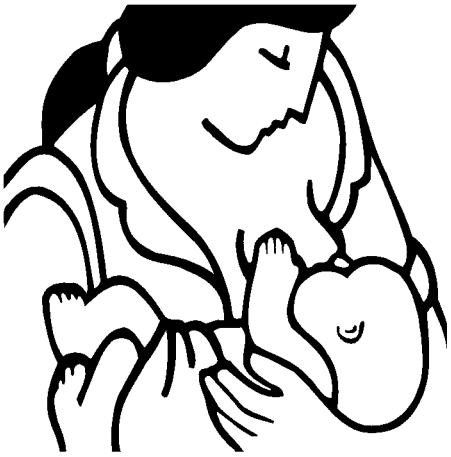

Comparative Analysis of Implementation of the Innocenti Declaration

in WHO European Member States

Monitoring Innocenti targets on the protection, promotion and support of breastfeeding

WORLD HEALTH ORGANIZATION
Regional Office for Europe, Copenhagen
and Headquarters, Geneva

UNITED NATIONS CHILDREN'S FUND
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EUROPEAN HEALTH21 TARGET 11

HEALTHIER LIVING

By the year 2015, people across society should have adopted healthier patterns of living

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The Innocenti Declaration states that by 1995 all Member States should have achieved the targets outlined in the Innocenti Declaration and progress was reported at the World Health Assembly in 1998. By 1995 each Member State should have: appointed a national breastfeeding coordinator; established a multi-sectoral breastfeeding committee; ensured that all maternity facilities practice all *Ten Steps to Successful Breastfeeding*; taken action to give effect to the principles and aims of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions; and enacted legislation protecting the breastfeeding rights of working women. The information in this document is based on completed questionnaires filled out by national nutrition counterparts regarding implementation of the Innocenti Declaration. The document provides a useful tool to compare situations, both at a European level and within sub-regions of Europe. Both WHO and UNICEF encourage and support national authorities in planning, implementing, monitoring and evaluating policies related to protecting, promoting and supporting breastfeeding.

Keywords

COMPARATIVE STUDY
BREAST FEEDING
INFANT NUTRITION
INFANT FOOD – standards
HEALTH PROMOTION
HEALTH POLICY
EUROPE

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[1] International Baby Food Action Network

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FOREWORD

To invest in breastfeeding is to invest in health. Therefore, we are extremely grateful to Nutrition Counterparts in Ministries of Health, who invested time to find the information on breastfeeding in their countries and to return the completed questionnaires on the implementation of the Innocenti Declaration. We hope that the information collated in this document, on the breastfeeding situation in Europe, provides a useful tool to compare situations, both at a European level and within sub-regions of Europe.

It was difficult to decide which countries should be placed in which sub-region and we hope that the approach we developed is useful and aids comparison. Our approach does not represent any official categorization of WHO Member States and we used this merely to simplify the analysis and interpretation of the data for the reader.

It is timely to make this comparison on the Innocenti Declaration because by 1995 all Member States should have achieved the targets outlined in the Innocenti Declaration and progress reported at the World Health Assembly in 1998. By 1995 each Member State should have: appointed a national breastfeeding coordinator; established a multi-sectoral breastfeeding committee; ensured that all maternity facilities practice all *Ten Steps to Successful Breastfeeding*; taken action to give effect to the principles and aims of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions; and enacted legislation protecting the breastfeeding rights of working women.

WHO and UNICEF were called upon to encourage and support national authorities in planning, implementing, monitoring and evaluating policies related to protecting, promoting and supporting breastfeeding. We hope that this report will assist national authorities in this process and we are ready to assist Member States to ensure that their efforts are sustained and enhanced. Comments and recommendations are welcomed regarding this report and also suggestions on how the questionnaire could be improved as we hope to repeat the exercise in the future and so continue to monitor trends and achievements.

We encourage policy makers to use this report as a tool to measure the level of implementation of the targets of the Innocenti Declaration. Additional indicators such as the status of, support and commitment to the Innocenti Declaration by governments will be included next time. For example: how much of a country's health budget is devoted to the BFHI and breastfeeding protection, promotion and support? How many staff are employed in committees and do they meet regularly to discuss clear aims and objectives and evaluate outcomes (e.g. prevalence of exclusive breastfeeding)? Have governments made a public commitment and has any head of state told the nation that by investing in breastfeeding, the health of the nation will improve.

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INTRODUCTION

The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative" in Italy in 1990. The Declaration sets a global goal and has become a guide for governments aiming to protect, promote and support breastfeeding.

The Declaration affirms the importance of breastfeeding for the healthy growth and development of infants and stresses its contribution to women's health by reducing the risk of breast and ovarian cancer, reduction of bleeding by helping the uterus return to its previous size, delay of new pregnancy and by providing social and economic benefits.

The Declaration sets a goal for achieving optimal health for infants and mothers:

> ***All women should be enabled to practice exclusive breastfeeding[2] and all infants should be fed exclusively on breast-milk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods[3], for up to 2 years of age or beyond.***

In order to attain these goals, governments should have developped national breastfeeding polices and appropriate targets for the 1990s which should further be monitored and evaluated.

By the year 1995 all governments should have achieved the following operational Innocenti targets:

1. Appointed a national breastfeeding coordinator and appropriate authority, and established a multisectoral national breastfeeding committee composed of representative form relevant government departments, non-governmental organizations, and health professional associations;

2. Ensured that every facility providing maternity services fully practices all *Ten Steps to Successful Breastfeeding* set out in the joint WHO/UNICEF statement "Protecting, promoting and supporting breastfeeding: the special role of maternity services"; [4]

3. Taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequently relevant World Health Assembly resolutions in their entirety; and

4. Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

[2] "Exclusive breastfeeding" means that no other drink or food is given to the infant, with the possible exception of small amounts of medical supplements (medicines and vitamin drops)

[3] "Complementary food" means any food, whether manufactured or locally prepared, suitable as a complement to breast-milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant (Article 3 of the International Code of Marketing of Breast-milk Substitutes)

[4] A joint WHO/UNICEF Statement WHO, Geneva, 1989

The Innocenti Declaration calls upon International Organizations to:

1. Draw up action strategies for protecting, promoting and supporting breastfeeding, including global monitoring and evaluation of their strategies;
2. Support national situation analyses and surveys and the development of national goals and targets for action; and
3. Encourage and support national authorities in planning, implementing, monitoring and evaluating their breastfeeding polices.

In 1991, the 44th World Health Assembly (body deciding WHO's policy) welcomed the Declaration as a basis for international health policy and action and requested the Director-General to monitor achievements in this connection (resolution WHA44.33). At the he 45th World Health Assembly (1992) Member States were urged to give full expression at national level to the operational targets contained in the Innocenti Declaration.

International Code of Marketing of Breast-milk Substitutes

Since 1974, the World Health Assembly has adopted a number of resolutions urging Member States to support, protect and promote breastfeeding. Following the joint WHO/UNICEF meeting on infant and young child feeding in 1979, a statement and a series of recommendations were prepared and adopted by consensus[5]. The 33rd World Health Assembly, in 1980, endorsed the statement and recommendations and made particular mention of the recommendation that "there should be an international code of marketing of infant formula and other products used as breast-milk substitutes". In 1981 the International Code of Marketing of Breast-milk Substitutes (the Code) was adopted by the 34th World Health Assembly in the form of a recommendation[6]. All Member States were urged to adopt it as a minimum requirement; to translate it into national legislation, regulations or other suitable measures; to involve all concerned parties in its implementation; and to monitor compliance with it. The resolution stresses that the adoption and adherence to the Code is only one of several important actions required in order to protect healthy practices in respect of infant and young child feeding.

The aim of the Code is "to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes[7], when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (Article 1). In promoting this aim, the Code sets out detailed provisions on the:

- Appropriate dissemination of information and provision of education on infant feeding (Article 4)
- Marketing of breast-milk substitutes, feeding bottles and teats to the general public and mothers (Article 5) [8]

[5] Document WHA33/1980/REC/1, Annex 6

[6] World Health Organization. *International Code of Marketing of Breast-milk Substitutes.* Document WHA34/1981/REC/1, Annex 3, Geneva, 1981

[7] "Breast-milk substitutes" means any food being marketed or otherwise represented as a partial or total replacement for breast-milk, whether or not suitable for that purpose (Article 3 of the Code)

[8] The Code applies to the marketing, and practices related thereto, of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast-milk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use (Article 2 of the Code).

Footnote continues on next page

- Measures to be taken in health care systems (Article 6), and with regard to health workers
- (Article 7) and employees of manufacturers distributors (Article 8)
- Labelling (Article 9) and quality of breast-milk substitutes and related products (Article 10)
- Implementation and monitoring of the Code's provisions (Article 11)

Summary of Articles 4 to 11 of the International Code of Marketing of Breast-milk Substitutes[9]

- Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding
- Educational materials should include information on the benefits and superiority of breastfeeding; maternal nutrition and the preparation for and maintenance of breastfeeding; the social and financial implications and health hazards associated with the use of infant formula
- No advertising or other form of promotion to the general public of products within the scope of the Code
- No free samples of products within the scope of the Code to pregnant women, mothers or members of their families
- No gifts of articles or utensils to pregnant women or mothers of infants and young children which may promote the use of breast-milk substitutes or bottle-feeding
- No promotion of products covered by the Code in any facility of the health care system
- No company "mothercraft nurses" or "professional service representatives" permitted in health care system
- No brand names on donated equipment and materials
- Information provided by manufacturers and distributors to health professionals regarding products within scope of the Code should be restricted to scientific and factual matters
- No financial or material inducements should be offered to health workers or their families to promote products within scope of the Code
- No samples of infant formula, other products or equipment or utensils should be provided to health workers, unless it is for professional evaluation or research
- Personnel employed in marketing products within scope of the Code, should not, as part of their job, perform educational functions in relation to pregnant women or mothers of infants and young children
- The message on the label should include: the words "Importance Notice" or equivalent; a statement of the superiority of breastfeeding; a statement that the product should be used only on advice of a health worker as to the need for its use and the proper method of use; instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation,
- "Humanized" and "maternalized or similar terms should not be used on container nor label
- Containers nor labels of infant formula should not have pictures of infants, nor other pictures or text which may idealize the use of infant formula
- All products should be of a high recognized standard as the quality of products is an essential element for the protection of the health of infants
- Governments should take action to give effect to the principles and aim of the Code
- Governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system
- Manufacturers and distributors should take steps to ensure that their conduct at every level conforms to the principles and aims of the Code
- NGOs, professional groups, institutions and individuals should draw the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of the Code
- The Code calls for annual reporting by Member States to the Director-General and by the Director General to the World Health Assembly, in even years, on the status of its implementation

[9] These principles are not all laid down in the Code in this form, but have been distilled from the various provisions of the Code

In 1991 the Commission of the European Communities (now European Union) adopted Directive 91/321/EEC[10]. This Directive addresses only the marketing of infant formulae and follow-up milks and excludes other products covered by the International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981. The Code covers all breast-milk substitutes, feeding bottles and teats and has stricter marketing and labelling provisions.

