implementation of BFHI, the current status, lessons learned, challenges and recommendations.



In addition, experts presented the latest science on breastfeeding, the number of lives that could be saved, the economic impact, the long term health benefits and the need for strong political commitment to raise exclusive breastfeeding rates under the framework of the Global Nutrition Targets for 2025, the Sustainable Development Goals and the broader Maternal, Newborn, Child and Adolescent health context.

The majority of the Congress was dedicated to discussion of the updated guidance on protection, promotion and support of breastfeeding in maternity facilities. Over the course of the Congress, representatives of the External Review Group, which supports the drafting of this guidance,

presented key content on the expectations of each maternity facility, incorporation of BFHI practices into national standards of care, capacity strengthening, external assessment processes, funding, incentives for facilities, scale-up strategies, and national organization of the Initiative. Following each speaker, working groups operating in different languages (Arabic, English, Portuguese, Russian and Spanish) discussed the key issues from the guidance and brought their suggestions back to the plenary for synthesis. Key messages developed from the working groups included:

- Breastfeeding must be treated as the norm in all countries
- BFHI should be mainstreamed as much as possible into other programmes, initiatives, policies
- Advocacy for BFHI must be increased at the global and national levels
- BFHI should cover both healthy and preterm/LBW newborns
- BFHI should cover public and private facilities, not just public facilities
- The Code should remain a strong part and parcel of the BFHI
- Global BFHI guidance should recognize different country contexts
- There are challenges to operationalizing all these issues

Participants had numerous other opportunities for learning and networking. Regional groupings of countries met twice during the Congress to enable cooperation among countries and commit to supporting implementation and follow up after the BFHI Congress. An evening reception, breaks and lunches allowed participants to interact informally. Thirty countries presented posters on BFHI implementation, compliance with the Code, certification processes and contextual adaptations.



Queen Letizia Ortiz Rocasolano of Spain discusses poster presentations with Congress participants.

Introduction

The Baby-Friendly Hospital Initiative (BFHI) was launched in 1991 by WHO and UNICEF to further the protection, promotion and support of breastfeeding in maternity facilities all around the world, incentivizing the adoption of policies and care practices for the successful start to exclusive breastfeeding and ensuring adherence to the Code of Marketing of Breast-milk Substitutes (BMS).

During the last quarter century, the BFHI's Ten Steps to Successful Breastfeeding have become global guidance, more than 20,000 maternity facilities have been designated as being "Baby-Friendly", thousands of health workers have attended the training courses and BFHI has proven impact to increase the likelihood of babies being exclusively breastfed for the first six months. But scaling up to full coverage and long-term sustainability while maintaining quality of the Initiative have proven to be challenging for many countries.

The 25th anniversary of the Initiative was the perfect moment to celebrate the successes from the past and to set a future course to ensure that every newborn receives the appropriate care that enables breastfeeding immediately after birth. To this end, WHO and UNICEF hosted the 2016 BFHI Congress. The objectives of the BFHI Congress were to:

- Celebrate achievements in improving quality of care for breastfeeding mothers
- Examine the current status of the Baby-friendly Hospital Initiative
- Discuss new guidance on country implementation of the Ten Steps for Successful Breastfeeding
- Form or strengthen regional networks to improve country programmes for maternity facilities

More than 300 people attended the Congress, representing over 130 government delegates, over 20 development partners (NGOs, international professional associations and donors) and a number of technical professionals from UNICEF and WHO country, regional and headquarter offices.



Opening ceremony



High-level officials of WHO, UNICEF, and Member States welcomed all participants and opened the Congress. Anne Marie Worning, WHO's Assistant Director General, Family Women and Children Cluster, began with a description of the importance of breastfeeding and the context of breastfeeding within WHO. She emphasized the irreplaceability of breast milk, the emotional bond between mother and child, and psychomotor and social developmental outcomes. She pointed out how the full benefits of breastfeeding are, however, reserved for a minority of children. She also described WHO's new standards for improving quality of maternal and newborn care in health facilities, based partially on the Ten Steps to Successful Breastfeeding. The Baby-Friendly Hospital Initiative can provide the detail and infrastructure of support to ensure that breastfeeding support is appropriately managed.

Marilena Viviani, Director of UNICEF's Geneva Liaison Office welcomed the participants on behalf of UNICEF. She described how the Congress is an opportunity to recognize the progress made in the last 25 years but also to examine work that still needs to be done. She described the Global Breastfeeding Advocacy Initiative, led by UNICEF and WHO, in collaboration with international partners. The initiative advocates with countries to implement the International Code of Marketing Breast-milk Substitutes, strengthen family leave and workplace policies, and improve access to breastfeeding support in health facilities and communities.



Francesco Branca, Director, WHO Department of Nutrition for Health and Development, described the joint WHO/UNICEF collaboration in encouraging all maternity facilities to protect, promote and support breastfeeding to ensure that the babies born in these facilities are given nourishment of the highest quality. What started as baby steps in 1991 has grown into a global movement.

Sophie Gregoire-Trudeau, First Lady of Canada, welcomed the BFHI Congress participants via video link. She described how infant health and care for mothers is a priority for Canada and that the BFHI

strongly supports breastfeeding in maternity facilities. She offered her congratulations and wishes for a successful BFHI Congress.



difficulties.

Jurate Sabaliene, Vice-Minister of Health of Lithuania (the host of the 2014 BFHI global network meeting) described how the BFHI has led to healthier and safer mothers and babies in Lithuania. During the last ten years, neonatal mortality in Lithuania has dropped to 2.5 per 1000 exclusive breastfeeding has increased by 30%. Many women face difficulties at the start of breastfeeding, but BFHI is key in helping address these

Letizia Ortiz Rocasolano, Queen of Spain, participated in the opening morning of the BFHI Congress. The Queen chose not to give a speech, but listened to many of the speeches and commented on the importance of accommodating new mothers needs when they go back to work. The Queen visited the posters and spoke with country representatives about their experiences with implementing the BFHI. She then participated in a small reception before having to depart for other responsibilities.



Laurence Grummer-Strawn, a Technical Officer in WHO's Department of Nutrition for Health and Development offered a tribute to two of the major contributors to the creation and development of BFHI who passed away in 2016. Dr Audrey Naylor developed the model hospital policy that formed the basis of the 1989 Ten Steps to Successful Breastfeeding and created the first BFHI training course. Dr Miriam Harriet Labbok oversaw the 2009 revision of the BFHI

Guidance and served on the External Review Group writing the 2017 Guidance up until the time of her death. He then presented the objectives of the BFHI Congress with a description of the ways each were to be addressed.

The lived experiences with maternity care and breastfeeding

A panel of mothers from Australia, Cameroon, Ecuador and Switzerland presented their personal experiences with childbirth and breastfeeding from around the world. They described experiences of wonderful care from supportive nurses in Baby-Friendly hospitals but also negative experiences with excessive supplementation, missed diagnoses of “tongue tie,” postpartum depression, and allergic reactions to formula. The women shared a high value of breastfeeding, with one woman saying “I think breast milk is divine food cooked by God himself – with the right temperature, the necessary nutrients, synchronized with baby’s demands. “



Case studies' reports



UNICEF and WHO collected in-depth information from 37 countries on the current status of the BFHI, key challenges, lessons learned, and advice for shaping future directions of the initiative. For 15 countries, these were in the form of case studies and for 22, interviews with key informant were conducted. Maaïke Arts, Nutrition Specialist at UNICEF, gave an overview of the process for these in-depth studies. This was followed by oral presentations from six of the case studies (Bolivia, China, Ireland, Kenya, Kuwait, and the United States).

