Istituto per l'Infanzia
IRCCS Burlo Garofolo
Trieste, Italy

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

Promotion of Breastfeeding in Europe
EU Project Contract N. SPC 2002359

Protection, promotion and support of breastfeeding in Europe: current situation

December 2003

Istituto di Ricovero e Cura a Carattere Scientifico (IRCCS) "Burlo Garofolo"
Unità per la Ricerca sui Servizi Sanitari e la Salute Internazionale
Via dei Burlo 1, 34123 Trieste, Italy – Phone: +39 040 322 0379 Fax: +39 040 322 4702 E-mail: cattaneo@burlo.trieste.it

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Abbreviations

BF	breastfeeding
ABF	any breastfeeding
EBF	exclusive breastfeeding
PBF	predominant breastfeeding
FBF	full (exclusive plus predominant) breastfeeding
MBF	breastfeeding plus other food, including formula
NBF	no breastfeeding
BFH	Baby Friendly Hospital
BFHI	Baby Friendly Hospital Initiative
BM	breastmilk
CF	complementary feeding
EC	European Commission
EU	European Union
EURODIET	Nutrition and Diet for Healthy Lifestyles in Europe
GIFA	Geneva Infant Feeding Association
IBCLC	International Board Certified Lactation Consultant
IBLCE	International Board of Lactation Consultant Examiners
IEC	Information, Education, Communication
ILO	International Labour Organisation
NGO	Non-Government Organization
UNICEF	United Nations Children's Fund
WBFW	World Breastfeeding Week
WHA	World Health Assembly
WHO	World Health Organisation

Introduction

BF provides ideal nutrition for healthy growth and development of infants and children. The anti-infective properties of human milk protect infants against several infectious diseases. Babies who are not breastfed have a higher risk of hospitalisation in the first year of life due to serious bacterial illness. Research evidence also shows that BF has profound effects on the development of the immune system. Babies not fed human milk have higher rates of allergies and other chronic diseases later in life. BF protects the health of mothers too: it decreases the risk of certain forms of breast and ovarian cancers, and it helps with family planning. A higher rate and duration of BF is associated with reduced cost for the family, the health care system, and society in general.

The protection, promotion and support of BF is therefore of the utmost importance in public health, as emphasised in important European documents (EURODIET, French Initiative and Council Resolution on Nutrition and Health). The EURODIET reports suggest a framework for future BF promotion in Europe and strongly recommend a review of existing BF programmes and, based upon the conclusions, the formulation and implementation of an action plan on BF promotion.

The current Project directly addresses these latter recommendations. Its overall objective is to develop a strategy and a model plan of action to protect, promote and support BF to be used as models for country-specific initiatives and planning. This report on the current situation in 29 countries constitutes the first official document of the Project. A second document will review and evaluate the effectiveness and feasibility of available interventions. This will allow participants to gauge the gap between what is done and what should be done. Based on the first two documents, the Project team will develop the blueprint or model plan of action.

Methods

Data on the current situation was gathered through a written questionnaire (Annex 1) completed during January and February 2003. The questionnaire was originally sent to key people in the 15 member states of the EU, as well as to:

- Iceland and Norway, officially included in the project as countries associated with the EU;
- Switzerland, in response to an expressed interest in being involved in the Project, though it is not officially included.

Through the European Office of WHO, the questionnaire was also sent to:

- Cyprus, Czech R, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovak R and Slovenia, as EU accession countries;
- Bulgaria and Romania, as candidate EU countries.

Some of the questionnaires were returned incomplete. The United Kingdom sent four separate questionnaires for England, Wales, Scotland and Northern Ireland. Readers of this report should also consider that in each of the 10 sections of the questionnaire there was a blank box for free comments on the subject of the section; some of the information reported below is derived from these comments, but may not reflect the situation in all the countries.

The data thus gathered provided the framework for discussion in the First General Meeting of the Project's participants, held in Trieste on February 21st and 22nd 2003. The comments and amendments made by the participants on that occasion and in the course of subsequent consultations, mainly via e-mail, have been incorporated with the data drawn from the questionnaires. GIFA provided information on all countries regarding legislation on maternity protection and the implementation of the ILO 183 Convention. The whole process was approved by the members of the Steering Committee who met in Trieste on June 21st 2003.

Table 1 shows the countries from which the questionnaire was returned, the name and type of key informant, as well as the number and type of other sources of information. Annotated summaries relating to each of the 10 sections of the questionnaire are reported in the following pages. Details on each item for each country (with the exception of Cyprus for which the data has not been made available) can be found in Annex 2.

Table 1. Key informants and other sources of information by country.