By June 1994 all EU governments should have incorporated the Directive into National Legislation. However, since all EU governments are also Member States of the World Health Organization, they should consider revising their legislation to comply with the recommendations of the World Health Assembly as expressed in the Code. This would not contravene the European rules on competition.

The Baby-Friendly Hospital Initiative

In 1992, WHO and UNICEF jointly launched the Baby-Friendly Hospital Initiative (BFHI). The initiative was constructed to help countries reach the operational targets and goals that have been established as global markers of progress in the protection, promotion and support of breastfeeding. The BFHI stimulates action on three of the four Innocenti Declaration targets (target 2, to some extent target 1 and possibly 3).

The BFHI aims to support women exercising their rights to breastfeed and to ensure the cessation of free and low-cost infant formula supply to hospitals. The BFHI recognises that hospital practices - through such routine procedures as separating mothers from their babies and initiating artificial feeding - have greatly contributed to the trend away from breastfeeding. Existing data on the prevalence of breastfeeding (Annex 1) are problematic. Breastfeeding prevalence surveys are sparse and where the data exist the varying definitions used for terms such as “exclusive breastfeeding” make comparison and interpretation extremely difficult. Standardized methods and regular monitoring on breastfeeding prevalence is needed. This information would assist governments in developing strategies for improving the health of infants and children.

The BFH initiative targets maternity services and hospitals particularly health workers and those responsible for setting maternity or -hospital polices to change their practices and to help mothers succeed in breastfeeding. The changes in hospital practice provide an environment for women and children where they are not subjected to advertising and promotional activities for infant formula or feeding bottles, and where they receive effective and well-informed help for a sound start to breastfeeding.

Through a WHO/UNICEF training programme that has been translated into the official languages of the United Nations and into many others, the professional staff of maternity hospitals are trained in lactation management and support. To become a baby-friendly hospital every facility providing maternity services and care for newborn infants make a commitment to fulfil the initiative's *“Ten Steps to Successful breastfeeding”* outlined in the joint WHO/UNICEF statement entitled “*Protecting, promoting and supporting breastfeeding: the special role of maternity services*[11]. These include pledging to ensure that women and newborns can remain together all the time and that women must be free to begin breastfeeding promptly after birth and to continue exclusive breastfeeding on demand during their hospital stay. A major goal is to end the distribution of free and low-cost breast-milk substitutes in all maternity centres and hospitals.

[10] Official Journal of the European Communities, No. L 175, 4.7.1991, pg. 35
[11] A joint WHO/UNICEF statement, Geneva, World Health Organization, 1989

TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff
2. Train all health care staff in skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding within a half-hour of birth
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants
6. Give newborn infants no food or drink other than breast-milk, unless medically indicated
7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

At the 45th World Health Assembly (1992) Member States were urged to encourage and support all public and private health facilities providing maternity services so that they become “baby-friendly”. This can be achieved by providing the necessary training and by encouraging the collaboration of professional associations, women’s organizations, consumers and other nongovernmental groups and the food industry in this endeavour.

AIM OF THIS REPORT

This report is an analysis of the situation regarding the progress made towards achieving the operational targets of the Innocenti Declaration in WHO European Member States. The information collected will help to:

- Provide a comparative analysis of the situation in 1996-97
- Identify gaps and areas where more emphasis and action are needed
- Assist countries in planning future strategies and developing their relevant plans of action.

METHOD

A standard questionnaire (Annex 2) was posted or emailed to 49 WHO nutrition counterparts, (nominated by Ministries of Health) or Ministries of Health where no counterpart existed in December 1996, June 1997 and August 1997. The questionnaire was distributed in English, French or Russian. Thirty-five completed responses (response rate of 71%) were received during the period 1997-1998 and the Nutrition Programme WHO Copenhagen compiled this report from these.

To facilitate comparative analysis, interpretation and to draw conclusions and recommendations Member States were grouped into 8 geographical sub-regions: Balkan, Baltic, Central Asia Republics (CAR) and Turkey, Central and East Europe (CEE), West Europe, South Europe, Commonwealth of Independent States (CIS) and Nordic Countries (Table 1). The country data are presented in tables.

To supplement these data additional information has been added on prevalence of breastfeeding (Annex 1); the state of the implementation of the International Code of Marketing of Breast-milk Subsitutes (Annex 3) and on the BFHI implementation in Europe (Annex 4).

Table 1: Member States of the WHO European Region to which questionnaire was sent

BALKAN	BALTIC	CAR and TURKEY	CEE	WEST EUROPE	SOUTH EUROPE	CIS	NORDIC
Albania	Estonia	Kazakstan	Bulgaria*	Austria	Greece*	Azerbaijan*	Denmark
Bosnia & Herzegovina*	Latvia	Kyrgyzstan	Czech Rep.	Belgium*	Israel	Armenia	Finland
Croatia	Lithuania	Tajikistan	Hungary*	France*	Italy*	Belarus	Iceland
Slovenia		Turkmenistan	Poland	Germany	Malta	Georgia	Norway
The Former Yugoslav Republic of Macedonia		Uzbekistan	Romania*	Ireland*	Monaco*	Rep. of Moldova	Sweden
		Turkey	Slovakia	Luxembourg	Portugal*	Russian Fed.	
				Netherlands	San Marino*		
				Switzerland	Spain*	Ukraine	
				United Kingdom			

* No completed questionnaire received

RESULTS OF THE SURVEY

Table 2: Information on Breastfeeding Committees and Coordinators, NGOs, National Breastfeeding Policy and BFHI plan of action

Country/ Region	National Breastfeeding Committee	BFHI Committee	National Breastfeeding Coordinator	NGO(s) working on breastfeeding	National Breastfeeding Policy	Plan of action for BFHI implementation
BALKAN						
Albania	Y	Y	Y	Y	Y	Y
Croatia	Y	Y	Y	Y	NA	Y
Slovenia	NA	Y	Y	Y	N	Y
Rep. of Macedonia	Y	N[12]	Y	Y	N[13]	Y
BALTIC						
Estonia	Y	Y	Y	Y	N	N
Latvia	N	N	Y	Y	N	N
Lithuania	Y	Y	Y	Y	Y	NA
CAR & TURKEY						
Kazakstan	Y	Y	Y	Y	Y	N
Kyrgyzstan	Y	N	Y	Y	Y	Y
Tajikistan	Y	N	Y	N	Y	Y
Turkmenistan	Y	N	Y	N	Y	N
Uzbekistan	N	N	Y	N	Y	Y
Turkey	Y	Y	Y	N	Y	Y
CEE						
Czech Rep.	Y	Y	Y	Y	N	Y
Poland	Y	Y	Y	Y	Y	Y
Slovakia	Y	Y	Y	Y	Y	Y
W. EUROPE						
Austria	N	Y	N	Y	N	N
Germany	Y	Y	Y	Y	Y	N
Luxembourg	Y	Y	Y	Y	N	N
Netherlands	N	Y	N	Y	N	N
Switzerland	Y	Y	Y	Y	Y	Y
UK	Y	Y	Y	Y	Y	N[14]
S. EUROPE						
Israel	Y	Y	Y	Y	Y	N[15]
Malta	Y	NA	N	NA	N[16]	N
CIS						
Armenia	Y	N	Y	N	Y	Y
Belarus	Y	Y	Y	N	Y	Y
Georgia	Y	Y	NA	Y	Y	Y
Rep. Moldova	Y	N	Y	N	Y	Y
Russian Fed.	Y	Y	N	Y	Y	Y
Ukraine	Y	N	Y	N	Y	N
NORDIC						
Denmark	Y	Y	Y	Y	N	Y
Finland	Y	NA	Y	NA	N	Y
Iceland	Y	N	N	Y	N	N
Norway	N[17]	Y	N	Y	Y[18]	Y
Sweden	N	Y	N	Y	Y	Y

Y = Yes , N = No, NA = No Answer

[12] Breastfeeding Committee covers BFHI through separate body
[13] In preparation
[14] BFHI implementation is a matter for the UK BFHI and individual NHS units. Government has not set targets or developed plan of action
[15] In preparation
[16] In preparation
[17] Multidisciplinary group made up of voluntary professionals give advice on different aspects of breastfeeding (Ammefagrådet)
[18] Breastfeeding policy is an integrated part of the nutrition policy

Table 3: Organizations represented in National Breastfeeding Committees, BFHI Committees and NGO Breastfeeding Committees of Member States

Organization	National Breastfeeding Committee	BFHI Committee	NGO Breastfeeding Committee
Government departments dealing with:			
-health	24	19	3
-women's affairs	6	2	1
-other related issues	4	2	1
Nutrition institute or centre	11	5	3
Health professional associations	17	15	6
Universities	14	8	6
Medical schools	16	11	7
Nursing schools	13	7	4
Mother-to-mother groups	12	10	3
Breastfeeding counselling groups	13	10	5
Women's organizations	7	2	3
Infant food manufactures	1	0	1
Bottle and teat manufacturers	0	0	0
Advertising/marketing agencies	0	0	0
Other	7	4	0