Carmen Casanovas pointed out the importance of legislation on breastfeeding promotion in **Bolivia**, which made it clear how the BFHI needs to be applied to private facilities that had previously been exempted. They found that institutionalization of BFHI as part of public health policy with a dedicated budget allocation and national level staffing was a critical component of a successful programme. They pointed out challenges in changing health professional training curricula, in monitoring systems, and in building community support systems.



Liu Wei described the challenges of re-designating over 7000 hospitals across the **China**. The designation process includes issues on maternal health and specifically a reduction in caesarean sections. The process is decentralized to the provinces, but still it is impossible to visit all facilities. As a result, checks on BFHI facilities are conducted using surprise visits to selected facilities.

Genevieve Becker described **Ireland's** BFHI programme as involving "All mothers, All babies, All facilities." BFHI was the first health quality

programme in Ireland to have measureable standards and external assessment. BFHI is linked to newer quality of care programmes because the health care quality standards see BFHI participation as evidence of meeting the quality standards. BFHI practices have become integrated into the National Infant Feeding Policy, routine staff induction procedures, and midwifery training.



Betty Samburu discussed a high coverage of hospitals being designated in **Kenya**. They also pointed out many challenges with sustaining the BFHI, including inadequate funding, dependency on external donors, inadequate capacity building, lack of integration of BFHI in training, inadequate human resources, and changes of leadership within the Ministry of Health. Integration of BFHI in country nutrition action plans is a key component of the way forward.



Mona Alsumaie described **Kuwait's** BFHI programme, which has been in existence almost 20 years. To date, only 2 facilities are sustaining the designation. The professionalization of lactation support has been a driving force for the BFHI. Challenges include the fact that the government is subsidizing formula purchases, staff lack training, budgets are insufficient, and there is no effective monitoring system for the BMS Code.



Daurice Grossniklaus described the BFHI programme in the **USA**, which implemented by an independent NGO that has designated facilities since 1996. The pace of designations has skyrocketed in the last few years, due in part to political pressure from the Surgeon General and the First Lady. Two national programs that provided technical assistance to hospitals seeking designation helped over 180 hospitals along the process of becoming Baby-Friendly, using a quality improvement process of learning collaboratives. National monitoring of maternity care practices over time has also driven changes.



Protection, promotion and support of breastfeeding



Participants heard from a number of speakers on the latest science and policy around breastfeeding in 2016. Nemat Hajeebhoy, Deputy Director of Country Impact Nutrition at the Bill & Melinda Gates Foundation summarized the findings of the 2016 Lancet Breastfeeding Series. She pointed out how increasing exclusive breastfeeding rates

could save 820,000 children under 5 each year, reduce infection-related mortality under 3 months by 88%, protect against infections and in the long term, reduce risk of obesity and type 2 diabetes, protect against hospital admissions, and reduce annual costs for healthcare. She described how breastmilk contains substances characterized only in the last few years, including bacteria from the mother's gut microbiome, immune cells primed in the mother's intestine, carbohydrates that shape the baby's microbiome, small RNAs that control genes in the baby, microvesicles (exosomes) that also control genes in the baby, and stem cells that survive in the baby. Despite growing evidence, women still do not have the support they need to breastfeed.

Francesco Branca described the current global nutrition policy context and how breastfeeding fits within it. He highlighted the place of exclusive breastfeeding as one of the World Health Assembly (WHA) six global nutrition targets. He showed how breastfeeding is relevant to a number of the 17 Sustainable Development Goals (SDGs), including improving nutrition, reducing mortality and morbidity, ending poverty, promoting economic growth, and reducing inequalities, improving education, and enhancing sustainability and climate resilience. He described the prominence of breastfeeding in the Second International Conference on Nutrition's Framework for Action. Finally, he discussed the United Nations declaration of a Decade of Action on Nutrition 2016-2025 that gives new impetus to achieving the global targets for improving maternal, infant and young child nutrition.



Anthony Costello, Director of the WHO Department for Maternal, Newborn, Child and Adolescent Health showed how breastfeeding fits neatly into the three pillars of the Global Strategy for Women's, Children's and Adolescent Health (survive, thrive, and transform). He described the survival aspects of breastfeeding in terms of overall child survival, infectious disease deaths, preterm babies, and in natural disasters. He discussed how breastfeeding

contributes to babies thriving, with reduced morbidities and obesity, improved growth, increased intelligence, and improved maternal health. Finally, he described how the enabling environment for breastfeeding must be transformed to disseminate accurate information on the value of breastfeeding, foster positive social attitudes, regulate the breastmilk substitute industry, scale up breastfeeding interventions, and ensure maternity protection. He also presented WHO's new Standards for Improving Quality of Maternity and Newborn Care in Health Facilities, which incorporate most of the BFHI Ten Steps as quality standards.

25 years of BFHI – at global and country level



Felicity Savage, Chairperson of the World Alliance for Breastfeeding Action presented on the 25 year history of the BFHI, going back even further to the informal meetings and documents that led up to the launching of the initiative in 1991. Twelve lead countries (Bolivia, Brazil, Ivory Coast, Egypt, Gabon, Kenya, Mexico, Nigeria, Pakistan, Philippines, Thailand, and Turkey) helped to develop and test the initial implementation guidance, tools, assessors' manual, and interview sheets. Key events in the history of BFHI included the 1989 WHO/UNICEF Joint Statement on the Ten Steps, the 1991 launch, the 2001 Belarus study as the first randomized control trial (RCT) of the BFHI package, and the 2009 revision of the BFHI materials. Key

challenges faced by BFHI over the years have included the need to teach staff complex clinical skills, staff turnover, complexities of hospital assessment process, the HIV pandemic, incorporation of mother friendly standards, backlash on patient safety related to hypoglycaemia, jaundice and child overlaying, and providing sustained breastfeeding support after discharge.

Maike Arts, Nutrition Specialist at UNICEF, presented an overview of country experiences with BFHI based on the 37 case studies and key informant interviews. Most countries describe the BFHI in the context of a much broader policy environment for breastfeeding that includes priorities for quality health care, the Code, maternity protection, and social mobilization around breastfeeding. Funding for BFHI relies on government sources, external donors, and individual facility contributions. Most countries describe coordinating the BFHI out of a central government department, but some have outsourced this to NGOs or are more decentralized to regional governments. Some countries have made adaptations to the Ten Steps, such as by incorporating the Code into individual steps, picking specific “mother-friendly” criteria, or by adding in national priorities in maternal/child care. Countries have modified the assessment process to allow step-wise recognition of different steps or levels of compliance. A few countries have embedded the Ten Steps into broader MCH policies or quality improvement initiatives to help ensure scale up and sustainability. Most countries rely on in-service training as main capacity building strategy for the BFHI. The main challenges for BFHI can be summarized in terms of lack of government ownership, the voluntary nature of implementation, the vertical approach, maintaining momentum and funding over time, and the recurrent costs of training and assessment.



