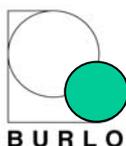




**European
Commission**
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Assessment



IRCCS Burlo Garofolo
Trieste, Italy



**Unit for Health Services Research
and International Health**
WHO Collaborating Centre for
Maternal and Child Health

Protection, promotion and support of breastfeeding in Europe: a blueprint for action

Developed and written by participants of the project:
Promotion of Breastfeeding in Europe
(EU Project Contract N. SPC 2002359)

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Abbreviations

BFH	Baby Friendly Hospital
BFHI	Baby Friendly Hospital Initiative
CME	Continuing Medical Education
CRC	UN Convention on the Rights of the Child
EU	European Union
EURODIET	Nutrition and Diet for Healthy Lifestyles in Europe
FAO	Food and Agriculture Organization
IBCLC	International Board Certified Lactation Consultant
IBLCE	International Board of Lactation Consultant Examiners
IEC	Information, Education, Communication
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
M2M	Mother-to-mother
NGO	Non-Governmental Organization
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
WHO/EURO	World Health Organization Regional Office for Europe

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I. Foreword

It is with great pleasure that I present this Blueprint for Action for the protection, promotion and support of breastfeeding in Europe, which has been developed by a project co-funded by the Directorate General for Health and Consumer Protection of the European Commission.

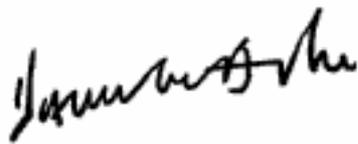
The promotion of breastfeeding is one of the most effective ways to improve the health of our children. It has also beneficial effects for mothers, families, the community, the health and social system, the environment, and the society in general.

There are numerous initiatives at local, regional, national and international level that promote breastfeeding. I believe, however, that the chances that these initiatives achieve good and permanent results will be much higher if action is based on sound plans including activities of proven effectiveness integrated into a coordinated programme.

The Blueprint for Action provides a framework for the development of such plans. The Blueprint will be made available to all those Governments, institutions and organizations who are willing to work together for the protection, promotion and support of breastfeeding. I invite them to use the Blueprint and translate its proposals and recommendations into action.

I am confident that these plans will contribute to meeting the demand of European citizens for better information for and support to the best start in life for their children.

I wish to thank the group of people who developed and wrote the Blueprint for Action for their contribution.



David Byrne
European Commissioner for Health and Consumer Protection

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III. Executive summary

The protection, promotion and support of breastfeeding are a public health priority throughout Europe. Low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment, result in greater expenditure on national health care provision, and increase inequalities in health. The Global Strategy on Infant and Young Child Feeding, adopted by all WHO member states at the 55th World Health Assembly in May 2002 provides a basis for public health initiatives to protect, promote and support breastfeeding.

Extensive experience clearly shows that breastfeeding can be protected, promoted and supported only through concerted and coordinated action. This Blueprint for Action, written by breastfeeding experts representing all EU and associated countries and the relevant stakeholder groups, including mothers, is a model plan that outlines the actions that a national or regional plan should contain and implement. It incorporates specific interventions and sets of interventions for which there is an evidence base of effectiveness. It is hoped that the application of the Blueprint will achieve a Europe-wide improvement in breastfeeding practices and rates (initiation, exclusivity and duration); more parents who are confident, empowered and satisfied with their breastfeeding experience; and health workers with improved skills and greater job satisfaction.

Prevailing budgets, structures, human and organizational resources will have to be considered in order to develop national and regional action plans based on the Blueprint. Action plans should build on clear policies, strong management and adequate financing. Specific activities for the protection, promotion and support of breastfeeding should be supported by an effective plan for information, education and communication, and by appropriate pre- and in-service training. Monitoring and evaluation, as well as research on agreed operational priorities, are essential for effective planning. Under six headings, the Blueprint recommends objectives for all these actions, identifies responsibilities, and indicates possible output and outcome measures.

1. Policy and planning

A comprehensive national policy should be based on the Global Strategy on Infant and Young Child Feeding and integrated into overall health policies. Specific policies for socially disadvantaged groups and children in difficult circumstances may be needed to reduce inequalities. Professional associations should be encouraged to issue recommendations and practice guidelines based on national policies. Long- and short-term plans should be developed by relevant ministries and health authorities, which should also designate suitably qualified coordinators and inter-sectoral committees. Adequate human and financial resources are needed for implementation of the plans.

2. Information, education, communication (IEC)

Adequate IEC is crucial for the re-establishment of a breastfeeding culture in countries where artificial feeding has been considered the norm for several years/generations. IEC messages for individuals and communities must be consistent with policies, recommendations and laws, as well as consistent with practices within the health and social services sector. Expectant and new parents have the right to full, correct and optimal infant feeding information, including guidance on safe, timely and appropriate complementary feeding, so that they can make informed decisions. Face-to-face counselling needs to be provided by adequately trained health workers, peer counsellors and mother-to-mother support groups. The particular needs of the women least likely to breastfeed must be identified and actively addressed. The distribution of marketing materials on infant feeding provided by manufacturers and distributors of products under the scope of the International Code of Marketing of Breast-milk Substitutes should be prevented.

3. *Training*

Pre- and in-service training for all health worker groups needs improvement. Pre- and post-graduate curricula and competency on breastfeeding and lactation management, as well as textbooks, should be reviewed and developed. Evidence-based in-service courses should be offered to all relevant health care staff, with particular emphasis on staff in frontline maternity and child care areas. Manufacturers and distributors of products under the scope of the International Code should not influence training materials and courses. Relevant health care workers should be encouraged to attend advanced lactation management courses shown to meet best practice criteria for competence.

4. *Protection, promotion and support*

Protection of breastfeeding is largely based on the full implementation of the International Code, including mechanisms for enforcement and prosecution of violations and a monitoring system that is independent of commercial vested interests; and on maternity protection legislation that enables all working mothers to exclusively breastfeed their infants for six months and to continue thereafter. Promotion depends on the implementation of national policies and recommendations at all levels of the health and social services system so that breastfeeding is perceived as the norm. Effective support requires commitment to establish standards for best practice in all maternity and child care institutions/services. At individual level, it means access for all women to breastfeeding supportive services, including assistance provided by appropriately qualified health workers and lactation consultants, peer counsellors, and mother-to-mother support groups. Family and social support through local projects and community programmes, based on collaboration between voluntary and statutory services, should be encouraged. The right of women to breastfeed whenever and wherever they need must be protected.

5. *Monitoring*

Monitoring and evaluation procedures are integral to the implementation of an action plan. To ensure comparability, monitoring of breastfeeding initiation, exclusivity and duration rates should be conducted using standardised indicators, definitions and methods. These have not been agreed yet in Europe; more work is urgently needed to develop consensus and issue practical instructions. Monitoring and evaluation of practices of health and social services, of implementation of policies, laws and codes, of the coverage and effectiveness of IEC activities, and of the coverage and effectiveness of training, using standard criteria, should also be an integral part of action plans.

6. *Research*

Research needs to elucidate the effect of marketing practices under the scope of the International Code, of more comprehensive maternity protection legislation, of different IEC approaches and interventions, and in general, of public health initiatives. The cost/benefit, cost/effectiveness and feasibility of different interventions need also further research. The quality of research methods need to substantially improve, in particular with regards to adequate study design, consistency in the use of standard definitions of feeding categories, and use of appropriate qualitative methods when needed. Ethical guidelines should ensure freedom from all competing and commercial interests; the disclosure and handling of potential conflicts of interest of researchers is of paramount importance.