Table 4: Information on the promotion, education and training of breastfeeding

Country/ Region	Activities /year promoting breastfeeding	Brief description of activity	Public health education on breastfeeding	Training on lactation management	National BFHI assessors training
BALKAN					
Albania	1996, 1997	TV/radio programmes	Y	Y	Y
Croatia	Y		Y	Y	Y
Slovenia	N		Y	Y	N
Rep. of Macedonia	since 1995	Breastfeeding week[19], mass media campaign	Y	Y	Y
BALTIC					
Estonia	since 1994	Breastfeeding week, TV, newspaper articles,	Y	Y	Y
Latvia	1996	Breastfeeding day	N	Y	Y
Lithuania	since 1994	TV programmes, newspaper articles, leaflets	Y	Y	Y
CAR					
Kazakstan	1997	Breastfeeding week, TV	Y	Y	N
Kyrgyzstan	Y		Y	Y	Y
Tajikistan	N		N	Y	Y
Turkmenistan	Y		Y	Y	NA
Uzbekistan	1996, 1997	Conference	Y	Y	N
Turkey	since 1987	Breastfeeding week, TV/ radio programmes, health education programmes, meeting mothers, posters,	Y	Y	Y
CEE					
Czech Rep.	1997	Media campaign, information material	Y	Y	Y
Poland	Y	TV/radio, newspapers	Y	Y	Y
Slovakia	since 1994	TV/radio, training courses, magazine, consultations	Y	Y	Y
W. EUROPE					
Austria	Y	Distribution of brochures to hospitals & Public Health Offices	Y	Y	N
Germany	N		N	Y	Y
Luxembourg	Y	Breastfeeding week, posters, leaflets, conferences, courses	Y	N	N[20]
Netherlands	Y	Breastfeeding week, media	Y	Y	Y
Switzerland	Y	Breastfeeding week	Y	Y	Y
UK	Y	Breastfeeding week, media	Y	N	Y
S. EUROPE					
Israel	1995	Conferences for nurses & doctors	Y	Y	N
Malta	since 1992	Breastfeeding week	N	Y	N
CIS					
Armenia	1994, 1996	Mass media campaign, booklet,	Y	Y	NA
Belarus	since 1994	Workshops/ conferences, PROBIT[21]	Y	Y	Y
Georgia	1996, 1997	Breastfeeding week & media coverage of event, posters, leaflets, conference, action "Medical students for breastfeeding", meeting mothers	Y	Y	Y
Rep. of Moldova	1996	Newsletter, booklet, poster	Y	Y	Y
Russian Fed.	Y	Booklets, newsletters	Y	Y	NA
Ukraine	1996, 1997	Breastfeeding week, seminars	N	Y	N
NORDIC					
Denmark	1997		N	N	Y
Finland	N		Y	Y	N
Iceland	N		N	N	N
Norway	since 1993	Media coverage	Y	Y	Y
Sweden	Y	Nordic breastfeeding week	Y	Y	N

Y = Yes, N = No, NA = No Answer

[19] UNICEF and the World Alliance for Breastfeeding Action (WABA), a global network of individuals and NGOs involved in the protection, promotion and support for breastfeeding collaborated in 1992 to introduce the first World Breastfeeding Week

[20] Possible to be trained in another country

[21] The objective of PROBIT (Promotion of Breastfeeding Intervention Trial) is to evaluate the effect of the WHO/UNICEF BFH breastfeeding promotion programme in prolonging the duration of breastfeeding & reducing infectious morbidity among healthy breastfed infants born at hospitals in Belarus

Table 5: The International Code of Marketing of Breast-milk Substitutes

	Has the International Code been implemented?	How was it impelemented?*	Is a National Law being drafted?	Is a ban on free & low-cost infant formula been included in national action?	Is monitoring of the Code given effect in national action?	Is an enforcement mechanism in place?
BALKAN						
Albania	N[22]	-	Y	Y	Y	N
Croatia	N	-	Y	NA	Y	N
Slovenia	N	-	N	N	N	N
Rep of Macedonia	N[23]	-	Y	Y	Y	NA
BALTIC						
Estonia	1996	1	N	N	Y	Y
Latvia	N	-	Y	N	Y	N
Lithuania	N	-	Y	NA	Y	N
CAR						
Kazakstan	N	-	Y	NA	NA	NA
Kyrgyzstan	N	-	Y	NA	NA	NA
Tajikistan	N	-	N	N	N	N
Turkmenistan	NA	-	NA	N	NA	NA
Uzbekistan	N	-	N	N	N	N
Turkey	1992	3	Y	Y	Y	Y
CEE						
Czech Rep.	N	-	Y	NA	Y	Y
Poland	1988	2	Y	N	Y	N
Slovakia	N[24]	-	NA	NA	NA	NA
W. EUROPE						
Austria	N	-	N	N	N	N
Germany	1994	1	N	Y	NA	N
Luxembourg	1993[25]	-	N	Y	N	N
Netherlands	1991	1	N	Y	Y	Y
Switzerland	1994[26]	3	N	N	N	N[27]
UK	1995[26]	1	N	Y	N	Y
S. EUROPE						
Israel	1990	1	Y	Y	Y	N
Malta	1990	2 & 3	Y	Y	N	N
CIS						
Armenia	N	-	NA	N	N	N
Belarus	N	-	Y	N	N	N
Georgia	N	-	NA	NA	NA	NA
Moldova	1994	1 &2	N	Y	Y	N
Russian Fed.	NA	-	NA	NA	NA	NA
Ukraine	N	-	Y	NA	NA	NA
NORDIC						
Denmark	1996	3	N	Y	Y	Y
Finland	1990,1992, 1994[28]	1&3	Y	Y	Y	Y
Iceland	N	-	Y	N	N	N
Norway	1983	2 & 3	Y	Y	N	N
Sweden	1983	3	Y	N	N	N

Y = Yes, N = No, NA = No Answer
* 1= law/regulation/decree, 2= agreement with health worker, 3= agreement with infant-food industry

[22] To be implemented 1996-97
[23] Code to be implemented through the new draft of the Law for health safety of foods and goods for common use, which is in the phase of enactment
[24] To be implemented 1997
[25] Implemented the European Commission Directive on infant formulae and follow-on formulae (Dir. 91/321/EEC)
[26] Voluntary Code of the Association of Swiss Producers of Baby Food was signed by all producers, except one firm, in Switzerland in 1994 and a Code-Panel is established to observe how rules are kept
[26] The Code is implemented on a statutory basis by the Infant Formula and Follow-on Formula Regulations 1995
[27] 1990 Food Trade Organization, 1992 Food Industry, 1994 Decree

Table 6: Baby-Friendly Hospital Initiative (BFHI)[29]

Country/ Region	No. of hospitals with maternity facilities	No/proportion/ Percentage of deliveries in health facilities	No. of hospitals targeted to become Baby-friendly	No. of hospitals designated baby-friendly[30]	No. of hospitals with a BFHI Certificate of Commitment[31]	No./percentage of hospitals that have ended distribution of free/low-cost breast-milk substitutes
BALKAN						
Albania	36	>80%	2	NA	0	Most
Croatia	28	48,000	21	3	4	0
Slovenia	14	99%	14	0	0	60%
Rep.of Macedonia	18	32,084	2[32]	0	0	100%
BALTIC						
Estonia	20[33]	99.9%	NA	NA	NA	100%
Latvia	10	96%	10	0	0	0
Lithuania	NA	NA	NA	NA	NA	NA
CAR & TURKEY						
Kazakstan	252	98.6%	3	0	0	NA
Kyrgyzstan	78	NA	10	0	0	7
Tajikistan	266	63%	5	0	0	100%
Turkmenistan	46	NA	NA	NA	NA	NA
Uzbekistan	NA	NA	NA	NA	NA	NA
Turkey	630	60%	630 by 2000	65	4	100%
CEE						
Czech Rep.	130	99.9 %	2	8	0	NA
Poland	427	100%	NA[34]	20	18	NA[35]
Slovakia	72	99%	NA	1	5	0
W.EUROPE						
Austria	90	98%	NA	1[36]	2	Most
Germany	300	97%	NA	6	6	100%
Luxembourg	7	99%	3	NA	NA	7
Netherlands	112	70%	60	NA	2	100%
Switzerland	180	95%	NA[37]	6-7	12	100%
UK	202	98%	NA	2	NA[38]	NA
S. EUROPE						
Israel	29	100%	3	0	0	10
Malta	6	90%	2	0	0	2
CIS						
Armenia	54	93%	10	0	0	100%
Belarus	130	99.9%	2	0	0	NA[39]
Georgia	NA	NA	NA	NA	NA	NA
Rep.of Moldova	105	58,000	3	5	0	100%
Russian Fed.	NA	1.3 million	NA	1	1	NA
Ukraine	542	95%	7	NA	NA	NA
NORDIC						
Denmark	50	68,000	5-6	2	0	100%
Finland	55	99.9%	NA[40]	NA	1	100%
Iceland	15	100%	0	0	0	100%
Norway	62	99.5%	62	35	NA	100%
Sweden	57	99.9%	57	57	57	100%

Y = Yes, N = No, NA = No Answer

[29] See Annex 4 which gives more recent data from 1998
[30] An officially designated baby friendly hospital/maternity facility has implemented the 10 steps to successful breastfeeding and has ended free and/or low-cost supplies of breast-milk substitutes
[31] A Certificate of Commitment is issued to hospitals/maternity facilities that are not yet complying with the standards but are committed to drawing up a work plan within a specific period of time
[32] Two hospitals are targeted to become baby-friendly in short term. In long term all of the hospitals are targeted to become baby-friendly
[33] Number does not include small special facilities
[34] No data available
[35] No data available
[36] As of October 29, 1998 there will be eight designated baby-friendly hospitals in Austria (based on information obtained from Ministry of Health October, 1998)
[37] All 180 hospitals are informed of the BFHI but it is up to the hospital to decide whether they want to participate in initiative or not
[38] The Department of Health does not have figures for the number of hospitals with the Certificate of Committment
[39] No data available
[40] No targets in figures

Table 7: Information on adoption of maternity legislation[41]