Application of the Code in BFHI



Marcus Stahlhofer, Technical Officer at WHO's Department for Maternal, Newborn, Child and Adolescent Health gave a presentation on the application the International Code of Marketing of Breastmilk Substitutes within the BFHI. The Code is a critical component of the protection of breastfeeding. It contains several restrictions on marketing that pertain to health care systems and to health workers, including:

- No advertising of breast-milk substitutes
 - No donations of BMS to hospitals
 - No free samples
 - No promotion in health services
- No company personnel to advise mothers
 - No gifts or personal samples to health workers
 - No use of space by companies when teaching mothers

As such, it is natural that the Code needs to be applied within maternity facilities and that monitoring for compliance with the Code should be part of any assessment of BFHI. Mr. Stahlhofer also pointed out where the Code can and should be incorporated into the Ten Steps. For Step 1, the breastfeeding policy should incorporate full compliance with the Code as hospital policy. For Step 2, training of hospital staff needs to include training on the Code. For Step 6, procedures need to ensure that BMS are not distributed to infants who do not have a medical indication for its use but also that demonstration of formula preparation for the infants who do need it is done away from breastfeeding mothers. Assessment of facility compliance with the Code includes documentation of paying at least wholesale price for BMS, prohibitions on contact between company staff and pregnant women or mothers, and refusal of gifts, non-scientific literature, equipment, money or support for in-service education or events.

Pre-service training and capacity building

A panel of speakers discussed the challenges of moving from a current BFHI model that depends on repeated in-service training on the Ten Steps to a model with strengthened pre-service training. Frances McConville, Technical Officer in WHO's Department for Maternal, Newborn, Child and Adolescent Health facilitated the panel. She pointed out that a well-prepared and engaged health work force is essential to the implementation of BFHI and the Code. International professional associations are valuable partners to the protection, promotion and support of breastfeeding worldwide. Mary Renfrew, Professor of Maternal and Infant Health at University of Dundee, described the fact currently, many textbooks have wrong information about breastfeeding and health workers are not well taught; therefore, there is a discrepancy across generations. While there

are many studies about how to support breastfeeding, there is still lack of evidence on implementation and education of health workers. There is also a serious evidence gap on how to educate and update all health workers.

Serena Debonnet, Board Member of the International Confederation of Midwives, discussed the role of midwives in supporting normal birth. She pointed out the need to standardize midwifery education and include more information on mother-baby-friendly practices. She also discussed the role of midwives in educating other health care workers. Andre Ndayambaje, Board of Directors of the Council of International Neonatal Nurses, discussed how training and capacity building are not the single work for one organisation or one person. None of us are alone – we all need all of us in a global inter-professional network playing one game towards one goal. Organizations like COINN are committed to improving the quality of care, but need support and funds.

Linda Smith of the International Lactation Consultant Association pointed out that there are already many resources for lactation education. ILCA has an online directory of courses that are rigorous and based on evidence based practices. Some are based in universities and there are textbooks available for nurses, midwives, doctors. There is a lot of information available through the Academy of Breastfeeding Medicine. Some trainings are made through online webinars, mostly in English. Olive Coccooman, Coordinator of the Every Newborn Action Plan (ENAP), described how ENAP provides a roadmap to end preventable mortality in newborns. Breastfeeding, Kangaroo Mother Care and skin-to-skin contact are essential practices. Felicity Savage, Chairperson of the World Alliance for Breastfeeding Action, said that pre-service training is a practical component and maybe the most important part to the implementation of BFHI. When professionals use the tools and skills in practice, seeing and learning how to feed the baby, this changes their attitude because a clinical practice experience gives them understanding.



Operational guidance on protection, promotion and support of breastfeeding in maternity facilities presentations and working group feedback

Introduction to updated guidance

A significant component of the BFHI Congress was the presentation and discussion of new Operational Guidance on the implementation the BFHI in countries around the world. The Guidance is not yet finalized, and feedback from the Congress will be used to shape it further. Laurence Grummer-Strawn, Technical Officer at WHO's Department of Nutrition for Health and Development, presented an introduction to the guidance, describing both the process and the major directions described in the document.

The overall process of revising the BFHI Guidance is overseen by an internal steering committee that was established by WHO and UNICEF in 2015. Two simultaneous processes are underway. To revise the guidelines on patient care, commonly referred to as the Ten Steps to Successful Breastfeeding, WHO created a Guidelines Development Group (GDG). The work of the GDG is governed by the WHO Guidelines Review Committee and has rigorous processes of reviewing evidence and developing recommendation statements. The GDG included 21 systematic reviews on the Ten Steps and systematic reviews on mother preferences and provider perspectives about the Steps. Their work is expected to be concluded by mid-2017.

Simultaneously, to revise the Implementation Guidance for countries operating a BFHI programme, WHO and UNICEF created an External Review Group (ERG). The ERG has met since December 2015 in order to collect information from case-studies, key informant interviews, WHO's global policy survey and review of key documents, and to craft updated Operational Guidance. It is the work of the ERG that was discussed in greater depth at the BFHI Congress. In 2017, the work of these two committees will be merged together into a single guidance document for implementation of the BFHI.

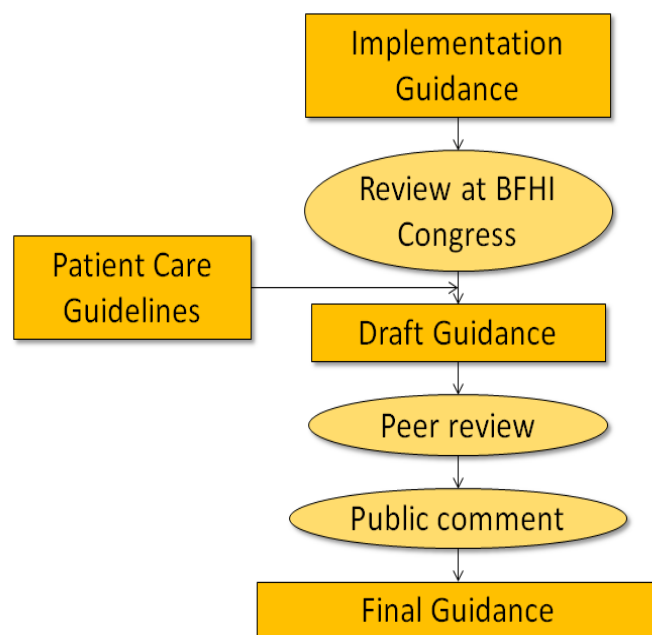


Figure 1: Development of Final BFHI Guidance

The scope of the Guidance will cover only the **role of maternity facilities** in protecting, promoting and supporting breastfeeding. Support for breastfeeding is equally important in communities and primary health care, but the Guidance will not include these domains. Because **preterm and low birth weight newborns** represent a significant portion of births in maternity facilities and need better care for early infant feeding, the new Guidance will include care for this population. Lastly, the Guidance will focus on the **care for breastfeeding** and not on “mother friendly” aspects of care as did the 2009 BFHI guidance. While “mother friendly” care is important for both the mother and the infant, the Guidance cannot cover all aspects of quality of maternity care.