IV. Introduction

The protection, promotion and support of breastfeeding are a public health priority because:

- Breastfeeding is the natural way to feed infants and young children. Exclusive breastfeeding for the first six months of life ensures optimal growth, development and health. After that, breastfeeding, with appropriate complementary foods, continues to contribute to the infant's and young child's nutrition, development and health.
- Breastfeeding is not fully promoted and supported. Many health care and social institutions provide services that often represent obstacles to the initiation and continuation of breastfeeding. As a result, not all children in Europe get this ideal start to life.
- Low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment, result in greater expenditure on national health care provision, and increase inequalities in health.¹

“If a new vaccine became available that could prevent one million or more child deaths a year, and that was moreover cheap, safe, administered orally, and required no cold chain, it would become an immediate public health imperative.

Breastfeeding can do all of this and more, but it requires its own “warm chain” of support – that is, skilled care for mothers to build their confidence and show them what to do, and protection from harmful practices. If this warm chain has been lost from the culture, or is faulty, then it must be made good by health services.”²

Protection, promotion and support of breastfeeding fall squarely into the domain of human rights. The Convention on the Rights of the Child (CRC),³ adopted by the United Nations General Assembly in 1989 and ratified so far by all countries except the United States of America and Somalia, states in its Article 24 that, “*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health ... States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures ... To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents*”.

Public health initiatives to protect, promote and support breastfeeding should be based on the Global Strategy on Infant and Young Child Feeding, adopted by all WHO member states at the 55th World Health Assembly (WHA) in May 2002.⁴ The Global Strategy builds on the International Code of Marketing of Breast-milk Substitutes⁵ and subsequent relevant WHA resolutions;^a the Innocenti Declaration on Protection, Promotion and Support of Breastfeeding;⁶ and the WHO/UNICEF Baby Friendly Hospital Initiative.⁷ It is also consistent with the FAO/WHO World Declaration and Plan of Action for Nutrition.⁸ The Global Strategy gives particular consideration to the special needs of children in difficult circumstances^b and includes policies for timely and appropriate complementary feeding. Breastfeeding is highlighted as a priority also in the First Action Plan for Food and Nutrition Policy of the European Office of WHO for 2000-2005.¹⁰

^a The International Code of Marketing of Breast-milk Substitutes and the subsequent relevant WHA Resolutions are jointly referred to in this document as the International Code.

^b It is recommended that EU countries and/or associations based in the EU adhere to the Operational Guidelines on Infant Feeding in Emergencies when they provide humanitarian aid to other countries or nutrition support to refugees and asylum seekers in EU countries.⁹

The importance of protecting, promoting and supporting breastfeeding has also been reiterated in important European Union (EU) documents. The EURODIET project strongly recommended a review of existing activities and the development and implementation of a EU action plan on breastfeeding.¹¹ Following on from EURODIET, the so-called 'French Initiative' on nutrition highlighted the need for action on breastfeeding surveillance and promotion.¹² The French Initiative led to the EU Council Resolution on Nutrition and Health in December 2000, where breastfeeding was officially recognised as a priority.¹³

This Blueprint for Action on Breastfeeding in Europe and its associated documents^{14,15} come as a logical extension of these projects, proposals, resolutions and action plans for policy, and offer a practical tool, which seeks to bring to fruition the aspirations of all these initiatives.

Why do we need this Blueprint?

Despite difficulties in interpreting available data, it is clear that breastfeeding rates and practices in EU countries fall short of best evidence-based recommendations.^{4,16} The Global Strategy on Infant and Young Child Feeding states: "*As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.*"

Extensive experience clearly shows that breastfeeding can be protected, promoted and supported only through concerted and coordinated action. EU countries are currently coordinating action in other health fields and social sectors. Action on breastfeeding in Europe is presently uncoordinated. Not all countries have national policies and plans, and even when these are in place they are sometimes not acted upon, or may not be compatible with universally recognised best evidence-based recommendations.

What is this Blueprint?

The Blueprint is a model plan that outlines the actions a national or regional plan should contain and implement if effective protection, promotion and support of breastfeeding are to be achieved. Underpinning all stages of the action plan is the need for policy, planning, management and financing; for information, education and communication; for pre- and in-service training; and for evaluation and monitoring. The Blueprint incorporates specific interventions and sets of interventions; most of the recommended interventions have been previously graded by level of evidence.¹⁵ The Blueprint also includes interventions, which, though not based on research evidence of effectiveness, public health experts consider as essential contributions to the effective implementation of an action plan.

The Blueprint is put forward as a model to be acted upon as necessary. Some countries/regions in Europe may already have well coordinated structures and practices in place that are of a high standard and require little or no further action. Others may have poorly coordinated practices that may or may not be policy driven or evidence based; the necessity to apply the Blueprint's actions in these latter countries/regions is more obvious. Information gathered for this Project would indicate that the situation in most European countries/regions lies somewhere between these two scenarios thereby requiring the careful selection and adaptation of Blueprint actions to address deficits in individual national and regional policies and practices.

The Blueprint does not recommend specific Europe-wide operational strategies. This would require the incorporation of the multiplicity of different structures and funding arrangements prevailing across all countries, which would be impossible. Operational strategies or action plans, based on the Blueprint, can only be effective at national or regional level where due account can be taken of the prevailing budgets, structures, human and organizational resources.

How was this Blueprint developed?

The Blueprint for Action was developed by a group of breastfeeding experts representing all EU and associated countries. Within the group of national respondents to the Project most of the key relevant health and allied professional bodies and stakeholder groups were represented, including mothers. Before developing the Blueprint, the group analysed the current situation (prevailing breastfeeding rates and practices) in all the participant countries.¹⁴ The group then undertook a thorough review of breastfeeding interventions, together with an analysis of the research evidence supporting them, in order to identify the gaps between what is done and what should be done.¹⁵ The draft Blueprint was then submitted for consideration and review by a larger group of stakeholders, identified as having a specific relevant role and expertise in their respective countries.

To whom is this Blueprint addressed?

The Blueprint is aimed at informing key public health policy makers and governmental bodies concerned with women's issues, children's welfare and education in the EU and other countries participating in the Project. It is also directed at stimulating cooperation between all those persons working in the public and private sector, including NGOs, who play important roles in the protection, promotion and support of breastfeeding. A concise version of the Blueprint, aimed at informing the general population and the media, is also available.

How can this Blueprint be used?

National and regional public health, social and educational authorities will be able to apply relevant aspects of the Blueprint in the development or revision of their national and regional breastfeeding policies and initiatives, including operational plans. The implementation and evaluation of regional and national action plans based on the Blueprint will be the responsibility of the relevant authorities involved, down to the district and health facility levels. An integral part of this process will be getting commitment from the relevant bodies to work together towards the implementation of the actions proposed. These bodies will include hospital and community health authorities, national and regional Government departments, relevant professional organisations, NGOs, schools, colleges, employer and employee bodies, and many more. Outcome and output measures are also suggested in the Blueprint. Progress and process indicators should be based on these when developing national and regional operational plans.

What is the expected outcome of this Blueprint?

It is hoped that the application of the Blueprint will achieve a Europe-wide improvement in breastfeeding practices and rates (initiation, exclusivity and duration); more parents who are confident, empowered and satisfied with their breastfeeding experience; and health workers with improved skills and thus greater job satisfaction. The attainment of these expected outcomes will entail the implementation of a series of national and local breastfeeding action plans adequately resourced and regularly reviewed and updated as required.