Country/ Region	Minimum 12 weeks maternity leave	Paid maternity leave[42]	Entitlement for nursing breaks (2 x 30 minutes/day)	Are any women not covered by legislation?	Are there any other restrictions?	Who is affected by restrictions?
BALKAN						
Albania	Y	Y	Y	N	N	
Croatia	Y	Y	N	Y	N	
Slovenia	NA	Y	N	N	N	
Rep. of Macedonia	Y	Y	N	Y	N	unemployed
BALTIC						
Estonia	Y	Y	Y	N	N	
Latvia	Y	Y	Y	Y	N	unemployed
Lithuania	NA	NA	NA	NA	NA	
CAR						
Kazakstan	Y	Y	Y	N	N	
Kyrgyzstan	Y	Y	Y	N	N	
Tajikistan	Y	Y	Y	Y	N	
Turkmenistan	NA	Y	Y	NA	NA	
Uzbekistan	NA	Y	NA	N	N	
Turkey	Y	Y	Y	N	N	
CEE						
Czech Rep.	Y	Y	Y	N	N	
Poland	Y	Y	Y	N	N	
Slovakia	Y	Y	N	N	N	
W. EUROPE						
Austria	Y	Y	Y	N	N	
Germany	Y	Y	Y	N	N	
Luxembourg	Y	Y	Y	N	N	
Netherlands	Y	Y	Y	Y	N	free-lancers
Switzerland	N	N	Y	N	N	
UK	Y	Y	N	N	N	
S. EUROPE						
Israel	Y	Y	Y	N	N	
Malta	Y	N	N	N	N	
Spain						
CIS						
Armenia	NA	NA	NA	NA	NA	
Belarus	Y	Y	Y	N	N	
Georgia	N	Y	N	N	NA	
Rep. of Moldova	Y	Y	Y	N	Y	unemployed
Russian Fed.	NA	NA	NA	NA	NA	
Ukraine	Y	Y	Y	N	N	
NORDIC						
Denmark	Y	Y	Y	Y	NA	
Finland	Y	Y	N	N	N	
Iceland	Y	Y	N	N	N	
Norway	Y	Y	Y	N	N	
Sweden	Y	Y	Y	N	N	

Y = Yes, N = No, NA = No Answer

[41] Has country adopted maternity legislation as a minimum in accordance with International Labor Organisations standards (ILO)
[42] At least two-thirds of previous earnings

Table 8: General Overview - data on implementation of targets set out in the Innocenti Declaration based on responses received from 35 Member States, 1997-1998

	Questions	Yes	No	No Answer
1.	**National Breastfeeding Committees**			
	Is there a National Breastfeeding Committee?	28 (80%)	6 (17%)	1 (3%)
	Is there National Breastfeeding Coordinator?	27 (77%)	7 (20%)	1 (3%)
	Is there a National Breastfeeding Policy?	22 (63%)	12 (34%)	1 (3%)
	Is there training on lactation management?	31 (89%)	4 (11%)	-
	Is there a public health education programme on breastfeeding?	28 (80%)	7 (20%)	-
	Are there activities promoting breastfeeding?	30 (86%)	5 (14%)	-
2.	**Baby-Friendly Hospital Initiative (BFHI)**			
	Is there a BFHI Committee?	23 (66%)	10 (28%)	2 (6%)
	Is there a plan of action for BFHI implementation & set targets?	21 (60%)	13 (37%)	1 (3%)
	Is there training of national BFHI assessors?	21 (60%)	11 (31%)	3 (9%)
3.	**International Code of Marketing of Breast-milk Substitutes**			
	Has the International Code of Marketing of Breast-milk Substitutes been implemented?	15 (43%)	18 (51%)	2 (6%)
	Is a national law being drafted?	18 (51%)	12 (34%)	5 (14%)
	Is a ban on free & low-cost infant formula supplies included in national action?	13 (37%)	13 (37%)	9 (26%)
	Is monitoring of the Code given effect in national action?	14 (40%)	13 (37%)	8 (23%)
	Is an enforcement mechanism in place?	7 (20%)	20 (57%)	8 (23%)
4.	**Maternal legislation**			
	Is there a minimum 12 weeks leave?	27 (77%)	2 (6%)	6 (17%)
	Is there a paid maternity leave?	30 (86%)	2 (6%)	3 (9%)
	Entitlement for nursing breaks (2 x 30 minutes/day)?	22 (63%)	9 (26%)	4 (11%)
	Are any women not covered by legislation?	6 (17%)	25 (71%)	4 (11%)
	Are there any other restrictions?	1 (3%)	28 (80%)	6 (17%)
5.	**Non-Governmental Organizations**			
	Are there NGOs working on breastfeeding?	25 (71%)	8 (23%)	2 (6%)

DISCUSSION

At the time the Innocenti Declaration was welcomed by the World Health Assembly in 1991, countries in the former Soviet Union and others were in the process of gaining independence and so many were unlikely to have received any information about the objectives of the Declaration. Out of the current (1998) 51 WHO Member States in the WHO European Region, 19 countries became Member States after 1990 (Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Georgia, Kazakstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Slovakia, Slovenia, Tajikistan, The Former Yugoslav Republic of Macedonia, Turkmenistan, Uzbekistan). Despite this many of these countries have made impressive progress towards improving child health through increasing awareness of the importance of breastfeeding in a relatively short space of time.

1. The National Breastfeeding Committee

	Yes	No	No Answer
Is there a National Breastfeeding Committee?	**28**	**6**	**1**

As stated in the first operational target of the Innocenti Declaration, all countries should establish a multisectoral national breastfeeding committee. Ideally, it should be composed of representatives from relevant government departments, health professional associations, relevant non-governmental organizations such as mother-to-mother support groups and ideally also a representative from the national Committee for UNICEF. The choice of title of the Committee remains at the discretion of the national authorities or initiative-takers.

Out of the 35 reporting Member States, 28 countries have established national breastfeeding committees. Countries with no committee are found in all regions.

In Norway there is no officially appointed breastfeeding committee but a multidisciplinary group made up of voluntary professionals (called Ammefagrådet) has existed for several years. The members of Ammefagrådet are appointed based on their competence and interests in breastfeeding. Members of Ammefagrådet initiated the implementation of the BFHI with the support and funding from the Directorate of Health. The BFHI in Norway started in 1993.

Sixty-nine percent (69%) of the national breastfeeding committees in WHO Member States include representatives from the government departments dealing with health issues, 49% from health professional associations and 46% from medical schools. Other representatives included members from UNICEF.

	Yes	No	No Answer
Is there National Breastfeeding Coordinator?	**27**	**7**	**1**

The first operational target of the Innocenti Declaration also calls for the appointment of a national breastfeeding coordinator of appropriate authority.

Twenty-seven Member States have national breastfeeding coordinators. In Norway the BFHI coordinator also has the function of a breastfeeding coordinator. Contact details of the countries breastfeeding coordinators can be found in Table 13.

	Yes	No	No Answer
Is there a national breastfeeding policy?	**22**	**12**	**1**

The Innocenti Declaration calls for governments to develop national breastfeeding policies and set appropriate national targets. National authorities are further urged to integrate their breastfeeding policies into their overall health and development policies. In so doing they should reinforce all actions that protect, promote and support breastfeeding within complementary programmes such as prenatal and perinatal care, nutrition, family planing services, and prevention and treatment of common maternal and childhood diseases.

In 22 of the reporting 35 Member States a national breastfeeding policy has been established. The breastfeeding policy is an integrated part of the nutrition policy in Norway. In the United Kingdom a written national breastfeeding policy has been distributed widely within the National Health Service (NHS) “Breastfeeding: Good practice guidance to the NHS”. The only regions in which all countries have established national policies are the regions of CAR/Turkey and CIS. Policies are less common in the Balkan and Baltic States. In the Western European region three countries reported having no written policy.

Table 9: Breastfeeding training and public health programmes

	Yes	No	No Answer
Is there training on lactation management?	31	4	0
Is there training of national BFHI assessors?	21	11	3
Is there a public health education programme on breastfeeding?	28	7	0
Are there activities promoting breastfeeding?	30	5	0

Ideally, all health care workers should be trained in the skills necessary to implement breastfeeding policies. Through lactation management training activities they become communicators of updated breastfeeding knowledge, attitudes and skills.

Eighty-nine percent (89%) of the 35 reporting Member States provide training on lactation management and in 60% of the countries there is training of national BFHI assessors. The only countries which reported not providing training on lactation management are some countries from the Western European and Nordic regions.

Eighty percent (80%) of the 35 reporting Member States have public health education programmes on breastfeeding and in 86% there are activities promoting breastfeeding. Activities include mass media events, publication of leaflets, brochures, posters, organization of conferences and courses, counselling, and the organization of the World Breastfeeding Week (WBW) (34%), an initiative introduced, in 1992, by UNICEF and the World Alliance for Breastfeeding Action (WABA)[43]. Annual themes link the celebrations in every country. The theme for World Breastfeeding Week 1999 is "Breastfeeding - Education for Life". The aim is to promote formal and non-formal education on

[43] WABA - World Alliance for Breastfeeding Action is a global network of organizations and individuals who believe breastfeeding is the right of all children and mothers and who dedicate themselves to protect, promote and support this right

breastfeeding as a source of life. It will target a wide range of audiences from pre-school children right up to professional institutions as well as communities. WBW 1999 will also look into curriculum

development at all levels of education, teaching methods, visual aids and various forms of information technology to help communicate lessons and messages on breastfeeding.

In Norway breastfeeding has been heavily focused within the health care system and also in the media in the last few years. A great number of teaching materials have been developed, including the video "Breast is Best". The video is used for teaching mothers on a regular basis in most maternity wards and many mother-and-child health care centres. It has received very positive reviews and it has been translated into 14 languages. Following Norway's successful campaign almost all Norwegian women seem to have a strong motivation to breastfeed**.** This motivation can be observed in the national breastfeeding rates. In 1992 around 98% of mothers in Norway were breastfeeding on discharge from the maternity ward, around 75% were still breastfeeding at three months after giving birth, about 50% at six months and 10% of children were still receiving some breast-milk at one year of age. In the past few years there has been a general increase in breastfeeding in Norway. The most striking increase is in the duration of breastfeeding at 9 months of age with more than 40% still breastfeeding[44]. To maintain and further increase the high breastfeeding rates Norway recognizes the need to improve training on lactation management in the education of health personnel working with infants and mothers.

2. Baby-Friendly Hospital Initiative

	Yes	No	No Answer
Is there a BFHI Committee?	**23**	**10**	**2**

In 23 Member States BFHI committees have been set up. Only 42% (5 out of 12) of the CAR and CIS countries have established BFHI committees.

In Norway a national – level BFHI authority was formed, partly by the already existing Ammefagrådet. Members of the Ammefagrådet initiated the implementation of the BFHI with the support and funding from the Directorate of Health.

As mentioned by Denmark and the Republic of Macedonia the activities of the BFHI committees are covered by the national breastfeeding committees. This or similar arrangement could also be the case in other Member States.