He summarized seven key directions from the new Guidance:

1. The Ten Steps to Successful Breastfeeding are the responsibility of every maternity facility and should not be limited to facilities that voluntarily want to do something extra.
2. Countries need to establish national standards of care based on the Ten Steps that apply to all facilities.
3. The BFHI must include private facilities, not just public ones.
4. The BFHI needs to be integrated with other health care improvement and quality assurance initiatives in order to be sustainable over time.
5. While designation as a Baby-Friendly Hospital is one way to incentivize facilities to make needed changes, other incentives for participation are encouraged.
6. Regular internal monitoring within facilities of both practices and outcomes is a crucial element of the BFHI.
7. Maternity facilities need external assessment for quality assurance, but the process needs to be streamlined enough to be manageable within existing resources.

Topic 1. Implementation in maternity facilities

The more specific content of the Operational Guidance was broken into four parts for presentation and discussion. Julie Stufkens made the first presentation on the implementation of the BFHI within the maternity facilities, on behalf of the External Review Group.

The core purpose of the BFHI is to ensure appropriate care before and during the maternity facility stay in order to facilitate early initiation, success with exclusive breastfeeding in the first six months, and continued breastfeeding for 24 months or more. Facilities are responsible for ensuring that families receive quality, unbiased information about infant feeding. They must also respect the mother’s preferences and support her to successfully feed her newborn in the way she chooses.



Appropriate clinical care is at the heart of the BFHI. The primary responsibility of maternity facilities is to ensure that their clinical practices support breastfeeding. Specific guidelines on the Ten Steps to Successful Breastfeeding are currently under review by the Guidelines Development Group, and as such, could change from the 2009 version.

In addition to ensuring that clinical care is appropriate, maternity facilities must adopt a number of administrative and management procedures in order to support breastfeeding and the sustained application of the clinical procedures. These include:

- Adoption of a written policy on breastfeeding that is routinely communicated to all health care staff
- Full compliance with the International Code of Marketing of Breast-milk Substitutes
- Regularly (at least 2x/year) assessment of the competency of staff to carry out the clinical practices
- Establishment and operation of an ongoing data management system to monitor compliance

With regard to training, it should be noted that each maternity facility is not necessarily responsible for training its own staff on a regular basis. The primary responsibility for building knowledge and skills of health workers resides with the national pre-service education system, and thus, clinical training on the Ten Steps needs to be incorporated into this training. Only where corrective measures are needed, should maternity facilities establish their own training courses. The focus of the training and also of monitoring of capacity building activities should be on knowledge and skills, not on use of a specific curriculum.

For monitoring, systems are needed to regularly evaluate whether clinical practices are being followed. Medical charts, monitoring systems, and maternal questionnaires are options for assessing compliance. If clinical practices are found to be below pre-established thresholds, corrective action such as policy change, retraining, and analysis of problems may be needed.

Maternity facilities will need to engage in a process of quality improvement in order to fully change current practices to come in line with the BFHI standards. Changing health care practices takes time and there are several well-developed models of quality improvement in health care that can be adapted to country needs.

Following each presentation on the Implementation Guidance, participants broke up into nine working groups to provide detailed feedback on the issues presented. Groups operated in English, Spanish, French, Portuguese, and Russian. Some of the ideas that emerged from the working groups included the following¹:

¹ Some comments/ideas were raised more than once in response to different questions. In those cases it is only documented in the most relevant section.

- Implications of extending BFHI to include preterm and low birthweight newborns:
 - There is a need for a single set of steps that apply to all babies, not a separate set for premature/low birthweight infants.
 - Recommending rooming-in for preterm babies will have significant space implications since mothers will need a place to stay for a significant amount of time.
 - Human milk banks are needed to support preterm infants.
 - It needs to be clarified which premature infants are being targeted.
 - Clearer guidelines on skin-to-skin care and Kangaroo Mother Care are needed.
 - There is a need for capacity building of clinical and other staff in supporting breastfeeding for this group, and also for BFHI assessors.
 - There is a need for guidance to address the need for non-nutritive suckling among premature infants and on the appropriate use of human milk fortifiers.
 - There need to be clear criteria on when preterm and low birthweight babies can be put to the breast.



- How to improve monitoring at facility level:
 - Monitoring indicators are needed for all of the Ten Steps.
 - Some participants said that internal monitoring needs to be conducted more frequently than every 6 months. Others said that twice a year is too frequent.
 - Monitoring tools need to be developed and disseminated to facilities.
 - Some countries have used score cards successfully.
 - Computerized monitoring tools are needed. Monitoring indicators need to be incorporated into existing management information systems.
 - A questionnaire administered to mothers upon hospital discharge could evaluate if procedures were followed.
 - Some monitoring can be done with spot checks.
 - The reason why data are needed needs to be communicated clearly.

- How to strengthen the quality improvement process:
 - The national breastfeeding authority has an important role to play
 - Change management is important
 - Each maternity facility needs to have a coordinator of BFHI activities.
 - More examples of quality improvement procedures are needed.
 - There needs to be guidance on how to assess staff competency.
 - BFHI needs to be incorporated into broader hospital quality assurance processes
 - It would be valuable to harness consumer demand. Facilities will listen to parents claiming their rights.
 - A performance contract with a hospital might be a useful tool
- How to expand the scope of the BFHI:
 - Mother-Friendly steps need to be incorporated into BFHI as an Eleventh Step. The Mother-Friendly standards need to be updated.
 - The Code needs to be incorporated as a Step.
 - Pre-service training needs to be integrated (in Step 2)
 - BFHI in community settings is important (the warm chain of support)
 - BFHI should be broadened to include all health facilities (e.g. children's hospitals, paediatric wards), not just maternity facilities.
- More detailed guidelines from WHO are needed:
 - More guidance is needed on breastfeeding after a caesarean section
 - Guidance on application of the International Code needs to be updated to address the latest strategies of BMS companies (e.g. use of social media).
 - The list of medical reasons for supplementation needs to be updated.
 - Better guidelines on conflict of interest are needed.
 - More guidance is needed on how to do internal monitoring.
 - WHO and AAP guidelines need to be better aligned. The role of professional associations needs to be clarified.
 - Global guidelines need to be more regularly translated into other languages besides English.

Topic 2. Setting national healthcare standards

The second section of the Implementation Guidance, dealing with the integration of BFHI standards into national healthcare standards was presented by Randa Saadeh, on behalf of the External Review Group.

Protection, promotion and support for breastfeeding in maternity facilities needs to be integrated into all relevant national policies and standards of care in order to build sustainability and long-term



funding. BFHI cannot last long as a standalone vertical programme. Examples where BFHI can be integrated include the national nutrition policy, a plan of action for breastfeeding, a child survival strategy, or a national development strategy. It is important that the clinical practices defined in the Ten Steps should be written into the standards of care for all professionals who work in maternity facilities. This would include obstetrics/gynaecology, midwifery, paediatrics, neonatology, nursing, or dietetics. Without such incorporation, adherence to the BFHI standards will naturally vary from facility to facility.