The Blueprint recognizes that mothers who decide to artificially feed their infants, having received full, correct and optimal infant feeding information, should be respected in their decision and should get all the support they require, as well as receive expert information on what, when and how complementary foods should be given. Because bonding and nurturing imply more than feeding, any support to mothers should extend beyond feeding, to foster the establishment of an optimal relationship with the child.

Overview of the current situation^c

The current situation in the 29 countries surveyed in the course of this project is extremely varied. However, a number of common conclusions can be drawn:

- Most countries are collecting some data. However, data collected on breastfeeding rates is frequently inconsistent, sometimes inaccurate and often incomplete. Definitions and methods used differ between countries. No evidence was found of a single standard system for data collection being applied across Europe.
- Despite difficulties in interpreting available data, it is clear that breastfeeding rates and practices generally fall short of WHO and UNICEF recommendations. Indeed targets and recommendations proposed in national policies and by professional organisations are not being achieved either. In some countries, initiation rates are very low. Even in countries where initiation rates are high, there is a marked fall-off in breastfeeding in the first six months. The exclusive breastfeeding rate at six months is low throughout Europe.
- Health care systems in European countries have the resources and the potential to effectively protect, promote and support breastfeeding through intersectoral and interdisciplinary cooperation and commitment. Yet, only 18 countries in this Project have national and/or regional policies, and except for five countries, these policies do not meet current best practice standards as set out in the Global Strategy on Infant and Young Child Feeding. Common EU recommendations are lacking.
- Many countries have yet to achieve the goals and the objectives set for 1995 by the Innocenti Declaration.^d Some countries have advanced more than others and have a national coordinator and committee (but often without adequate financial or other resources to make the substantial changes required), an active Baby Friendly Hospital Initiative (BFHI), and some legislation on maternity protection and on marketing of breast milk substitutes. Other countries are lagging behind. There appears to be a general lack of commitment to allocate sufficient funding to breastfeeding initiatives.
- The BFHI (and other initiatives that promote evidence-based changes in hospital practices) are implemented in many countries, but only a few countries have achieved widespread participation across the whole maternity care sector. In some countries, none of the maternity hospitals have, as yet, achieved the standard for BFH designation. Expansion of the BFHI beyond the maternity care setting to include community health care services and paediatric hospitals is taking place in some countries.
- Pre-service course curricula for health professionals in general appear to be ineffective in ensuring competency in the skills necessary to support breastfeeding. Those providing breastfeeding knowledge and skills at pre-service level need to be adequately trained themselves in breastfeeding.
- The use of quality-assessed courses for training is low. The breastfeeding courses for pre- and in-service that do exist need to have their effectiveness evaluated and their content revised or revamped as necessary. An assessment of the effectiveness of locally developed/adapted courses has only been carried out in one country.

^c More details in reference ¹⁴

^d The four operational targets of the Innocenti Declaration for 1995 were: 1) to appoint a national breastfeeding coordinator and establish a multisectoral national breastfeeding committee; 2) to ensure that every facility providing maternity services fully practices all the 10 Steps to Successful Breastfeeding; 3) to give effect to the principles and aim of the International Code in their entirety; and 4) to enact legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

- Increasing numbers of International Board Certified Lactation Consultants (IBCLC) are found in many countries, which may indicate an enhanced awareness of the need for their expertise.
- National legislation regulating the marketing of breast milk substitutes falls short of the International Code. Most EU, accession and candidate countries apply the EU Directive of 1991,¹⁷ which does not cover all the provisions of the International Code and has not been updated to take into account subsequent relevant WHA resolutions. The regulations contained in the International Code have not been adequately communicated to health workers and the general public, and no effective monitoring of compliance has taken place, except by NGOs that have no powers to censure infringements.
- In many countries, the legislation on maternity protection with relevance to breastfeeding goes beyond the minimum standards recommended by the ILO 183 Convention,¹⁸ even though only four countries ratified the Convention so far. Where national legislation does not meet the ILO standards, it is especially with regard to the provision of lactation breaks. Even in countries with maternity protection legislation that meets the ILO standards, many categories of working mothers (e.g., women employed for less than 6-12 months at the time of application for maternity leave, contract workers, irregular part-time workers and apprentices/working students) are outside the remit of this legislation.
- Voluntary mother-to-mother (M2M) and peer counselling^e support groups and organisations are active in most of the participant countries. The geographical coverage of their services is generally low to medium, rarely high. The degree of co-ordination among the various support groups is weak in most countries though well developed in others. Links with the health care system are often inadequate to achieve an effective degree of integration and coordination with the relevant available statutory services.

^e In this document, peer counselling means the support given to mothers, almost always individually, by a woman (not always a mother) specifically trained and often certified to be a peer counsellor; peer counselling can be made available or can be offered more actively; peer counsellors may work as volunteers, or may be paid and work under the direction of the health authority or agency that set up the peer counselling programme. Voluntary M2M support means the support given by experienced breastfeeding mothers, individually or in groups, to other mothers, individually or in groups, on a volunteer basis; some groups are self-established and self-training and tend to work as part of a looser organization; other groups (e.g., La Leche League, National Childbirth Trust) form part of larger organizations which provide high quality training, regular continuing education, accreditation, excellent information on breastfeeding, as well as clearly defined responsibilities and operational guidelines, including documentation of all activities and regular reporting.

Determinants of breastfeeding

For an action plan to be effective and feasible it must take due account of the determinants of breastfeeding. These factors can be categorized as in the table below. Determinants should be considered also when designing protocols for monitoring breastfeeding attitudes, practices and rates. The different spheres of influence of these determinants imply that their effect needs to be monitored and acted upon at the appropriate level in the health care system and in the society.

Mother, child, family	<ul style="list-style-type: none"> • Age, parity, physical and psychological health of the mother • Breastfeeding experience of the mother herself, and with previous children • Education, employment, social class, ethnicity, area of residence • Knowledge, attitudes, confidence in the ability to breastfeed • Marital status, family size, support from father/partner and family • Lifestyles (smoking, alcohol, drugs, diet, physical exercise) • Birth weight, gestational age, mode of delivery, health of the newborn • Access to role-models who have had positive breastfeeding experiences
Health care system	<ul style="list-style-type: none"> • Access to antenatal care and quality of care • Quality of assistance during delivery and in the first few days • Access to postnatal maternal and child health care, and quality of care • Type and quality of professional support to lactation management • Access to peer counselling and M2M support
Public health policies	<ul style="list-style-type: none"> • Level of priority and financial support given to breastfeeding • Official policies, recommendations and plans • Monitoring and surveillance systems • Quality of pre- and in-service training of health workers • Financial support for voluntary M2M support activities • IEC and use of different media for breastfeeding advocacy
Social policies and culture	<ul style="list-style-type: none"> • Legislation on and enforcement of the International Code • Legislation on maternity protection and its enforcement • Representation and portrayal of infant feeding and mothering in the media • Obstacles and barriers to breastfeeding in public • Prevalence and level of activity of community based M2M support groups • Level of community awareness and knowledge

Overview of the review of interventions^f

Interventions for the protection, promotion and support of breastfeeding, as with any other health care and public health intervention, should ideally be based on evidence of effectiveness. The review of interventions carried out by this Project took into consideration, in addition to controlled studies, reports of successful experiences. The Project recognised that many aspects of the protection, promotion and support of breastfeeding, in particular those not related to the health care sector, are not amenable to the rigorous evaluation of effectiveness implicit in the concept of evidence-based medicine. The interventions were then categorised under policy and planning; information, education and communication; training; and protection, promotion and support of breastfeeding. In each category, interventions were graded by quality of the evidence base.