Fifty-four percent (54%) have representatives from government dealing with health issues, 43% from health professional associations and 31% from medical schools. No representatives from the baby food industry, advertising and marketing agencies or bottle and teat manufacturers were members of any committees.

	Yes	No	No Answer
Is there a plan of action for BFHI implementation & set targets?	**21**	**13**	**1**

Twenty-one of 35 reporting Member States have a plan of action. Out of the 11 countries from the Baltic, Western European and Southern European regions only one country has a plan of action.

A general target observed in several Member States' plans of action is the prolongation of the duration of exclusive breastfeeding. In Turkey the goal is to breastfeed the baby exclusively during

[44] For most parts of Norway data does not distinguish exclusive breastfeeding from partial breastfeeding

the first 6 months and in Switzerland 80% of mothers should exclusively breastfeed their babies at least until the end of the fourth month. In Norway the two main goals identified at the outset of BFHI (in Norway called the "mother-child friendly initiative") focused on making the start of breastfeeding

easier and on increasing the overall duration of breastfeeding (exclusive breastfeeding for the first 4-6 months and partial breastfeeding throughout at least the first year of life). In Turkey all 630 hospitals are targeted to become "baby-friendly" by the year 2000.

According to Swedish national statistics[45] on breastfeeding for infants born in 1993 one effect of the BFHI has been an overall increase in breastfeeding rates of roughly 4%. In 1993 around 94% of women were exclusively breastfeeding [46] on discharge, around 76% at two months after giving birth and about 37% were exclusively breastfeeding at six months.

Finnish mothers are motivated towards breastfeeding and nearly all mothers breastfed on discharge from maternity hospitals and 55-60% of mothers breastfeed up to age 6 month. However, this is rarely exclusive breastfeeding.

	Yes	No	No Answer
Is there training of national BFHI assessors?	21	11	3

In Luxembourg there is no national BFHI assessor training but BFHI assessors have the possibility of being trained abroad. In the United Kingdom training is available for BFHI assessors through the Baby Friendly Initiative. In Norway two people were trained as master assessors who have consequently educated sixteen other Norwegians to become assessors.

3. International Code of Marketing of Breast-milk Substitutes

Table 10: Implementation of the International Code of Marketing of Breast-milk Substitutes

	Yes	No	No Answer
Has the international code of marketing of breast-milk substitutes been implemented?	15	18	2
Is a national law being drafted?	18	12	5
Is a ban on free & low-cost infant formula supplies included in national action?	13	13	9
Is monitoring of the International Code given effect in national action?	14	13	8
Is an enforcement mechanism in place?	7	20	8

All WHO Member States adopted the International Code of Marketing Breast-milk Substitutes in 1981 at the 34th World Health Assembly. Member States who joined after this date have automatically accepted all earlier WHO resolutions. The Code was adopted as a recommendation and it is therefore up to Member Sates whether or not they wish to translate it into national legislation, regulations or other legal measures.

Of the 35 reporting Member States, 15 countries have taken action to implement provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health

[45] Breastfeeding in Sweden, 1996 Report from the Swedish Breastfeeding Institute for the WABA Global Forum, Bangkok, December 2-4 1996
[46] The Swedish definition for "exclusive breastfeeding" allows for the occasional bottle of breast-milk substitute.

Assembly Resolutions or have incorporated the mandatory provision of the European Union's Commission Directive 91/321/EEC on infant formulae and follow-on formulae.

The rules of composition, labelling and advertising laid down in the Commission Directive should be in conformity with principles and the aims of the Code, bearing in mind the particular legal and factual situation existing in the European Union. The Directive does not, however, cover the full range of products or marketing practices dealt with under the Code.

Since 1981 a wealth of information on the implementation and monitoring of the Code has been provided by Member States, and the organizations, groups and institutions collaborating with governments. Information on actions taken during the period 1994-1998 has been published in a recent WHO document [47]. This document provides information on action taken by WHO Member States from all regions in the World and by other interested parties. It complements information provided in the context of the last two reports by the Director-General on infant and young child nutrition presented to the 97th and 101st session of the WHO Executive Board (January 1996 and January 1998) and the 49th and 51st World Health Assemblies (May 1996 and May 1998), respectively. Attached in Annex 3 is a summary of information on action taken by WHO Member States in Europe which was published in 1998.

According to information in the WHO document [46] only two-thirds of Member States in the European region were reported to have taken action giving effect to the Code. Out of all six WHO regions (African, South-East Asia, Eastern Mediterranean, European, Western Pacific, the Americas), Europe has the lowest proportion of Member States who have implemented the Code. It should, however, be remembered that out of the current (1998) 51 WHO Member States in the WHO European Region, 19 countries (more than one-third) became Member States only after 1990 and many are still enduring social and economic unrest as a result of gaining independence.

Sweden and Norway were the first two countries to implement the Code (1983). In Norway the Director of Health has taken the initiative to have the Norwegian version of the Code revised.

The United Kingdom adopted the Infant Formula and Follow-on Formula Regulations 1995. These regulations give partial effect to the aims and principles of the International Code and are enforced by Trading Standards Officers and the courts. Previously there was a voluntary agreement with the infant food industry, which was negotiated in 1983.

In Kazakstan preparatory work has begun on drawing up a "Code of regulations" following a seminar on the Code in Almaty in June 1997.

Recognizing the importance of sound infant and young child nutrition for future health, governments play a prime role in the protection and promotion of breastfeeding as a means of improving infant and young child health. While not all the problems associated with infant feeding practices can be solved simply by a code of marketing, it is one of the key ways of improving the situation. Governments are encouraged to take steps towards implementing the Code as a proper legal instrument, as one of the many means of improving infant and young child health. As stated in the code governments should undertake a variety of health, nutrition and other social measures to promote healthy growth and development of infants and young children, and that the Code is only one aspect of these measures.

According to the information reported here by the 35 countries all maternity facilities in: Armenia, Estonia, Germany, Luxembourg, the Netherlands, The Republic of Moldova, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey and the Nordic countries have ended

[47] World Health Organization, *The International Code of Marketing of Breast-milk Substitutes: summary of action taken by WHO Member States and other interested parties, 1994-1998*, WHO, Geneva, 1998

distribution of free/low cost breast-milk substitutes. In Iceland the distribution of free breast-milk substitutes was never practiced.

4. Maternity legislation

Table 11: Maternity legislation

	Yes	No	No Answer
Is there a minimum 12 weeks leave?	27	2	6
Is there a paid maternity leave?	30	2	3
Entitlement for nursing breaks 2 x 30 minutes/day?	22	9	4
Are any women not covered by legislation?	6	25	4
Are there any other restrictions?	1	28	6

As stated in the Innocenti Declaration "All women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breast-milk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed while receiving appropriate and adequate complementary foods, for up to two years of age or beyond." To achieve this child-feeding ideal an appropriate environment of awareness and support should be created to enable women to breastfeed in this manner. This includes the elimination of obstacles that prevent or obstruct breastfeeding within the workplace. Theoretically, legislation ensuring maternity leave and breastfeeding breaks for working women would increase the amount of care for mothers and children during the first years of childhood. The International Labour Organization's (ILO) revised Maternity Protection Convention of 1952 (No. 103)[48] provided for a maternity leave of 12 weeks, free medical care, and two half-hour nursing breaks for women employed in industry and commerce.

Maternity legislation granting a minimum 12 weeks' maternity leave and paid maternity leave has been adopted in 77% and 86% of the 35 reporting Member States respectively. In Norway maternity leave is up to one year with 80% of previous earnings. In the United Kingdom statutory maternity leave is at least 14 weeks (regardless of length of employment) and further maternity absence is possible (up to the infants' 28th week of life) depending on length of employment. Statutory maternity pay in the United Kingdom is usually 90% of salary for the first six weeks and at least £52.50 for the next 12 weeks (rates may be higher depending on National Insurance contributions). In several Member States maternity leave can be up to three years (not fully paid).

The Maternity Protection Convention, 1919 (No.3), states in Article 3 (d) that a women shall "if she is nursing her child, be allowed half an hour twice a day during her working hours for this purpose". The Maternity Protection Convention (Revised), 1952 (No.103), extends this protection by stating that interruptions of work for the purpose of nursing are to be counted as working hours and that the time or times allowed for nursing breaks are to be prescribed by national laws or regulations.

Out of the responding 35 countries 22 countries make provisions for nursing breaks in the workplace. In the UK nursing breaks are a matter for negotiation and agreement between employer and employee.

[48] The 1952 Convention (No. 103) retained the same principle elements of protection set out in the 1991 Convention (No.3), however, the means and manner of providing benefits were made more explicit. The revision of the maternity Protection Convention (revised), 1952 (No. 103) , and Recommendation, 1952 (No.95) has been put on the agenda of the 87th Session (1999) of the International Labour Conference

In five Member States some categories of women are not covered by the maternity legislation. These include women who are unemployed (Republic of Macedonia, Republic of Moldova, Latvia) and women who work free-lance (the Netherlands).

5. Non-Governmental Organizations

	Yes	No	No Answer
Are there NGOs working on breastfeeding?	**25**	**8**	**2**

Non-governmental organizations are key players in supporting, promoting and protecting breastfeeding. Besides monitoring company and hospital practices, NGOs organize courses on Code implementation and distribute training material and information to hospitals staff and policy makers. The work of several NGOs has been invaluable in bringing about implementation of the Code and an end to the distribution of free and low-cost breast-milk substitutes.

NGOs working on breastfeeding are represented in 25 Member States. Limited information was provided on the members of the NGOs. Members of NGOs are mostly from health care professions and only a minority had representatives from government departments.

6. Maternity facilities and Baby-friendly hospitals

Table 12: Number of maternity facilities and Baby-Friendly Hospitals[49]

REGION	No. of hospitals with maternity facilities	No. of hospitals targeted to become "baby-friendly"	No. of hospitals designated as "baby-friendly"	No. of hospitals with "BFHI certificate of commitment
BALKAN	96	39	3	4
BALTIC	30	10	0	0
CAR & TURKEY	1272	648	65	4
CEE	629	2	29	23
WESTERN EUROPE	891	63	16	22
SOUTHERN EUROPE	35	5	0	0
CIS	831	22	6	1
NORDIC	239	125	94	58
TOTAL	**4023**	**914**	**213**	**112**

At the 45th World Health Assembly (1992) Member States were urged to encourage and support all public and private health facilities providing maternity services so that they become "baby-friendly" by providing the necessary training in the application of the principles and by encouraging the collaboration of professional associations, women's organizations, consumers and other nongovernmental groups, the food industry, and the competent sector in this endeavour.