As noted earlier, responsibility for building knowledge and skills of health workers concerning these standards should primarily reside with the national pre-service education system. Countries have a mandate to ensure that health workers receive appropriate pre-service training that covers the BFHI clinical standards and the Code and refresher trainings throughout their career. Training needs to include both didactic and practical components. Of course, the training needs of existing health workers also cannot be ignored, but for long-term sustainability, BFHI needs to move away from a model primarily dependent on in-service training. Electronic courses can play a role in training but must be combined with face-to-face interaction and direct observation. It is critical to include components of competency-based assessment.

Some of the ideas that emerged from the working groups included the following:

- How can the BFHI standards be made into national standards?
 - Work at the political level, including via advocacy from international organizations.
 - Include an indicator on breastfeeding in the SDG reports.
 - Breastfeeding needs to be presented and perceived as a human right.
 - Incorporate the BFHI into all relevant policies.
 - Make the BFHI standards mandatory.
 - Incorporate the BFHI into the hospital accreditation system.
 - Incorporate the BFHI into pre-service education and all relevant protocols for clinical management.
 - Strengthen demand creation for BFHI standards
- Strengthening pre-service education:
 - For most countries, pre-service education falls in the domain of the Ministry of Education, not the Ministry of Health, making it more difficult to effect changes in curriculum. In other countries, professional associations control pre-service education so it is not even under government control.
 - The WHO model chapter on breastfeeding for medical textbooks is very helpful.
 - If mother-friendly standards are to be included in BFHI, there is a need for training on the steps.
 - Countries need guidance on how to select trainers for BFHI courses. Master trainers would be helpful. Greater reliance on training of trainers and identification of resource persons were help.

- Comments on in-service education:
 - Physicians groups are traditionally resistant to expanded training on infant feeding, particularly in in-service settings.
 - WHO and UNICEF need to set standards for trainings
 - International Board Certified Lactation Consultants (IBCLCs) and non-governmental organizations can make important contributions in conducting in-service trainings.
 - The Ministry of Health should provide more in-service training opportunities.
 - There is a need for greater flexibility in the required number of hours for training.



- Other:
 - Countries should have a paid staff person to coordinate BFHI.
 - Consider changing the name of the BFHI. BFHI should not be described as an “initiative” since it needs to be ongoing and sustainable.
 - Formula companies should be taxed at a higher rate.
 - Trainings also need to focus on changing attitudes.

Topic 3. National implementation



The third section of the Implementation Guidance, dealing with the external assessment processes and working with maternity facilities to achieve the needed changes, was presented by Rukhsana Haider, on behalf of the External Review Group.

Traditionally, external assessment leading to designation of facilities has been the primary focus of the BFHI. External assessment is a critical component of quality assurance that provides opportunities for feedback and correction. It should operate alongside internal monitoring systems. External assessment can often

identify areas of non-compliance to standards or other deficiencies that internal workers don't easily see on their own.

External assessments would preferably be embedded in other existing systems, such as hospital certification or accreditation, to help institutionalize the process for all facilities and to reduce costs. If such systems do not exist or the BFHI standards cannot be incorporated, it may be necessary to maintain vertical programmes for a time. In this case, the Ministry of Health, health professional organizations, or well-functioning NGOs may operate the external assessment process, but the Ministry of Health should provide oversight.

The traditional external assessment process has been found to be cumbersome and costly for most countries and so streamlining is needed. It is recommended to reduce the number of indicators, number of women or records reviewed. Focus should be on clinical standards and the International Code. Direct observation and maternal interviews are most important sources of information for external assessment. Document reviews, medical chart abstractions, and health care worker interviews are also useful, but less critical.

Facilities must be regularly reassessed at least every 5 years, preferably every 3. This has been a major shortcoming of BFHI in many countries, where facilities that have received the designation are rarely revisited to ensure that the BFHI standards are still applied.

To encourage maternity facilities to make the needed changes, a variety of strategies may be employed to get their attention. Mandatory standards for all facilities would be the strongest incentive and is most equitable for all families in the country. However, mandatory standards are typically fewer in number and rigor, and thus it may be challenging to fully implement all of the Ten Steps in this way. Performance-based financing is a scheme by which facilities receive lower payment rates if they are not in full compliance with quality standards, or vice versa, higher rates for

optimal performance. Paying “extra” for meeting the standards is not likely to be sustainable and goes against the principle of reaching all infants, but penalties for not meeting standards may be more feasible.

BFHI has long assumed that the recognition as being designated as a “Baby-Friendly” facility would serve as a strong incentive to participate in the programme. However, this has not proven to be effective in many countries as coverage remains low. While countries are still free to pursue this option, it is no longer a major focus for the global BFHI. Public accountability on certain quality indicators or outcomes may also incentivize participation if the public understands which practices and outcomes are most desirable.

National BFHI programmes should aim to reach 100% of maternity facilities. However, since this is unlikely to be achieved immediately, plans should be made on how to scale-up efforts over time. Some potential strategies to consider include starting with teaching hospitals to establish standards of care among new health professionals, targeting role model facilities within each region of the country, starting with larger hospitals to have the largest public health impact from the beginning, working with groups of facilities that support each other in a collaborative improvement process, and focusing on a technical assistance approach to help facilities where they most need help.



Some of the ideas that emerged from the working groups included the following:

- How the BFHI could be integrated into hospital accreditation:
 - BFHI designation could serve as part of the accreditation assessment process for maternity facilities. Hospitals that are “Baby-Friendly designated” might be exempt from certain aspects of accreditation.
 - Facility designation should become part of hospital accreditation, as is already the case in several countries.
 - Accreditation will only be valuable if the BFHI standards are mandatory for all facilities.
 - Accreditation schemes vary considerably by country.
 - Incorporation into accreditation standards is much more difficult than it initially appears. Only small steps are likely to be effectively monitored in this way.
- Some groups saw the designation of facilities as a critical part of a successful programme:
 - Removing designation would be “throwing the baby out with the bath water.”
 - Designation is a means of demand generation.
 - The BFHI standards would need to be compulsory in teaching hospitals.
- Other groups saw that designation could be an optional component of BFHI:
 - Implementation of BFHI is too complex for many countries. A phased implementation approach is needed.
 - While the BFHI process is important, designation is not.
 - Designation of facilities should depend on the country.
 - Designation does not always equal good quality. Designation does not lead to sustainability.
- How to improve the assessment/designation process:
 - Government ownership is crucial.
 - Reassessment of facilities needs to be conducted more frequently. Designation must be considered to be time-bound. It is important to be able to remove the designation.
 - Designation of Baby-Friendly facilities should allow for multiple levels of compliance. A phased or step-wise approach is needed.
 - A simple tool for hospital accreditations would be useful.
 - Existing BFHI designation processes can be used but streamlined. Simplified indicators and forms are needed.
 - Consider having minimum standards at global level that countries may then add upon.
 - Better assessment of adherence to the Code is needed in BFHI.