The review leads to the following conclusions on effective interventions:

- The combination of several evidence-based strategies and interventions within multi-faceted integrated programmes seems to have a synergistic effect.
- Multi-faceted interventions are especially effective when they target initiation rates as well as duration and exclusivity of breastfeeding, using media campaigns, health education programmes adapted to the local situation, comprehensive training of health workers and necessary changes in national/regional and hospital policies.
- The effectiveness of multi-faceted interventions increases when peer support programmes are included, particularly in relation to exclusivity and duration of breastfeeding.
- Interventions spanning the pre- and post-natal periods, including the crucial days around childbirth, seem more effective than interventions focussing on a single period. The BFHI is an example of a wide-ranging intervention of proven effectiveness, and its extensive implementation is highly recommended.
- Health sector interventions are especially effective when there is a combined approach, involving the training of staff, the appointment of a breastfeeding counsellor or lactation consultant, having written information for staff and clients, and rooming-in.
- The impact of health education interventions to mothers on initiation and duration of breastfeeding is significant only when current practices are compatible with what is being taught.
- The provision of breastfeeding information to prospective parents or new mothers, with no or brief face-to-face interaction (i.e. based on leaflets or telephone support), is less effective than the provision of information with extended face-to-face contact. The use of printed materials alone is the least effective intervention.
- The effectiveness of programmes which expand the BFHI beyond the maternity care setting to include community health care services and/or paediatric hospitals, currently being implemented in some countries, has so far not been evaluated. However, these programmes are based on a combination of initiatives that on their own are well evidence-based.
- The development and enforcement of laws, codes, directives, policies, and recommendations at various levels (national, regional) and in various situations (workplace, hospital, community) represent important interventions, however it is currently difficult to gather strong evidence for their effectiveness (few studies, mainly within multifaceted interventions).

^f More details in reference ¹⁵

- Workplace interventions are especially effective when mothers have the flexibility to opt for part-time work and have guaranteed job protection along with provisions for workplace breastfeeding/lactation breaks. These provisions, whether in response to a legislative requirement or as part of a breastfeeding supportive workplace policy, involve time off without loss of pay during the working day to breastfeed or express breast milk, with suitable facilities being provided by the employer.

The decision to implement a set of interventions needs to consider feasibility and cost, in addition to effectiveness. Feasibility and cost are country and area specific because they depend on local economic, social and cultural conditions. Political commitment is more fundamental to the successful implementation of breastfeeding interventions than feasibility and cost issues. It is recognised that in an ideal situation, where cost is not the primary determinant, a public health intervention with a higher cost may be deemed feasible based on economies of scale and a more favourable ratio of benefit to cost. Some strategies and interventions may be recommended even if they are not strongly evidence-based; this applies in particular to legislation and general policies that are not easily amenable to rigorous scientific evaluation. However, expert opinion and experience show that these initiatives do have long-term benefits on the number of mothers successfully breastfeeding.

Finally, a programme for the protection, promotion and support of breastfeeding is not just a list of separate interventions. Interventions are usually multifaceted, interrelated and integrated in order to maximise their combined and cumulative effect. Moreover, the effect will depend on continuity, because a change in the behaviour of mothers, families and health workers, and of the infant feeding culture in a given society, requires that interventions and programmes be sustained for a sufficient length of time.

V. The Blueprint for Action

1. *Policy and planning*

Interventions to protect, promote and support breastfeeding will be more effective if they are embedded in a comprehensive national policy on pregnancy, childbirth and infant and young child feeding (IYCF), including timely and appropriate complementary feeding, which are integrated into concerted and coordinated national and regional health plans, and implemented with adequate resources and sound management in a health system that covers equitably the whole population.

A plan should set goals, for example:

- Increase the number of babies who receive exclusive and continued breastfeeding;
- Achieve BFH status in all hospitals providing maternity services;
- Ensure universal access to breastfeeding-supportive antenatal and postpartum care.

As well as having time-framed targets aimed at the whole population, goals can be formulated to address the needs of specific groups currently least likely to breastfeed or to support breastfeeding. For example:

- Increase exclusive and continued breastfeeding rates two-fold among less educated mothers;
- Achieve BFH status in 50% of teaching hospitals by 2010;
- Ensure 100% free access to breastfeeding-supportive antenatal and postpartum care to low-income mothers.

Each goal can have several objectives considered to be relevant to its achievement. The goal to “increase the number of babies who receive exclusive and continued breastfeeding”, for example, could have the following objectives:

- To inform key stakeholders of the policies and recommendations developed to protect, promote and support breastfeeding, and to get commitment from them for their implementation;
- To improve pre- and in-service training to ensure that health workers get all the knowledge and skills needed to protect, promote and support breastfeeding effectively.
- To stimulate the training of peer counsellors and the establishment of M2M support groups;
- To set up a standard system for accurate, timely and comprehensive collection and dissemination of data on breastfeeding rates at different ages, using universally agreed definitions throughout;
- To inform mothers and their families about the importance of breastfeeding and to give them basic knowledge on lactation management;
- To ensure that working mothers get the legislative protection and support needed to exclusively breastfeed for six months;
- To implement all the provisions of the International Code.

Goals and objectives are important because they indicate what the Action Plan seeks to achieve and allow for the development of outcome indicators. The achievement of goals and objectives will be dependent on the effectiveness of the operational plans aimed at their attainment. The objective “to improve pre- and in-service training”, for example, can be achieved in different ways and with different interventions and activities, depending on an analysis of local situations and resources. The implementation of these interventions and activities will be monitored through appropriate progress and process indicators clearly stipulated in operational plans.

1.1 Policy

Recommended objectives	Responsibility	Outputs and outcomes
1.1.1. To develop a comprehensive national policy based on the Global Strategy on IYCF and integrate it into overall health policies	Relevant ministries, national breastfeeding and/or IYCF committees	Policy drafted, finalised, published and disseminated
1.1.2. To develop specific policies for socially disadvantaged groups and children in difficult circumstances to reduce inequalities	Relevant ministries, national breastfeeding committees	Policy drafted, finalised, published and disseminated
1.1.3. To encourage professional associations to issue recommendations and practice guidelines based on the national policies and encourage their members to follow them	Relevant ministries, professional associations	Recommendations drafted, finalised, published and disseminated

1.2 Planning

Recommended objectives	Responsibility	Outputs and outcomes
1.2.1. To set priorities, objectives and targets based on the comprehensive national policy	Relevant ministries, breastfeeding committees	Priorities, objectives and targets set
1.2.2. To develop a long term (5-10 years) strategic plan within the national health plan and to re-plan after evaluation	Relevant ministries, breastfeeding committees	Strategic plan developed, agreed and published
1.2.3. To develop short term (1-2 years) national/regional operational plans and to re-plan based on monitoring	Relevant ministries, regional health authorities	Operational plans developed, agreed and published
1.2.4. To coordinate breastfeeding initiatives with other public health and health promotion plans and activities	Relevant ministries, regional health authorities	Intra- and inter-sectoral coordinating committees established; other public health plans and activities reflect breastfeeding policies