The number of hospitals with maternity facilities ranged from 6 in Malta to 630 in Turkey. Over half of the hospitals with maternity facilities are located in only five Member States (Germany, Poland, Tajikistan, Turkey, Ukraine).

[49] See Annex 4 which gives more recent data from 1998

The 914 hospitals targeted to become baby-friendly in the European Region include 630 Turkish hospitals, which are targeted to become baby-friendly by the year 2000. This figure from Turkey increases the overall percentage of targeted hospitals from 7% to 23%.

An officially designated baby-friendly hospital has transformed its maternity services to be baby-friendly through the implementation of the "Ten steps to successful breastfeeding" and has ended free and/or low-cost supplies of breast-milk substitutes. Out of 4023 hospitals 213 have been designated as "baby-friendly". The three countries with the highest number of designated hospitals are Turkey with 65 hospitals, Sweden with 57 and Norway with 35 hospitals (73% of all designated hospitals).

There are no hospitals designated as "baby-friendly" or which have received the BFHI certificate of commitment in the Baltic region, Southern European countries or the Republics in Central Asia.

Additional more recent country-by-country figures for 1998 for Baby-Friendly Hospitals (UNICEF, Geneva, 1998) are given in Annex 4.

NATIONAL BREASTFEEDING COORDINATORS IN WHO MEMBER STATES

Table 13: Contact details of National Breastfeeding Coordinators in WHO European Member States

Country	Contact Person	Address	Telephone	Fax
Albania	Dr. Linda Ciu,	Rr. Fadil Rada, P. Rruga URA SH1 App.5, Tirana, Albania	(355-42)-248 84	same as Tel
Armenia	Dr.Anahit Demirchian	Tumanian 8, Yerevan 375001	(374-2)-564282	(374-2)-151097
Austria	No Coordinator			
Belarus	Dr. Zinaida A Sevkovskaya	Mother & Child Health Protection, Ministry of Health 39 Miasnikov str , 220048 Minsk	(375-172)-226598	(375-172)-226297
Croatia	Prof. Dr. Josip Grguric	Children's Hospital Zagreb, Klaiceva 16, Zagreb	(3851)-440 455	(3851) 455 1308
Czech Rep.	Dr. Josf Novacek	President of National Committee UNICEF Vysenradska 51,120 00 Prague 2	(420-2)-24484553	(420-2)-24915328
Denmark	Tine Vinther Jerris	Østbanegade 55/5 Postbox 2639, DK-2100 Copenhagen	(45)-35265470	(45)-35430213
Estonia	Ruth Soonets	Children's Policlinic of Tartu, Orn 3, EE 2400, Tartu,	(372-27)-422159	-
Finland	Ritva Kuusisto	RY/ETRA Annankatu 29A 9, FIN-00100 Helsinki	(358-9)694 4177	-
Germany	Prof. Dr. K.W. Tietze National Breastfeeding Committee	Robert Koch-Institut Postfach 65 02 80, D-13302 Berlin	030-45473328	030-45473203
Georgia	No name provided			
Iceland	No Coordinator			
Israel	Janice Wasser MPH	Mother & Child Health Department, Public Health Services, Ministry of Health , Jerusalem	(972-2)-6247125	
Kazakstan	Prof. Tamara K. Chuvakova	Head of Department of Neonatology, Ministry of Health, 28-69 ul Vinogradov, 480091 Almaty,	(7-3272)-24 15 60 (office) (7-3272)-62 12 05 (private)	
Kyrgyzstan	Apisa Kushbakeeva	Chief Paediatrician Ministry of Health 148, ul Moskovskaja, Bishkek	(8-3312)-26 12 13 (office) (8-3312)-47 49 18 (private)	(8-3312)228424
Latvia	Ass. Prof. Ieva Ranka	Latvian Breastfeeding Association	536189 459806	(3717) 828155
Lithuania	Dr. Giedra Leviniene	Medical Academy of Kaunas Eiveniu str 2 3007 Kaunas,	(370-7)-733453 or (370-7)-799627	
Luxembourg	Sylvie Paquet	Direction de la Santé Division de la Médecine Préventive et Sociale 22 rue Goethe, L-1637, Luxembourg	(352)-478-5568	(352)-291121
Malta	No coordinator – Maria Ellul can be contacted	Nutrition Unit, Health Promotion Department, 7 Harper Lane, Floriania NLT14,	(356)-242862	(356)-235107
Moldova	Ludmila Ciocarlea	Ministry of Health Department of Medical Assistance to Mother and Child	(3273)-73-53-27	(3273)-738781
Netherlands	No Coordinator			
Norway	Dr. Gro Nylander	Kvinneklinikken Rikshospitalet, 0027 Oslo	22869201	22869235

Table 13: Contact details of National Breastfeeding Coordinators in WHO European Member States

Country	Contact Person	Address	Telephone	Fax
Poland	Krystyna Mikiel-Kostyra	Institute of Mother & Child UL Kasprzaka 17 A 01-211 Warsaw	632 36 74	
Russian Fed.	No information			
Slovakia	Dr. Viera Halamova	Lamanskeho 10 831 03 Bratislava	421-7-375691	421-7-365 084 (at UNICEF)
Slovenia	Dr. Borut Bratanic	BFHI Committee, UNICEF Linhartova 13, 1000- Ljubljana, Slovenia	(386 61) 1314340	386 611314302
Sweden	No coordinator			
Switzerland	Dr. Andrée Lappé	Swiss Committee for UNICEF Baumackerstr 24 , CH-8050 Zürich	(41-1)-3031106	(41-1)-3031156
Tajikistan	Nozira Pulatovna Artykova	Apt.33, 24/1 ul. N. Karabaeva, Dushanbe, Tajikistan	21 36 56 or 33 29 39	
Turkey	-	Ministry of Health, General Directorate Mother Child Health & Family Planning, Sihhiye, Ankara, Turkey	(90312) 435 2210	(90312) 431 4872
Turkmenistan	Aziz Mul'kamanovich Redzhepov	Chef Paediatrician, Ministry of Health, 90 ul. Magtumguly, Ashgabat	993 12 25 59 04 (office) 44 83 89 (private)	993 12 25 50 32 (office)
Ukraine	Sushma Elena Grigorjevna	Chief Neonatologist Ministry of Health Grushevskogo 7, Kiev 252021		
United Kingdom	Cynthia Rickitt	8 Beal Walk High Shincliffe, Durham DH1 2PL	(44191) 386 0781	(44191) 386 8423
Uzbekistan	Rakhmatullaeva	Feruza Khamidullaevna Olimpiya No. 42 flat 18	29 10 01(private)	

CONTACT PEOPLE AT UNICEF AND WHO

Table 14: Contact people at UNICEF and WHO

Organization	Contact Person	Address	Tel No.	Fax No.
UNICEF Geneva	Ms Hind Khatib	UNICEF Palais des Nations CH-1211 Geneva Switzerland	41-22 909 56 47	41-22 909 5909
WHO Headquarters	Ms Randa Saadeh Programme of Nutrition	WHO Headquarters 20, Avenue Appia CH-1211 Geneva 27 Switzerland	41-22 791 33 15 Email: Saadehr@who.ch	41-22 791 4156
WHO Headquarters	Dr Felicity Savage King Programme of Child Health and Development	WHO Headquaters 20, Avenue Appia CH-1211 Geneva 27 Switzerland	41-22 791 26 33 E-mail: Savagekingf@who.ch	41-22 791 4853
WHO Regional Office for Europe	Dr Aileen Robertson Acting Regional Adviser for Nutrition	WHO, Regional Office for Europe, 8 Scherfigsvej DK-2100 Copenhagen Denmark	45-3917 1362 Email: aro@who.dk	45-39 17 1818 45-39 17 1854
WHO Regional Office for Europe	Dr Viviana Mangiaterra Regional Adviser for Child Health Development	WHO, Regional Office for Europe, 8 Scherfigsvej DK-2100 Copenhagen Denmark	45-3917 1717 Email: vma@who.dk	45-39 17 1818

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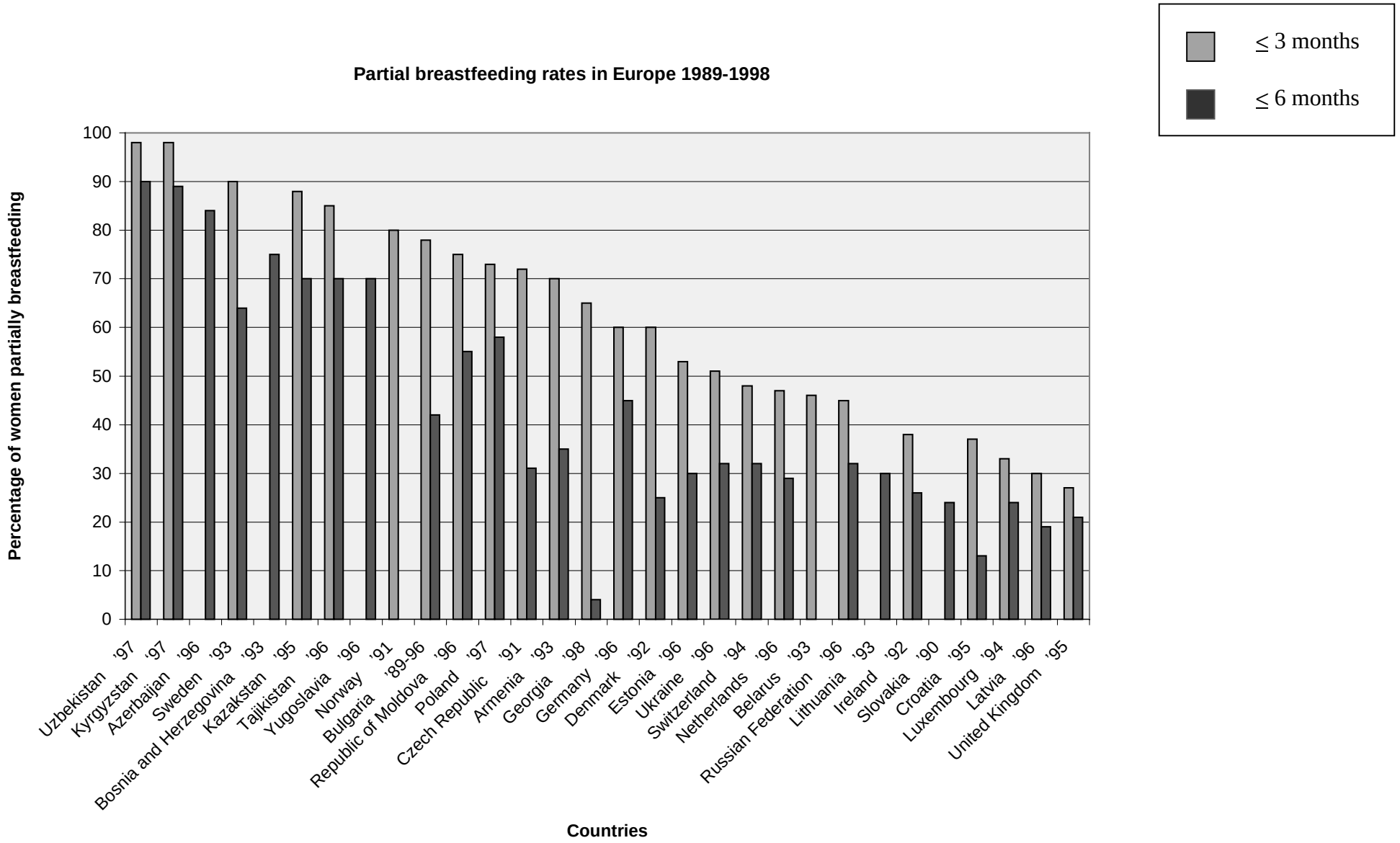
Annex 1: Data on partial breastfeeding prevalence