- Assessments should be used more for education of maternity facilities than for policing.
- If assessments are conducted by groups other than the government, there needs to be close collaboration with government.
- Consider the model of one health facility assessing another.
- The Code should be treated as a separate Step for assessment.
- ISO standardisation could be explored.
- Comments on incentivizing participation of maternity facilities:
 - Legislation to achieve 100% compliance is needed, but should be applied gradually over time.
 - Financial incentives are problematic because the funds could be pulled at any time. Incentives should not be about money.
 - If a facility were to receive financial incentives for participating in BFHI, they should reinvest those back into the programme.
 - Use ISO standards as incentives.
 - Applying penalties for non-compliance with standards is tricky. It may be better to talk about disincentives. Fines for violation of the Code would be appropriate, however.
 - Visible score cards and other visible systems might be useful.
 - Pay-for-performance would be one way to incentivize designation by paying more to designated facilities. It is working well in some countries.
 - Need to enlist the expertise of business thinkers to understand what incentives maternity facilities would pay attention to.
- Other:
 - BFHI must be understood as a minimum standard, not a golden standard.
 - Country should generate an annual report on the state of implementation of the BFHI by province.
 - Regular reporting to the WHA might be an incentive for countries.



Topic 4. National leadership and coordination



The fourth and final section of the Implementation Guidance, dealing with national leadership and coordination of the BFHI, was presented by Isabella Sagoe-Moses, on behalf of the External Review Group.

Countries need to have a national coordination body responsible for breastfeeding in general and the protection, promotion and support for breastfeeding, specifically in maternity facilities. Such a committee should be multisectoral if possible. The functions of managing BFHI may be added onto those of an existing governmental department or existing professional organization or NGO. But it is important to have government oversight if the body resides outside of government. This national coordination body has overall responsibility over 8 key functions:

1. Ensure oversight of BFHI implementation in all maternity facilities in the country.
2. Incorporate protection, promotion and support of breastfeeding in maternity facilities into national policy documents, professional standards of care.
3. Ensure that all health professionals and managers engaged in maternal and newborn care have adequate capacity to implement the national BFHI standards and management procedures.
4. Develop external assessment systems.
5. Develop and implement incentives for compliance and/or sanctions for noncompliance with the national standards.
6. Execute strategies to scale up application of the BFHI standards to all maternity facilities.
7. Develop and maintain a monitoring system on the implementation of the programme.
8. Ensure the ongoing funding of the initiative.

Countries need to monitor the progress of BFHI internally, both in terms of activities for implementation as well as outcomes, at the national and sub-national level. The most appropriate indicators for monitoring will of course depend on the national action plan, but key indicators likely include status of regulations on the BFHI standards, training delivered, facilities having been assessed, and facilities complying with minimum level of standards. Monitoring rates of early breastfeeding initiation and exclusive breastfeeding through hospital discharge are key outcomes.

Financing for BFHI needs to be sustainable over time and match with the selected strategies and activities. Funding from external funders, including foundations, NGOs, and UN agencies, should be used only for specific interventions on a temporary basis. Some countries have charged fees to designated facilities as a primary funding source, but the fees need to be of a level which does not create a barrier to participation.

Some of the ideas that emerged from the working groups discussing this element of the implementation guidance included the following:

- Suggestions for national organization:
 - Each country needs to have a national committee working on BFHI. The national committee should be embedded in the Ministry of Health. A government employee needs to run the committee. Finances for the committee need to be governmental.
 - Engagement of national government in BFHI is essential.
 - BFHI needs strong leadership.
 - A lot of work has been done by NGOs that should be sustained.
 - The BFHI committee should be institutionalized.
 - Membership of civil society is important.
 - BFHI should be integrated into other related initiatives such as Essential Newborn Care
 - BFHI needs to have a dedicated person in WHO/UNICEF offices as well as in the government.
 - Membership of national committee should be held by positions, not individual people.



- Suggestions for national monitoring:
 - Countries should rely more on electronic monitoring.
 - Indicators for monitoring need to be simple.
 - BFHI indicators should be added to national surveys, such as DHS and MICS.
 - National monitoring systems are currently saturated so adding BFHI indicators will be difficult.

- Every three years, countries should report on the percent of facilities designated, percent re-designated, and the percent of births that occur in designated facilities.
- Indicators are needed on the rate of adherence to each step.
- WHO should specify what indicators are needed for national monitoring. Others argued that “one size fits all” indicators don’t work. There should be a list of potential indicators and countries can pick from these.
- Maternal satisfaction would be a useful indicator.
- Required reporting is a key step to hold countries accountable.
- Monitoring should be decentralized.
- The current definition of exclusive breastfeeding needs to be revisited.
- Indicators are needed at multiple levels, including national, district, facility, and household.
- Suggestions for financing:
 - Embedding BFHI into accreditation processes would ensure financing since accreditation needs to be paid for.
 - Demonstration of impact can help to secure government budget.
 - BFHI needs to be included in national budget planning.
 - Tying BFHI to other initiatives would help with financing.
 - Governments are responsible for policy but sometimes work can be delegated to others.
- Suggestions for stronger advocacy:
 - WHO should communicate a strong message to Member States about the importance of the BFHI.
 - WHO and UNICEF need to develop and disseminate tools for advocacy on BFHI.
 - A World Health Assembly resolution is needed calling for Member States to make the Ten Steps mandatory for all facilities.
 - WHO should publish the status of the BFHI by country.
 - An awareness campaign for BFHI is needed.
 - Advocacy needs to focus on child rights.
 - BFHI needs reinvigorating.
 - Pitch BFHI as a “green” movement.
 - Add BFHI indicators to the State of the World’s Children and WHO reports.
 - Have more public celebration of facility designations.
 - BFHI needs to have more engagement from professional groups.
 - Cost/benefit studies on BFHI should be published.
 - T-shirts with the BFHI logo should be disseminated widely.
 - BFHI needs a better communication plan.
 - An advocacy network should be created.

Regional networks to support BFHI implementation

During the BFHI Congress, countries had two working sessions within regional networks to strengthen intra-regional collaboration and apply the learnings of the Congress to future implementation. The first regional meeting, occurring on the first day of the Congress, focused on identifying the current players, existing networks, and opportunities for collaboration. The second Regional meeting focused on concrete actions that governments, WHO, UNICEF and BFHI-related NGOs will take to enhance or support regional networks for follow up to the BFHI Congress and improving BFHI implementation. Several regions held follow up meetings after the Congress to further develop plans.

In general, the countries were grouped according to WHO regions, but participants in AFRO found the need to separate into Anglophone and non-Anglophone countries and participants in PAHO/AMRO found the need to separate by English and Spanish. In addition, the BFHI Network is a group of industrialized countries that have been meeting together for a number of years. This group found it advantageous to continue together as a group rather than each country joining with their own WHO regional grouping. As a result, the following groups were formed:

- Africa (English)
- Africa (non-English)
- Caribbean (English)
- Latin America (Spanish)
- Eastern Mediterranean
- Europe (largely Russian speaking)
- Southeast Asia
- Western Pacific
- Industrialized countries



During the time that regions were meeting, representatives of health professional organizations met to discuss how training for health professionals can be enhanced to incorporate the BFHI steps into pre-service training. The groups present committed to work together to develop better standards of training that are appropriate for a number of different health professions.