1.3 Management

Recommended objectives	Responsibility	Outputs and outcomes
1.3.1. To designate a suitably qualified national/regional coordinator with clear terms of reference related to policies and plans	Relevant ministries, regional health authorities	National/regional coordinators designated/appointed
1.3.2. To establish a national/regional intersectoral breastfeeding committee to advise/support the national/regional coordinator	Relevant ministries, regional health authorities	National/regional committees established
1.3.3. To ensure continuity of the national/regional coordinator's and committee's activities	Relevant ministries, regional health authorities	Breastfeeding coordinators and committees meet regularly
1.3.4. To regularly monitor progress and periodically evaluate results of the national/regional plan	Breastfeeding coordinators and committees	Regular progress reports and periodic evaluation reports produced

1.4 Financing

Recommended objectives	Responsibility	Outputs and outcomes
1.4.1. To assign adequate human and financial resources for the protection, promotion and support of breastfeeding [§]	Government, relevant ministries and authorities	Realistic year-on-year budget allocated
1.4.2. To ensure that planning, implementation, monitoring and evaluation of activities are carried out independent of funding from manufacturers and distributors of products under the scope of the International Code	Government, relevant ministries and health authorities, local health providers	Sources of funds clearly and transparently indicated

2. *Information, education, communication (IEC)*

Adequate IEC is crucial for the re-establishment of a breastfeeding culture in countries where artificial feeding has been considered the norm for several years/generations. IEC messages must be consistent with policies, recommendations and laws, as well as consistent with practices within the health and social services sector. A key objective of IEC activities should be, as highlighted in the CRC, to fulfil the right of all segments of the society to clear, full and unbiased information about breastfeeding. Breastfeeding is the normal way to feed and bring up infants and young children, and should be portrayed universally as such. Expectant and new parents have the right to full, correct and optimal infant feeding information, including guidance on safe, timely and appropriate complementary feeding, so that they can make informed decisions.¹⁹

[§] Adequate financial resources could also be allocated to public-interest breastfeeding-related NGOs and voluntary breastfeeding organizations, should governments recognise that their role is critical and their activities relevant for the protection, promotion and support of breastfeeding.

Reports on the use of breast milk as an indicator of environmental contamination intended for the public, including parents, should be carefully worded and scientifically correct. Such reports should include the possible ways women can reduce the levels of residues (smoking, drugs, cosmetics, food) and advice of their significance. The fact that the solution is to prevent environmental contamination and not to replace breastfeeding with artificial feeding should be clearly stated.

2.1 IEC for individuals

Recommended objectives	Responsibility	Outputs and outcomes
2.1.1. To provide mothers with individual face-to-face counselling by adequately trained health workers, peer counsellors and M2M support groups	Relevant health authorities, health workers, peer counsellors, M2M support groups	Audit of mothers' breastfeeding knowledge/skill and of how this information is conveyed
2.1.2. To ensure that all IEC materials produced and distributed by health authorities contain clear, accurate and coherent information, are consistent with national and regional policies and recommendations, and are used to support face-to-face interactions ^h	Relevant health authorities, breastfeeding coordinators and committees, health workers, peer counsellors, M2M support groups	Materials available meet the criteria of this objective; audit of IEC materials and one-to-one breastfeeding communication procedures is carried out
2.1.3. To identify and actively address the particular information and skill needs of primiparae, immigrants, adolescents, single mothers, less educated women and others in society that are currently least likely to breastfeed, including mothers with previous difficult and unsuccessful breastfeeding experience	Relevant health authorities, breastfeeding coordinators and committees, health workers, peer counsellors, M2M support groups	IEC services and materials produced meet high quality standards and are sensitive to the particular needs of the client groups
2.1.4. To identify and address the information needs of other family and kinship members, e.g. mother's partner/infant's father, infant's grand-parents, siblings, etc.	Relevant health authorities, breastfeeding coordinators and committees, health workers, peer counsellors, M2M support groups	Audit materials and supports available for these 'significant others'
2.1.5. To ensure that there is no advertising or other form of promotion to the general public of products under the scope of the International Code	Relevant health authorities, breastfeeding coordinators and committees	No commercial marketing materials distributed

^h IEC materials for mothers should include the importance of breastfeeding and the basics of breastfeeding management, including dealing with commonly occurring concerns, as well as contact details for expert assistance if needed.

2.2 IEC for communities

Recommended objectives	Responsibility	Outputs and outcomes
2.2.1. To develop and disseminate IEC packs that are consistent with national policies and recommendations, for use in health and social service facilities, in all levels of schools, with infant and child care provider groups, with policy and decision makers, and in the media ⁱ ; the information should be free-of-charge at the point of delivery	Relevant health, social and educational authorities, breastfeeding coordinators and committees, professional associations, NGOs, M2M groups	IEC packs developed and distributed; audit the effectiveness of distribution systems for IEC packs
2.2.2. To present exclusive breastfeeding for six months and continued breastfeeding up to two years and beyond as the normal way to feed and bring up infants and young children in all written and visual materials relating to or making reference to IYCF and to the role of mothers	All multi-media organisations and commissioning authorities with responsibility for content of books, programmes, etc.	Information outlining their responsibility disseminated to the multi-media organisations; monitoring measures in place
2.2.3. To use the international, national and local breastfeeding awareness weeks as an opportunity to stimulate public debate in different settings and media and to disseminate important information	Breastfeeding coordinators and committees, all relevant stakeholders	Published reports of awareness week activities
2.2.4. To monitor, inform and use all organs of the media to promote and support breastfeeding and to ensure that it is at all times portrayed as normal and desirable	Relevant health, social and educational authorities, breastfeeding coordinators and committees	Multi-media channels and networks given sound and up-to-date information, and used to promote and support breastfeeding

3. Training

As stated in the conclusion of the document on the current situation,¹⁴ both pre- and in-service breastfeeding training for all health worker groups needs improvement, similarly to how improvements are taking place in relation to other topics in health care. A long-term strategy must be based on appropriate changes in pre-service curricular competency training. If effective, such a strategy would, in time, lead to a reduction of expenditure on in-service breastfeeding training. Health workers should receive up-to-date information and continuing medical education (CME) from statutory and voluntary agencies and institutions that are free from commercial influence and pressure.

ⁱ The content of the packs should be sufficiently flexible to allow for adaptation to meet the specific needs of the organisations involved and their target audiences. Special attention should be given to the infant feeding information needs of groups in society (e.g. immigrants, adolescents, low income families) less likely to breastfeed.

3.1 Pre-service training

Recommended objectives	Responsibility	Outputs and outcomes
3.1.1. To develop, or review if existing, a minimum (contents, methods, time) standard for pre- and post-graduate curricula and competency on breastfeeding and lactation management for relevant health workers	Deans of relevant health faculties, professional competency authorities, national breastfeeding committees	Curricula and competency standards developed/updated and implemented
3.1.2. To develop, or review if existing, course textbooks and training materials in line with the updated standard curricula and recommended policies and practices	Deans and teachers of relevant health faculties, professional associations	Textbooks and training materials developed or updated, and in use

3.2 In-service training

Recommended objectives	Responsibility	Outputs and outcomes
3.2.1. To offer continuing interdisciplinary education based on WHO/UNICEF guidelines or other evidence-based courses on breastfeeding and lactation management, as part of induction and in-service education for all relevant health care staff, with particular emphasis on staff in frontline maternity and child care areas	CME authorities, maternity and child health service provider institutions, health schools, in-service practice development coordinators, professional associations	In-service practical training provided for all relevant health workers and up-dates offered on a regular basis, based on recognised guidelines and courses
3.2.2. To develop, or review if existing, training materials to be used for such interdisciplinary continuing education, ensuring that materials and courses are not influenced by manufacturers and distributors of products under the scope of the International Code	CME authorities, in-service practice development coordinators, health schools, breastfeeding committees, professional associations	Materials developed and reviewed; protocols in place to monitor and ensure that no conflicts of interest exist in the content of courses and materials
3.2.3. To encourage relevant health care workers to attend advanced lactation management accredited courses and to acquire the IBCLC or equivalent certification shown to meet best practice criteria for competence ^j	CME authorities, health service employers, IBLCE, professional associations	Number of certified lactation consultants per infant born increased
3.2.4. To encourage e-networking amongst breastfeeding specialists in order to increase knowledge and skills	Professional associations, public interest NGOs	Mailing lists, websites and discussion groups activated

^j The IBCLCE credential is awarded to successful candidates after a competency-based exam, irrespective of the lactation management course followed. The IBCLCE exam has been administered worldwide in several languages for 20 years. Re-certification is mandatory every five years. Certificants must adhere to a Code of Ethics and work according to Standards of Practice. An independent commission for certifying agencies since 1988 has regularly accredited the IBCLCE certification process.