While compiling the data for the figure in Annex 1 it became clear that there is no systematic way in which figures on the number of women exclusively breastfeeding are collected. Various definitions are used including: partial, predominant and exclusive breastfeeding. The main problem appears to be that the definition "exclusive" is not precise. From the surveys reviewed only a handful of investigators appear to define "exclusive" breastfeeding as "frequent, on demand feeding, without giving bottles, dummies or other foods or fluids, but allowing for essential medicines". There is clearly a need to review the definitions and develop a standardised methodology which can be routinely applied when breastfeeding surveys are carried out.

The lack of representative and comparable national data on the number of women breastfeeding makes any statement about the breastfeeding prevalence in the WHO European Region extremely difficult. Clearly there is a need to develop standardised definitions to facilitate this process. The data on the percentage of infants who are breastfed in the figure in Annex 1 have been taken from different sources. These data should be interpreted cautiously, because the definitions used by the investigators were different and in some cases not clearly defined in the survey reports.

The figure in Annex 1 must therefore be interpreted cautiously but with these provisions, it appears that the practice of breastfeeding varies dramatically in the European Region. Breastfeeding rates range from over 90 % in Uzbekistan at ≤ 6 months compared with only 4 % in the same age group in Georgia. Within countries the prevalence of breastfeeding also changes rapidly during the first few months and in some countries women appear to stop breastfeeding very early. For example in Georgia rates appear to drop from over 60 % at ≤ 3 months to only 4 % at ≤ 6 months. This may reflect problems with the methodology rather than presenting the truth. In some countries there has been dramatic improvements in breastfeeding levels due to the strategies that have been implemented e.g. in Norway the prevalence of breastfeeding in the 3rd month was 25-30 % in 1969 compared with 80 % in 1991.

Surveys carried out in the Central Asian Republics indicate that, despite the high prevalence of breastfeeding, only a low percentage of infants are exclusively breastfed. The lack of exclusive breastfeeding, in addition to deteriorating socio-economic conditions, water contamination, and problems with immunisation all pose threats to infant health. In Kazakhstan, even if the mean duration of breastfeeding is relatively long (around 12 months), exclusive breast-feeding until around 6 months is rare. In addition from qualitative surveys carried out in the region it appears that mothers do not give their infants the fore and the hind milk. In the following countries Sweden, Poland, Kyrgyzstan, Georgia, Luxembourg, Kazakhstan and Uzbekistan the rate of "exclusive" breastfeeding at ≤ 3 months is 76, 38, 31, 31, 17, 12 and 4 % respectively. In some countries, where great efforts have been made to educate the public, the percentage of exclusively breast-fed infants is extremely high (e.g. in Norway and Sweden).

The development of standard methodology to assess levels of exclusive breastfeeding is needed. The results obtained from surveys using standard methodology would improve the ability of policy makers to assess the national situation and develop appropriate intervention strategies in a timely fashion.

Annex 2: Questionnaire

Assessing progress towards meeting the operational targets of the Innocenti Declaration

Country

1. Is there a breast-feeding committee in your country?…….…….. □Yes □No

   A Baby-friendly Hospital Initiative committee?…….……...□Yes □No

   Nongovernmental organizations (NGO) working on breast-feeding? …….…… □Yes □No

   If yes to any of the above, who is represented on each type of committee?

Representative	national breast-feeding committee	BFHI committee	NGO breast-feeding committee
• Government department dealing with:			
- health	□	□	□
- women's affairs	□	□	□
- other related issues (specify)	□……	□……	□……..……
• Nutrition institute of centre	□	□	□
• Health professional associations	□	□	□
• Universities	□	□	□
• Medical schools	□	□	□
• Nursing schools	□	□	□
• Mother-to-mother groups	□	□	□
• Breast-feeding counselling groups	□	□	□
• Women's organizations	□	□	□
• Infant food manufacturers	□	□	□
• Bottle and teat manufacturers	□	□	□
• Advertising/marketing agencies	□	□	□
• Other	□……	□…….……..	□…….……..

2. Is there a national breast-feeding coordinator……..□Yes □No

If yes, please give full name,
address, phone and fax number ……
……
……
……
……

3. Is there a written national breast-feeding policy,
which I routinely communicated to all health –care staff?……. ……..□Yes □No

4. Is there a plan of action for BFHI implementation ……..……..…….□Yes □No
and set targets

If yes, please attach a copy

5. How many hospitals with maternity facilities
do you have in your country?…….……..

What is the proportion of deliveries in health facilities?…….

How many hospitals are targeted to become baby-friendly?…….

How many hospitals are designated baby-friendly? …….

How many hospitals have a ‘ BFHI Certificate of Commitment’? ……..

How many hospitals have ended distribution of
Free/low-cost breast-milk substitutes?……..….

6. Is there a breast-feeding training programme in your country?

-training of lactation management?…….□Yes □No

-training of national BFHI assessors?……..……. ……. □Yes □No

How many senior staff are trained in breast-feeding?
(e.g. Wellstart or other institution) …….

Has your country a public health education programme on breast-feeding …….□Yes □No

For example, breast-feeding week, newsletters etc
Or a mass media campaign on breast-feeding?……..…… ……. □Yes □No

If yes, what year? …….

Describe briefly …….

…….

…….

7. Has the International Code of Marketing of Breast-milk Substitutes been adopted in your country?……..……□Yes □No

If yes, when

Was this adopted for example, as:

□ law/regulation/decree
□ agreement with health workers
□ agreement with infant-food industry

Does national action include a ban on free and low-cost supplies of infant formula?…….……..……..□Yes □No

Is the national action to give effect to the International Code being monitored?……..□Yes □No

Is an enforcement mechanism in place?…….……..……□Yes □No

Is a national code being drafted? …..…….……..……□Yes □No

8. Has your country adopted maternity legislation as a minimum in accordance With International Labor Organization standards, i.e.

Minimum 12 weeks' maternity leave…….……..……□Yes □No

Paid maternity leave (at least two-thirds of previous earning)……..…..…… □Yes □No

Entitlement to nursing breaks for 30 minutes, twice a day.……..…… □Yes □No

Are any groups of women not covered by this legislation? ……..……□Yes □No

Are there any other restrictions?……..……..……..……□Yes □No

If yes, what are these groups? ……...…..……
……..……
……..……
……..

Annex 3: International Code of Marketing of Breast-milk Substitutes

Extracted from WHO report on "*The International Code of Marketing of Breast-milk Substitutes: summary of action taken by WHO Member States and other interested parties, 1994-1998* (WHO, Geneva, 1998)

European Region

43. 1995 the Government of **Austria** adopted an ordinance[50] for health and consumer protection relating to infant formula and follow-on formula in accordance with the European Union's Commission Directive 91/321/EEC of 14 May 1991 on infant formulae and follow-on formulae.[51]

44. The Government of **Denmark** adopted regulations, published on 17 March 1997, to give effect to Directive 91/321/EEC.

45. In **Finland** Ordinance No. 337 of 29 April 1994 on breast-milk substitutes and complementary foods[52] covers the composition, marketing, sale, and other forms of supply of breast-milk substitutes and complementary foods, and related informational materials and advertising. Other provisions deal with composition, labelling (including prohibitions and restrictions), and marketing. The Ministry of Health and Social Welfare is responsible for ensuring that objective and unambiguous informational material is made available to families and to professionals responsible for infant and young child nutrition.

46. Law No. 94-442 of 3 June 1994[53] in **France,** which amends the Consumer Code, contains a new section (8) dealing with advertising and commercial practices concerning infant formula, defined as "foods intended for consumption by infants up to the age of four months and presented as satisfying all nutritional requirements for such infants". Advertising for infant formula is authorized only in the print media intended for health professionals; it is prohibited in retail trade, as are infant formula samples and any other promotional activity in favour of the direct sale of such products. Manufacturers and distributors are likewise prohibited from supplying infant formula free of charge to the public, samples of such products, or any other promotional gifts, whether directly, or indirectly through the health services or their employees.