Global NGOs and donors attending the Congress also met together during these two timeslots to discuss how they can better support BFHI going forward. Key themes that emerged included the need to foster and maintain national ownership of the BFHI, the need to build long-term sustainability through any projects or funds provided, and the need to incorporate support for BFHI into a broader base of support for health systems strengthening. There was considerable discussion of the need for greater advocacy on the importance of BFHI at global and national levels.

Additional opportunities for sharing

Aside from the formal sessions of the Congress, participants had numerous opportunities for learning and sharing about the BFHI. Representatives from 30 countries displayed posters describing the BFHI programme in their country (Annex 1). Many of the posters demonstrated innovations in improving breastfeeding, engaging with facilities, going beyond maternity facilities, and integrating with other breastfeeding activities. The posters were on display throughout the Congress and participants had numerous opportunities to view the posters and meet the authors.



An evening reception was held to welcome participants on the first day of the Congress. The UN Choir provided entertainment, singing folk songs from around the world. During the reception, participants were invited to add stars to a 10-meter long timeline of the 25 years of BFHI history. Each star included a description of a key event in the national implementation of the initiative. The timeline became a visible display of the 100s of stars that have made improved support for

breastfeeding a reality for mothers around the world.



Closing ceremony

The Congress was closed with summary statements and descriptions of next steps. Each of the regional networks made a short presentation on their next steps to continue the collaboration on building strong BFHI programmes. Laurence Grummer-Strawn and Maaïke Arts presented a brief summary of the feedback received from working groups, pointing out areas of general agreement as well as diversity of opinion. Key conclusions included that there is:

- Agreement that breastfeeding is the norm and should be perceived as such by all countries;
- Agreement that BFHI should be mainstreamed as much as possible into other programmes, initiatives, policies;
- Agreement that increased advocacy, including by WHO and UNICEF, is needed to achieve increased political and financial commitment for breastfeeding, including for the BFHI;
- Agreement that BFHI should cover both healthy and preterm and LBW newborns;
- Agreement that BFHI should cover public and private facilities;
- Agreement that the Code should remain a strong part and parcel of the BFHI;
- Agreement that the BFHI needs to allow enough flexibility to work in different country contexts.



Another conclusion is that there were a variety of opinions on the importance of mother-friendly practices, how best to support community linkages, whether designation needs to be a central component of BFHI, how to operate BFHI when government commitment is weak, and whether the name of the BFHI should be changed.

As next steps, WHO and UNICEF will continue to revise the implementation guidance based on the feedback received. For many of the concepts upon which there was overall consensus, countries can immediately begin to incorporate the new ideas discussed at the Congress. For other issues, countries are advised to wait until 2017 when the new guidance is disseminated to consider changes to national BFHI programmes.

Marilena Viviani, Director of UNICEF's Geneva Liaison Office, thanked all the participants for their active participation in the Congress. She reiterated a key theme of the Congress on the importance of advocacy for BFHI. She also confirmed that WHO and UNICEF will jointly continue to advocate for BF and the BFHI.

Anne Marie Worning, WHO Assistant Director General of the Family Women and Children Cluster, closed the meeting by reminding participants that breastfeeding is one of the most effective ways to ensure child health and survival. If every child was breastfed optimally, about 800 000 children's lives would be saved every year. WHO is continuously reviewing the evidence on how to improve breastfeeding. The WHO/UNICEF Ten Steps to Successful Breastfeeding, which were originally published in 1989 based on the evidence available at that time, are currently being reviewed based on the latest evidence. The new WHO/UNICEF guidelines will be published in 2017. This meeting has given incredible contributions on how to better implement and scale up the initiative. Baby-Friendly should not be optional but rather an essential quality requirement of all health services.



Annex 1: List of posters presented

Country	Title of Poster	Authors
Australia	<i>The Baby Friendly Health Initiative Australia: Building a supportive and sustainable process one step at a time</i>	Nicole Perriman , Marjorie Atchan, Louise Duursma, Debra Thoms
Austria	<i>The Baby-friendly Hospital Initiative Austria</i>	Ingrid Zittera, Astrid Loidolt, Christina Wieczorek
Bangladesh	<i>Establishing and Revitalizing Baby Friendly Hospitals in Bangladesh</i>	S K Roy, M Islam, K Jahan, SB Salam, SM Akter
Cabo Verde	<i>BFHI Implementation in Cabo Verde</i>	Irina Spencer Maia, Gizela Alves, Teresa Martins
Canada	<i>Baby Friendly Situation in Canada</i>	Louise Dumas & Michelle Le Drew, on behalf of the Breastfeeding Committee for Canada
Canada	<i>Expansion of the Baby-Friendly Hospital Initiative to neonatal wards or Neo-BFHI: a global health initiative targeting preterm and ill infants.</i>	Laura N. Haiek, Mette Ness Hansen, Kerstin Hedberg Nyqvist, Ragnhild Måstrup, Leena Hannula, Aino Ezeonodo, Elisabeth Kylberg
Chile	<i>Restructuring Baby Friendly Hospital Initiative (BFHI) in Chile: Progress and Challenges</i>	Gaete Paola, Becerra Carlos
China	<i>Case study of China: Baby-friendly Hospital Initiative and Reassessment</i>	The department of Maternal and Child Health Care, the National Health and Family Planning Committee of the People's Republic of China

France	<i>The Baby Friendly Hospital Initiative in France IN FRANCE</i>	Kristina Löfgren, Caroline Francois
Gambia	<i>Modelling the Baby Friendly Hospital Initiative (BFHI) into the Baby Friendly Community Initiative (BFCl) in The Gambian Experience</i>	Malang N. Fofana
Georgia	<i>BFHI Georgian experience</i>	Ketevan Nemsadze, Nino Kiknadze, Tamar Bakhtadze
Germany	<i>BFHI in Germany</i>	Regina Rasenack
Hong Kong	<i>Journey of quarter of a century to the first Baby-Friendly Hospital in Hong Kong SAR</i>	Patricia Lai, Sheung Ip
Indonesia	<i>Current Issues on BFHI Implementation in Indonesia</i>	E Gustina, FH Agung, Wiyarni, U Roesli, Sabarinah, SE Irianto, N Rohmawati
Jamaica	<i>Strengthening the Baby Friendly Hospital Initiative in Jamaica</i>	Turner-Pitt Marchelle V., Edwards, Sharmaine E.
Japan	<i>Current situation of neo-BFHI activities in Japan</i>	Kiyoshi Hatasaki, Shin Kikuchi, Yoshihisa Nagayama, Yoshinori Kohno, Yuichi Kondo, Tomoko Hatakeyama, Atsuko Kurimoto, Michiko Nagayama
Kenya	<i>Baby Friendly Hospital Initiative: Extension of the Tenth Step to the Community Approaches, Progress, Successes and Challenges</i>	Betty Samburu, Judith Kimiye, Elizabeth Kimani-Murage, Fredrick Wekesah, Peter Muriuki, Milka Wanjohi, Nelson Muhia
Kenya	<i>Baby Friendly Hospital Initiative in Kenya Challenges, Lessons Learnt and Best Practices to Learn From Rift Valley Province</i>	Betty Samburu, Laura Kiige, Grainne Moloney, Racheal Musoke, Pam Malebe