4. Protection, promotion and support

Protection of breastfeeding is largely based on the elimination of obstacles through full implementation of the International Code and maternity protection legislation. A role is played also by protection from discrimination against breastfeeding in public, biased media portrayals and free formula milk schemes for disadvantaged groups.

Promotion depends on the implementation of national policies and recommendations based on the Global Strategy on Infant and Young Child Feeding, endorsed by all EU countries at the 55th World Health Assembly in 2002, on the WHO/EURO Action Plan for Food and Nutrition Policy, and on effective IEC.

Support is needed for both breastfeeding mothers and mothers who decide not to breastfeed. Mothers who, having received full, correct and optimal infant feeding information, decide to artificially feed their infants should be respected in their decision and should get all the support they require to effectively do so. Families should also receive expert information on what, when and how complementary foods should be given as this supports good nutritional care for the infant and young child.^k

Even in countries where breastfeeding initiation rates are high, duration rates often fall short of what is considered optimal, particularly in relation to exclusive breastfeeding rates. Fall-offs in exclusive breastfeeding rates typically occur shortly after discharge from hospital and at around four months of age, possibly coinciding with a return to work outside the home or because it is considered the right time to introduce complementary foods. Few women breastfeed their children beyond 12 months in the EU. Effective support is needed to improve this situation. Such support requires commitment and advocacy for social mobilisation and return to a breastfeeding culture at all levels. At individual level, it means access for all women to breastfeeding supportive services, including M2M support, and to continuity of care. Women who stop breastfeeding before they actually want to should be encouraged and supported to examine why this has happened. This knowledge may make it easier to accept the shorter than expected duration of breastfeeding, to reduce feelings of loss and failure, and may help attain longer breastfeeding with a subsequent baby.

4.1 Global Strategy on Infant and Young Child Feeding

Recommended objectives	Responsibility	Outputs and outcomes
4.1.1. To implement policies and plans based on the Global Strategy and WHO/EURO Action Plans	Ministry of Health and other relevant ministries	Policies and plans developed and implemented
4.1.2. To make breastfeeding policies and plans known to all health professional groups, relevant academic health professional colleges offering under graduate and post-graduate training, NGOs and the general public	Ministry of Health and other relevant ministries	Health workers and the general public have knowledge of the breastfeeding policy/action plan

^k Informed decisions, based on unbiased information, followed by adequate support, are particularly important for HIV-positive pregnant women. Guidelines on infant feeding in the context of HIV have been published by WHO.²⁰

4.2 The International Code

Recommended objectives	Responsibility	Outputs and outcomes
4.2.1. To develop EU regulations on the marketing of breast milk substitutes which would include all the provisions and the products under the scope of the International Code as a minimum requirement	European Commission	Regulations drafted and accepted by member states
4.2.2. To ensure that the International Code is reflected in the EU position at meetings of Codex Alimentarius	European Commission	Codex Alimentarius reports reflect this position
4.2.3. To develop national legislation based on the International Code, including mechanisms for enforcement and prosecution of violations, and a monitoring system that is independent of commercial vested interests	National governments, breastfeeding committees, consumers' associations	National laws updated, compliance procedures in place in accordance with all the provisions in the International Code
4.2.4. To encourage the full implementation of the International Code even before new EU regulations require this of member states	National and local governments, breastfeeding committees, NGOs	National and local compliance procedures in place in accordance with all the provisions in the International Code
4.2.5. To inform pre- and post-graduate health professionals and health service providers about their responsibilities under the International Code	Health schools, CME authorities, relevant health authorities	Information provided
4.2.6. To develop code of ethics covering the criteria for individual and institutional sponsorship of courses, educational materials, research, conferences and other activities and events, to avoid conflicts of interest that could adversely affect breastfeeding	Professional associations, academic institutions and service providers	Criteria and guidelines developed, published, implemented
4.2.7. To disseminate information to the public on the principles, aims and provisions of the International Code and on procedures for monitoring compliance and censuring violations	National and regional governments, NGOs, consumers' associations	Information disseminated to public and to body responsible for monitoring
4.2.8. To phase out the distribution of free formula to low income families, where this is still in place, and to replace it with incentives and initiatives to promote and support breastfeeding within families living in poverty or otherwise marginalized	National and regional governments, social support agencies	Free formula to low income families discontinued, incentives and initiatives equitable to all families and supporting breastfeeding developed and implemented

4.3 Legislation for working mothers

Recommended objectives	Responsibility	Outputs and outcomes
4.3.1. To upgrade national legislation where it does not meet ILO minimum standards ¹	National and regional governments	Legislation upgraded
4.3.2. To ensure that sufficient legislative supports are in place to enable working mothers to exclusively breastfeed their infants for six months and to continue thereafter	National and regional governments	Effective legislative supports enacted, financial support approved
4.3.3. To extend maternity protection provisions to women who are not currently entitled to these: e.g. women with short term contracts, casual and part-time workers, students and immigrants	National and regional governments	Legislation extended
4.3.4. To ensure that employers, health workers and the public are fully informed about maternity protection legislation and health and safety at work as related to pregnant and breastfeeding women	National and regional governments, employer organizations, trade unions	General awareness exists of maternity protection provisions
4.3.5. To inform employers of the benefits to them and their breastfeeding employees of facilitating breastfeeding following return to the workplace, and the facilities necessary to ensure that this is possible (flexible hours, time-off, and facilities for expressing and storing breast milk)	Relevant ministries, health and social authorities, employer organizations, trade unions	Employers informed of benefits and offering appropriate workplace supports

4.4 Baby Friendly Hospital Initiative^m

Recommended objectives	Responsibility	Outputs and outcomes
4.4.1. To ensure that government, health authorities, professional associations and relevant NGOs closely collaborate with UNICEF and WHO to implement the BFHI as a standard for best practice, and that all maternity and child care institutions and providers pursue the goal of achieving and maintaining the 'Baby Friendly' designation	National and regional governments, relevant health authorities, professional associations, NGOs, breastfeeding committees, maternity and child care service providers	BFHI committees and coordinators established and BFHI universally recognised as standard of excellence in breastfeeding

¹ Countries can obviously go beyond ILO standards.

^m The BFHI is considered a model of best practice. However, other initiatives or programmes may also support best practice. All initiatives need to be evaluated for effectiveness.