47. On 29 June 1994 the federal parliament in **Germany** adopted the Bill on the Advertising for Infant Formula and Follow-on Formula (Infant Food Advertising Act) to incorporate into German law the mandatory provisions of Commission Directive 91/321/EEC. Sections 3 and 4 of the Law of 10 October 1994,[54] which implement Articles 7-9 of the Directive, essentially reproduce the provisions of, respectively, Article 9 (labelling) and 4 (information and education) of the International Code. In keeping with a resolution by the parliament's committee on health, the Federal Government reported two years later on experience gained in implementing the Act and on the question of whether to set up an advisory council to assess promotional claims based on statements sought from the highest Laender (state) authorities responsible for food control, consumer associations, breastfeeding support groups, health professionals, and the food industry. A variety of often divergent views were expressed; however, the majority of the highest Laender authorities responsible for food control believed that gaps may exist in monitoring and enforcing the Act on the part of preventive health care institutions

[50] International Digest of Health Legislation, **47(**1): 50 (1996**).**
[51] International Digest of Health Legislation, **42**(4): 675-688 (1991).
[52] International Digest of Health Legislation, **45**(4): 505 (1994).
[53] International Digest of Health Legislation, **45(**4): 506 (1994).
[54] International Digest of Health Legislation, **46(**2): 208-209 (1995).

and professionals. In October 1996, the Federal Ministry for Health convened a meeting of all parties concerned to examine the functions of an

advisory council, and whether it should be established and where. Although no such body has yet been created, the Ministry has declared its willingness to reconvene a meeting of concerned parties when additional experience has been gained in implementing the Act.

48. In **Italy** Commission Directives 91/321/EEC and 92/52/EEC on infant formulae and follow-on formulae were adopted by Decree No. 500 of 6 April 1994.

49. Regulations concerning infant formulae and follow-on formulae were adopted in **Luxembourg** on 20 November 1993 to give effect to Commission Directive 91/321/EEC. Advertising of infant formula to the general public is prohibited. However, specialized child-care and scientific publications may be used for this purpose provided that the information is both scientific and factual, and does not infer tha tbottle-feeding is equal, or superior, to breastfeeding. Advdertising at the retail level, distribution of samples, or any other promotional practive direct to the consumer are also prohibited. Manufacturers and distributors of infant formula may not provide mothers or members of their families, whether directly or indirectly through the health services or health workers, free or low-price products, samples or any other promotional gifts.

50. As part of its national breastfeeding promotion policy, the Government of **Malta** has prepared draft legislation on the marketing and distribution of breast-milk substitutes in accordance with European Union law. The Minister of Health is expected to present the draft law to the cabinet in the near future, in the form of a white paper.

51. In 1994 the Ministry of Health in the **Netherlands** sent 15 000 letters to remind health workers throughout the country that samples of breast-milk substitutes should not be distributed to mothers or members of their families.

52. By Act of 19 March 1997, the Minister of Health and Social Welfare of **Poland** was authorized to introduce, in the form of a regulation, the prohibition of all forms of advertising and promotion of breast-milk substitutes and feeding utensils.

53. The Board of Health and Social Welfare in **Sweden** established a task force in January 1996 to review measures adopted in 1983 to give effect to the International Code in the form of a recommendation. Given that a majority of mothers are still breastfeeding at 6 months postpartum and a large number continue to do so until 12 months of age, it was decided that the Code should apply to products intended for use during the entire first year of life, including breast-milk substitutes, follow-on formula, and feeding bottles, teats and pacifiers. In the new approach to implementing the International Code, each article is presented with comments on how it should be interpreted and applied. Described as more strict, specific and to the point that the 1983 recommendation, the revision uses the equivalent of the word “shall” in place of “should”.[55]

54. New legislation[56] came into force in **Switzerland** on 1 July 1995, dealing with the quality and labelling of infant formula and follow-on formula; it is described as “compatible with both the corresponding provisions of the European Commission Directive 91/321/EEC and the International Code”. Following consultations with the Federal Office of Public Health, the Federal Commission on Diet, the Swiss Paediatric Society, the Federation of Swiss Physicians, and a working group established by the Swiss Committee for UNICEF, Swiss infant-formula producers, in collaboration with the Swiss Association of the Producers of Dietetic Products, accepted on a voluntary basis a new

[55] Ordinance of 1 March 1995 on foods. International Digest of Health Legislation, **46**(4)511-512 (1995).

Code of conduct on the marketing of infant formula that also took effect on 1 January 1995.[57] The new Code is described as taking explicit account of new developments in this area since 1982, in particular relevant resolutions of the World Health Assembly and the Commission Directive.

Information addressed to mothers dealing with the use of infant formula should refer to the need to consult a physician or other health specialist on infant feeding and should stress the importance of breast milk. All information relating to infant formula and intended for mothers, e.g. brochures, leaflets and advertisements, must be designed so as not to deter mothers from breastfeeding. Media advertising for infant formula is authorized only in publications devoted to child-rearing, scientific matters, or those supplied by qualified health-service staff. Manufacturers are responsible for ensuring that there is no advertising or any promotional offers at the retail level. Product samples provided by manufacturers to institutions and the qualified staff of health services are intended exclusively for mothers within the framework of counselling activities and are to be supplied only against a specific request. A panel composed of representatives of each of the parties participating in drafting of the Code of Conduct is responsible for ensuring compliance with its provisions.

55. The Infant Formula and Follow-on Formula Regulations[58] came into force in the **United Kingdom of Great Britain and Northern Ireland** on 1 March 1995 to implement Commission Directive 91/321/EEC. Provisions deal with composition of products sold in both the domestic and export market limit infant formula advertising to specified publications and restrict the content of advertisements; prohibit special infant formula advertising to specified publications and restrict the content of advertisements; prohibit special infant formula displays or promotions in retail outlets and promotion of infant formula to the general public, expectant mothers, and others by providing formula free or at reduced prices; lay down requirements for informational and educational materials dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children; and regulate when a manufacturer or distributor may make gifts of such equipment or materials.

[57] International Digest of Health Legislation, **46**(4): 585-587 (1995).
[58] International Digest of Health Legislation, 46 (3): 342-343 (1995).

Annex 4: Overview of BFHI Implementation in Europe [59]

Countries	National BF Committee	National Goals/Action Plan	No. of targeted Hospitals	Baby-Friendly Hospitals	Training Activities In 1996	Free and Low Cost Supplies	Govt. Action on Ending Free and Low Cost Supplies
Albania			0	0	Code training.	Yes	No
Armenia	Established	Developed in collaboration with Well-start.	10	0	Training on the 18-hour course of 600 health care practitioners.	Yes	No
Austria	Established	Being developed.	0	7	Training of LC's and assessors.	Yes	EUD
Azerbaijan	Established	Being developed.	19	0	Training of health staff on 18-hour course from nine maternities.	Yes	No
Belarus	Established	Developed	10	1	Trained 80 health care practitioners on 18-hour course, Code training and assessment training.		
Belgium	In process	In process	0	0	Training on 18-hour course in several hospitals.	Yes	EUD - adopted as their national legislation.
Bosnia & Herzegovina	Established	Developed	8	2	Training of health staff on the 18-hour course and assessment training.	available.	No
Bulgaria	Established		0	0			
Croatia	Established	Developed	20	14	Training on 40hour course for Health Care Practitioners	available.	No
Czech Republic	Established	Developed	20	10	Training of 70 health staff on 18-hour course.	Yes	In process.
Denmark	Established	Developed	5	5	In-service training to health staff in maternities.	No	EUD
Estonia	Established	Being developed.	4	0	Assessment training, Code training.	No	No

[59] UNICEF , Geneva, 1998

Annex 4: Overview of BFHI Implementation in Europe [59]

Countries	National BF Committee	National Goals/Action Plan	No. of targeted Hospitals	Baby-Friendly Hospitals	Training Activities In 1996	Free and Low Cost Supplies	Govt. Action on Ending Free and Low Cost Supplies
Finland	Established	NGO Action Plan	7	2	TOT on 40-hour course.		No
France		NGO Action Plan.	0	0	In-service training in 20 hospitals.	Yes	National legislation based on EUD.
Georgia	Established	Developed in cooperation with Wellstart.	5	5	Wellstart 40-hour course, Code training.		
Germany	Established	Developed	0	11	In-service training on 80 -hour course.	Yes	EUD
Greece	In process		0	0		Yes	EUD
Hungary	Established	Developed	25	9	TOT on 40-hour course planned.	Yes	No
Ireland	Established	Developed	1	0	Planned TOT on 40-hour course.	No	Voluntary Code
Israel		NGO and interested individuals work.	0	0	Health staff of two maternities on 18-hour course.		
Italy	Established	Being developed.	5	0	NGO training, area specific - Trieste region, training of 60 health staff on 18-hour course.	Yes	EUD with some amendments.
Latvia	Established	Developed	0	0	Trained 60 pediatricians, Code training.	No	No
Lithuania	Established	Developed	4	0	Code training, TOT on 40-hour course planned.	No	No
Luxembourg	Established	Developed	0	0	Informal training.	Yes	EUD
Moldova	Established	Developed	18	6		Yes	No
Netherlands	Established	Developed	6	3	TOT on 40-hour course, assessment training.	No	EUD
Norway	Established	Developed	37	35	4 courses implemented, 3 planned.	No	Voluntary agreement.

Annex 4: Overview of BFHI Implementation in Europe [59]

Countries	National BF Committee	National Goals/Action Plan	No. of targeted Hospitals	Baby-Friendly Hospitals	Training Activities In 1996	Free and Low Cost Supplies	Govt. Action on Ending Free and Low Cost Supplies
Poland	Established	Developed	20	21	Training of health staff of 11 hospitals.	No	National legislations are being developed.
Portugal	Established	Being developed.	3	0	TOT on 40-hour course planned.	No	Voluntary Code.
Romania	Established	Developed	9	10	TOT on 40-hour course, assessment training.	Yes	No
Russian Federation	In process	In process	18	3	Code training, TOT on 40-hour course planned, assessment training.	Yes	No
Slovak Republic	Established	Developed	8	5	Training of Health Care Practitioners on 40-hour course.	Yes	Drafted
Slovenia	Established	Established	5	1	HAC & 18hour Course	Yes	No
Spain	Established	Established	4	2	HAC & 40hour Course	Yes	EUD
Sweden	Established	Developed	64	64	On-going In-service training.	No	Voluntary agreement.
Switzerland	Established	Regional Action Plans developed.	30	20	Training of health staff for interested hospitals.	Yes	National legislation adopted.
The Former Yugoslav Republic of Macedonia	Established	Developed	6	0	Training of health staff on the 18-hour course and assessment training.	available.	No
Turkey	Established	Developed	157	80	Training of health staff and TOT on 40-hour course.	Yes	Government agreement.
UK	Established	Developed	25	3	Training of health staff of targeted hospitals.	No	National legislation.
Ukraine	Established	In process	0	0	HAC, TOT 40hour Course.	Yes	
Total	**25**		**553**	**319**			