Kyrgyzstan	<i>BFHI implementation experience in Kyrgyz Republic</i>	Kabylova Elmira, Jyldyz Artykbaeva, Tursun Mamyrbayeva, Gulsara Kozhonazarova, Damira Abakirova
Luxembourg	<i>Baby-friendly in a small country!</i>	Maryse Arendt
Norway	<i>Challenges and Successes: The Baby-Friendly Hospital Initiative in Norway (BFHI)</i>	Mette Ness Hansen, Ina Landau Aasen
Qatar	<i>Say Yes to Breastfeeding Initiative, (Qatar's First Integrated, Collaborative, Multidisciplinary Clinical Management of Breastfeeding Program), Defining Vision of BFHI, in Promotion, Protection and Support of Breastfeeding</i>	Mohammed Ilyas Khan
Russian Federation	<i>WHO/UNICEF Baby-Friendly Hospital Initiative in Russia</i>	L.V. Abolyan, S.V. Novikova
Rwanda	<i>Current Situation of BFHI and Exclusive Breastfeeding in Rwanda</i>	Evodia Dushimimana, Alex Mucumbitsi, Mary Kabanyana, Victor Mivumbi
Saudi Arabia	<i>BFHI in Saudi Arabia</i>	Albandri Abdulrahman Abunyan
Singapore	<i>The Journey of Baby Friendly Hospital Initiative (BFHI) in Singapore</i>	Chua Mei Chien
Spain	<i>Baby Friendly Initiative in Spain</i>	María-Teresa Hernández-Aguilar, Beatriz Flores-Antón, Juan-José Lasarte-Velillas, Francisco-Javier Soriano-Faura, Salomé Laredo-Ortiz, Francisco-José Pérez-Ramos, Carmen-Rosa Pallás-Alonso. (BFI-Spain Executive Committee)
Sri Lanka	<i>Breastfeeding: the success story of the Pearl of the Indian Ocean</i>	D. Dhammica Rowel, B. Kumudini Cooray

Switzerland	<i>The Baby-Friendly Hospital Initiative in Switzerland</i>	Anna Spaeth
The former Yugoslav Republic of Macedonia	<i>Success in the past and present challenge – Baby Friendly Hospital Initiative (BFHI) in Macedonia</i>	Naditza Yaneva, Biljana Anchevska,
Ukraine	<i>History and implementation of BFHI in Ukraine</i>	Lidiya Romanenko
United Arab Emirates	<i>UAE and Sharjah Experience in Supporting Breastfeeding</i>	Hessa Al Ghazal, Latifa Abdulla Alawadhi
United Kingdom	<i>The Unicef UK Baby Friendly Initiative: 22 years of learning, 1994-2016</i>	Anne Woods, Francesca Entwistle
Uruguay	<i>Buenas Prácticas de Alimentación del lactante y del niño/a pequeño/a en Uruguay</i>	C De León, C Romero, X Moratorio

Annex 2: Agenda

Baby-friendly Hospital Initiative Congress
24 - 26 October 2016, World Health Organization, Headquarters
Geneva, Switzerland

MONDAY, 24 OCTOBER

8:30 – 9:00	Registration and badges	
9:00 – 9:30 (EB Room)	Opening Ceremony Welcome Objectives of the BFHI Congress	Anne Marie Worning Marilena Viviani Sophie Gregoire-Trudeau (video) Francesco Branca Jurate Sabaliene Laurence Grummer-Strawn
9:30 – 9:50 (EB Room)	Panel of mothers – The lived experiences with maternity care and breastfeeding	Joanna Souza facilitating
9:50 – 10:50 (EB Room)	Panel of country case studies' reports Bolivia, China, Ireland, Kenya, Kuwait, USA	Maaïke Arts facilitating
10:50 – 11:00	Group picture	
11:00 – 11:30	Coffee/tea break	
11:30 – 12:10 (EB Room)	Protection, promotion and support of breastfeeding Latest science on breastfeeding Breastfeeding in the global policy context BFHI in the broader MCH context	Nemat Hajeebhoy Francesco Branca Anthony Costello
12:10 – 12:45 (EB Room)	25 years of BFHI - at global and country level Highlights of the BFHI over the past 25 years Overview of country experiences	Felicity Savage Maaïke Arts
12:45 – 13:45	Lunch	
13:45 – 14:45 (See Rooms list)	Taking stock of the BFHI in regions Regional meetings	

14:45 – 15:05	Poster sessions
15:05 – 15:25	Coffee/tea break
15:25 – 15:40 (EB Room)	Introduction to the updated guidance on protection, promotion and support of breastfeeding in maternity facilities Laurence Grummer-Strawn
15:40 – 16:20 (EB Room)	Presentation – Implementation in maternity facilities (Guidance Topic 1) Julie Stufkens
16:20 – 17:30 (See Rooms list)	Group discussions – Implementation in maternity facilities (Guidance Topic 1)
17:30	Adjourn
18:00 – 20:00 (WHO Cafeteria)	Celebration reception Brief remarks UN Choir performance Timeline of BFHI stars

TUESDAY, 25 OCTOBER

9:00 – 10:00 (EB Room)	Working groups report back – Implementation in maternity facilities (Guidance Topic 1)	
10:00 – 10:20 (EB Room)	Application of the Code in BFHI	Marcus Stahlhofer
10:20 – 10:50 (EB Room)	Presentation – Setting national health care standards (Guidance Topic 2)	Randa Saadeh
10:50 – 11:10	Coffee/tea break outside meeting rooms	
11:10 – 12:10 (See Rooms list)	Group discussions – Setting national health care standards (Guidance Topic 2)	
12:10 – 12:30	Poster sessions	
12:30 – 13:30	Lunch	
13:30 – 14:40 (EB Room)	Working groups report back – Setting national health care standards (Guidance Topic 2)	
14:40 – 15:20 (EB Room)	Panel discussion: Capacity building Pre-service training and capacity building	Frances McConville facilitating
15:20 – 15:50 (EB Room)	Presentation – National implementation (Guidance Topic 3)	Rukhsana Haider
15:50 – 16:10	Coffee/tea break outside meeting rooms	
16:10 – 17:30 (See Rooms list)	Group discussions – National implementation (Guidance Topic 3)	
17:30	Adjourn	

WEDNESDAY, 26 OCTOBER

9:00 – 10:00 (EB Room)	Working groups report back – National implementation (Guidance Topic 3)	
10:00 – 10:30 (EB Room)	Presentation – National leadership and coordination (Guidance Topic 4)	Isabella Sagoe-Moses
10:30 – 10:50	Coffee/tea break outside meeting rooms	
10:50 – 11:40 (See Rooms list)	Group discussions – National leadership and coordination (Guidance Topic 4)	
11:40 – 12:40 (EB Room)	Working groups report back – National leadership and coordination (Guidance Topic 4)	
12:40 – 13:40	Lunch	
13:40 – 14:00	Poster sessions	
14:00 – 16:20 (See Rooms list)	Developing regional networks to support implementation Regional meetings Coffee/tea break outside meeting rooms	
16:20 – 17:20 (EB Room)	Closing session Regional commitments Summary of meeting Maaïke Arts Laurence Grummer-Strawn Closing remarks Marilena Viviani Anne Marie Worning	
17:20	Adjourn	