4.4.2. To ensure adequate resources (funds, personnel/time) and technical support for training, change of practices, assessment and re-assessment of hospitals based on compliance with the BFHI	National and regional governments, relevant health authorities, quality assurance committees	Adequate budget/personnel allocation to achieve the standard of care based on BFHI for all expectant parents and breastfeeding mothers
4.4.3. To encourage hospitals that are not currently actively pursuing BFHI accreditation to ensure that their practices are nevertheless amended in line with the BFHI best practice standards	Relevant health authorities; quality assurance and BFHI committees	All hospitals/units using best practice standards
4.4.4. To incorporate the achievement of all the BFHI criteria into the standard national maternity service quality accreditation system ⁿ	Relevant health authorities; quality assurance, accreditation and BFHI committees	Maternity services accreditation standards include all the BFHI criteria
4.4.5. To develop a systematic approach to conveying breastfeeding information during antenatal care, consistent with relevant steps of the BFHI	Relevant health authorities, health service providers, health workers	Guidelines for antenatal care produced
4.4.6. To involve fathers and families to ensure appropriate support for mothers on discharge home	Health service providers, health workers	Fathers and families involved
4.4.7. To improve cooperation between hospitals and other health and social care facilities so as to ensure the implementation of Step 10 of the BFHI, i.e. adequate lactation support and counselling during the weeks after birth	Relevant health and social authorities; quality assurance and BFHI committees, peer counsellors, M2M support groups	Widespread implementation of Step 10 of the BFHI
4.4.8. To ensure that adequate resources and technical support for training and change in practices are provided to ensure that community health and social services for women, infants and children promote and support breastfeeding	Relevant health and social authorities, professional associations	Public and private health and social service providers promote and support breastfeeding in line with breastfeeding policies
4.4.9. To encourage the implementation of breastfeeding friendly initiatives beyond the maternity care setting to include community health and social services, paediatric hospitals/units and workplaces	Relevant health and social authorities; quality assurance and BFHI committees	Models of care based on the BFHI developed and implemented in other health and related service areas

ⁿ Protection, promotion and support of breastfeeding cannot be accomplished independent of the promotion of birth under physiological conditions. Increasing rates of caesarean section and birth under anaesthesia, both associated with disturbances of the hormonal production for lactation, may interfere with the success of breastfeeding.

4.5 Support by trained health workers

Recommended objectives	Responsibility	Outputs and outcomes
4.5.1 To ensure that health and social services staff, including volunteers, have the skills necessary to build maternal ability and confidence in breastfeeding, and to provide effective support	Relevant health and social authorities, agencies, voluntary organizations and health workers	Audit the number of staff and volunteers who are competent to effectively support breastfeeding
4.5.2 To encourage and support staff to achieve specialist knowledge in problem-solving to assist women with particular breastfeeding difficulties	Relevant health authorities, health service providers, health workers	Specialists, such as IBCLCs, trained and deployed
4.5.3 To ensure that services for the support of breastfeeding, including assistance provided by appropriately qualified lactation consultants or other suitably competent health care staff when needed, are accessible and affordable to all mothers	Relevant health and social authorities, agencies and organizations, health insurance providers	National health systems and/or voluntary health insurance companies cover the cost of skilled breastfeeding support and lactation consultant services
4.5.4 To provide particular assistance, where necessary, for mothers to provide or acquire breast milk for preterm or sick infants, including assistance with travel and accommodation if baby is in a distant specialist unit, and access to an accredited donor milk bank	Relevant health and social authorities, agencies and organizations	Assistance and support provided, at no extra cost to the mother
4.5.5 To establish national and regional breastfeeding centres of excellence to be used as resources for health workers and mothers, including free access to web-based resources	National and regional health authorities, breastfeeding committees	Centres established, access information disseminated to all relevant groups

4.6 Support by trained peer counsellors and mother-to-mother support groups

Recommended objectives	Responsibility	Outputs and outcomes
4.6.1 To encourage the establishment and/or increase the coverage of support provided by trained peer counsellors and M2M support groups, particularly for women less likely to breastfeed	Relevant health authorities, peer counsellors, M2M support groups	Training/establishment of peer counsellor and M2M support groups in areas where they are needed
4.6.2 To develop or review/update curricula (contents, methods, materials, time) for peer counsellor and M2M support training	Peer counsellors, M2M support groups	Curricula and competency standards updated/reviewed or developed
4.6.3 To strengthen the cooperation and communication between health workers based in different health facilities and trained peer counsellors and M2M support groups	Relevant health authorities, health workers, peer counsellors, M2M support groups	Procedures in place to facilitate effective use of statutory and voluntary breastfeeding expertise

4.7 Support in the family, community and workplace

Recommended objectives	Responsibility	Outputs and outcomes
4.7.1 To give appropriate information and support to breastfeeding mothers, their partners and families, including contact details on recognised breastfeeding support networks, both statutory and voluntary	Relevant health and social authorities, health workers, peer counsellors, M2M support groups	Breastfeeding mothers and their partners routinely given this information and support
4.7.2 To encourage family support through public education and local projects, and through community programmes based on collaboration between voluntary and statutory community services providers	Relevant health and social authorities, health workers, peer counsellors, M2M support groups	Local and community inter-sectoral projects established and evaluated
4.7.3 To identify and address the particular support needs of primiparae, immigrants, adolescents, single mothers, less educated women and others in society that are currently least likely to breastfeed, including mothers with difficult and unsuccessful breastfeeding experience	Relevant health and social authorities, health workers, peer counsellors, M2M support groups	Groups in society with differing information and support needs identified and their needs addressed appropriately
4.7.4 To encourage breastfeeding friendly policies/facilities in public service/amenity areas and to protect the right of women to breastfeed whenever and wherever they need	National and regional governments, relevant health and social authorities	Widespread breastfeeding friendly policies/facilities adopted and enacted

5. Monitoring

To ensure the effectiveness of an action plan, monitoring procedures must be integral to its implementation. To ensure comparability, monitoring of breastfeeding rates should be conducted using standardised universally accepted data collection methods. WHO recommends that the following definitions of breastfeeding be used:^{21,22}

- Exclusive breastfeeding: the infant receives only breast milk from his/her mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicine.
- Predominant breastfeeding: the infant's predominant source of nourishment is breast milk. However, the infant may also receive water and water-based drinks; Oral Rehydration Salts (ORS) solution; drop and syrup forms of vitamins, minerals and medicines; and ritual fluids (in limited quantities). With the exception of fruit juice and sugar-water, no food-based fluid is allowed under this definition.^o
- Complementary feeding: the infant receives both breast milk and solid (or semi-solid) food.
- No breastfeeding: the infant receives no breast milk.

^o The sum of exclusive and predominant breastfeeding is called full breastfeeding.

Data on the above categories of feeding can be gathered at any age. For instance, data could be gathered at 48 hours after birth (recall period: from birth), whether birth occurs in hospital or at home, and at about 3, 6 and 12 months of age (recall period: previous 24 hours; it is considered more difficult for mothers to have accurate recall of their infants' diets over longer periods of time).

It is generally accepted that current breastfeeding status data gathered using 24/48-hour recall periods are less accurate compared to data collected with more intensive methods (e.g. every week) and longitudinally since birth. For monitoring purposes, however, i.e. for the purposes of generating comprehensive on-going breastfeeding data, current status data represent the best compromise between accuracy and feasibility. If data were needed for research purposes, a longitudinal method of data collection would be required.

It is also recognised that the WHO categories of breastfeeding do not allow finer distinctions; for example, they would classify as complementary feeding the mother giving an occasional formula feed, and therefore almost fully breastfeeding, and the mother giving an occasional breastfeed, and therefore almost exclusively formula feeding. In addition, the WHO definition of complementary feeding does not allow distinguishing between feeding with and without the use of formula. Monitoring systems, or more often operational research, willing to gain a better understanding of different patterns of infant feeding, may add categories to the WHO definitions, provided they use them anyway for international comparisons.

Data collection can be whole population-based, i.e. incorporated into existing national or regional maternal and child health and welfare monitoring processes. Of crucial importance in interpreting/using data generated in this way are the accuracy (see previous paragraph), the relative completeness of the data sets achieved and the timeliness of its publication. Data collection can also be population representative survey-based, with surveys conducted at regular intervals. In these cases, the samples must be representative of the target population, and the sample sizes must be calculated to allow comparisons between population subgroups and subsequent surveys, if these are the objectives of a planned survey.

The current version of the European Community Health Indicators list (February 2004)^p includes:

- breastfeeding and exclusive breastfeeding at 48 hours;
- breastfeeding and exclusive breastfeeding at 3 and 6 months;
- breastfeeding at 12 months;

as recommended by other EU projects (Perinatal, Child, and Public Health Nutrition projects). This wording is not yet sufficient to lead to standard definitions and methods of data collection. More work is needed to develop consensus and issue practical instructions.

Monitoring and evaluation of practices of health and social services, and of implementation of policies, laws and codes, should also be an integral part of the action plan. The criteria for monitoring of practices will be suited to local circumstances and operational plan. However, it is useful to include at least some universal criteria, such as those developed by WHO and UNICEF for the BFHI for example, to ensure some comparability within and between countries. Some breastfeeding practice standards and performance indicators can be integrated into systems for health service accreditation and into audits of national policy implementation.

^p http://europa.eu.int/comm/health/ph_information/indicators/docs/ev_20040219_rd04_en.pdf

5.1 Breastfeeding rates

Recommended objectives	Responsibility	Outputs and outcomes
5.1.1 To set up a monitoring system based on universally agreed standard definitions and methods	Relevant ministries and authorities, national statistical bodies, breastfeeding committees	Monitoring system set up, data gathered and regularly analysed
5.1.2 To gather, in addition to breastfeeding, information on maternal age and other social variables that will help identify inequalities and socially disadvantaged groups	Relevant ministries and authorities, national statistical bodies	Other relevant variables incorporated into data collection systems
5.1.3 To publish and disseminate results, and use them for future planning of breastfeeding initiatives	Relevant ministries and authorities, national statistical bodies, breastfeeding committees	Results published, disseminated and used for re-planning, including commitment to address inequalities identified

5.2 Practices of health and social services

Recommended objectives	Responsibility	Outputs and outcomes
5.2.1 To draw up protocols and instigate procedures for the regular assessment of hospital and primary health care practices, based on standard best practice criteria as developed for the BFHI by WHO/UNICEF and by national/regional committees	Relevant ministries and authorities, BFHI and quality assurance committees	Regular assessment protocols and procedures in place for all maternity, child health and primary health care facilities
5.2.2 To put in place routine patient/client positive/negative feedback processes to determine the quality of the breastfeeding information and support given in maternity services, paediatric services and primary health care practices	Directors of hospitals and primary health care practices, quality assurance committees	Routine patient feedback procedures instigated and protocols put in place for addressing any sub-optimal practices discovered
5.2.3 To regularly monitor and evaluate the coverage, standard and effectiveness of IEC materials and activities	Relevant health authorities, breastfeeding coordinators and committees	Comprehensive coverage of high quality and regularly reviewed IEC materials to relevant health workers and users of maternity and child health services
5.2.4 To monitor the adequacy of public knowledge, attitudes and practices on the importance of breastfeeding, ways to support it and protect it	Relevant health, social and educational authorities	Surveys developed, undertaken and results published

5.2.5	To monitor the coverage and effectiveness of in-service training	CME authorities, breastfeeding committees, professional associations	Proficiency, competency and training coverage assessed
5.2.6	To publish and disseminate results, and use them for future planning of breastfeeding initiatives	Relevant ministries and health authorities, national statistical bodies, breastfeeding committees	Results published, disseminated and used for re-planning, including commitment to address problems identified

5.3 International Code, laws and policies

	Recommended objectives	Responsibility	Outputs and outcomes
5.3.1	To set up a monitoring system, independent of commercial interests, with responsibility for checking compliance with the International Code, investigating and if necessary prosecuting breaches, as well as producing information for the general public and the relevant authorities on any infringements that have taken place in the relevant jurisdiction	Relevant ministries and health authorities, breastfeeding coordinators and committees, consumers' associations	Monitoring procedures in place and operative; regular publication and dissemination of the outcome of infringements of the International Code occurring.
5.3.2	To monitor the implementation, in both public and private sectors, of national policies and legislation, including maternity protection laws, relating to breastfeeding ^q	National and regional governments, employer organizations, trade unions, public interest NGOs, professional associations	Monitoring carried out, regular publication of complaints and results

6. Research

The development of the Blueprint for Action, and more precisely the review of interventions,¹⁵ revealed the need for further research into several single and/or combined interventions and their effect on breastfeeding practices. In particular, there is a need to elucidate the effect of marketing practices under the scope of the International Code, of more comprehensive maternity protection legislation, of different IEC approaches and interventions, and in general of those public health initiatives that cannot be assessed through randomised controlled trials.²³ As an alternative, randomisation can be applied to clusters and communities, rather than individuals; even this, however, is often not feasible. Other types of controlled study designs should be applied in this case, such as non-randomised controlled studies or historical before-and-after studies comparing geographical areas or population groups.^{24,25} The cost/benefit, cost/effectiveness and feasibility of different interventions need also further research.

^q Government and public service sectors generally should show the lead in this area.

The quality of research methods needs to substantially improve, in particular with regards to:

- Consistency in the use of standard definitions of feeding categories (including recall periods) and of other variables;
- The use of valid criteria for recruitment of study subjects (inclusion and exclusion criteria; no self-selection);
- The use, when applicable, of an appropriate experimental design (randomised controlled trial and intention-to-treat analysis);
- The use of appropriate power and sample sizes compatible with the objectives of the research being undertaken (e.g. to detect statistical significance with narrow confidence intervals);
- Appropriate handling of confounders with proper factorial analysis (comprehensive baseline data);
- The use of appropriate qualitative methods when needed.

In implementing research, it is important to note that it is not possible or ethical to randomly assign mothers to breastfeed or not breastfeed. Assessing the effectiveness of mother support services, including M2M support, should be approached with caution, especially retrospectively, as users of these services are generally the groups in society most likely to breastfeed and are self-selecting. Prospective research in this area should also be approached with caution because of the myriad of confounding variables involved.

Ethical guidelines for research on breastfeeding/infant feeding by health authorities, health professional colleges, schools and professional associations should ensure freedom from all competing and commercial interests. The disclosure and handling of potential conflicts of interest of researchers is of paramount importance.

6.1 Research

Objectives	Responsibility	Outputs and outcomes
6.1.1 To foster and support research on breastfeeding based on agreed priorities and agenda, using agreed definitions of breastfeeding, and free from competing and commercial interests	European Commission, governments, research institutions, breastfeeding committees	Annual budget for research and its distribution; number of research projects and publications
6.1.2 To support and ensure intensive exchange of expertise in breastfeeding research among research institutions in Member States	European Commission, governments, research institutions, breastfeeding committees, professional associations	Number of collaborative projects and publications

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