Country	Key informant				Other sources		
	Name	Government	Public sector	Non profit sector	Government	Public sector	Non profit sector
AT Austria	Ilse Bichler			X	1	4	1
BE Belgium	Françoise Moyersoen*			X	0	3	5
BG Bulgaria	Stefka Petrova		X		3	1	2
CH Switzerland	Clara Bucher			X	0	0	0
CZ Czech Republic	Dagmar Schneidrová*		X		2	2	1
DE Germany	B Koletzko, H Przyrembel*	X	X		0	0	1
DK Denmark	Tine Vinther Jerris*		X		2	2	0
EE Estonia	Julia Deikina	X			3	2	0
ES Spain	Luis Ruiz			X	2	0	1
FI Finland	Kaija Hasunen	X			0	1	0
FR France	N Roques, F Ollivier			X	0	3	6
GB United Kingdom*	C Carson, J Calvert, J Warren, S Sky	X			4	1	1
GR Greece	Themis Zachou			X	1	3	2
HU Hungary	Katalin Sarlai			X	1	0	1
IE Ireland	Genevieve Becker*			X	5	0	1
IS Iceland	Geir Gunnlaugsson		X		0	3	1
IT Italy	Adriano Cattaneo		X		1	1	3
LT Lithuania	Roma Bartkeviciute	X			0	2	2
LU Luxembourg	Maryse Lehners*			X	1	4	1
LV Latvia	Iveta Pudule		X		3	2	3
MT Malta	Maria Ellul	X			0	0	0
NL Netherlands	Adrienne de Reede			X	0	1	3
NO Norway	Anne Baerug*		X		3	2	0
PL Poland	Krystyna Mikiel-Kostyra*		X		1	2	2
PT Portugal	Isabel Loureiro		X		1	1	1
RO Romania	Camelia Parvan	X			0	0	0
SE Sweden	Ulla Holmström	X			2	3	1
SI Slovenia	Mojca Gabrijelcic Blenkus	X			3	2	1
SK Slovak Republic	Viera Haľamová*		X		0	3	1

* National BF Coordinator or member of the National BF Committee

Features of national health systems with a bearing on breastfeeding

In the 15 EU member states, and in Switzerland, Iceland and Norway, health systems are generally:

- Universally accessible.
- Mostly free at delivery of services for pregnancy, childbirth and childhood; variable fees are paid to private practitioners in countries where most health care is delivered through the public sector but private practice is allowed.
- Reliant on nurses, midwives, health visitors and public health nurses as key providers of BF care in almost all countries.
- Obstetricians and paediatricians, as well as other doctors, are the main decision-makers influencing the provision of maternity hospital services. Paediatricians, public health and family doctors may also be influencial in the continuation of BF in some countries, where they are involved in the provision of care for infants and young children at primary health care level. Little systematic information is available on the role of these doctors.

- Almost all births take place in maternity hospitals, apart from the Netherlands where there is a 35% home birth rate (and most of the 65% of mothers giving birth in hospital are discharged within 12-24 hours).
- Regionalisation and decentralisation in some countries has meant that the implementation of national policies is mostly determined at local level.

The degree to which BF is protected, promoted and supported varies from country to country. In some countries, interest in BF has only come in response to critically low initiation and duration rates relative to other countries. Often this interest has been spearheaded and revitalised by mother-to-mother support groups and NGOs. Their contribution has in the main enhanced the input and quality of BF support given by health professionals and other groups. In some situations, however, BF mother-to-mother support groups and NGOs either have little cooperation with, or operate independently of, the mainstream health professional services. The BFHI has greatly contributed to the protection, promotion and support of BF in recent years in almost all countries.

In accession and candidate countries, health care for pregnant women and infants is also usually free at point of delivery (though there is a trend towards privatisation and the introduction of user fees) and is mostly provided by trained health professionals. In these countries, the health care system tends to be centralised in the smaller states and decentralised in the larger ones. In the past, the traditionally strong public health care systems in these countries aided the promotion of BF. In some cases, however, hospital practices were inappropriate and BF rates were consequently low. Protection, promotion and support of BF has been enhanced in almost all accession and candidate countries in recent years, as a result of the implementation of the BFHI; governments and public health care systems have generally responded positively to it. A feature that distinguishes these countries from EU countries is the different position of NGOs. These are often closely allied to, or in partnership with governments and health care institutions in the provision of BF services. In many cases, BF advocates in these countries work as volunteers with NGOs as well as being employed as health care professionals by governments or by health care institutions.

1 Policy and planning

Table 2 shows the number of countries with a national and/or local policy and/or a national recommendation for each of the criteria stated in the first column. A policy is a series of statements on what should be recommended. A recommendation is a more detailed and referenced document on what should be done.

Table 2. Countries with policies and recommendations meeting stated criteria (n=29).

Criteria	National policy	Local policy	National recommendation
Help mothers to start BF soon after birth	14	15	23
Breastfeed exclusively for six months	13	11	20
Continue BF up to two years and beyond	4	7	10
Implement the Ten Steps for Successful BF	14	14	23

Bulgaria has a law on starting BF soon after birth. Spain has national legislation mandating local governments to promote the BFHI in all hospitals; some local governments have enacted further legislation requiring the implementation of this national law at local level.

There are five countries, all of whom are either among accession or candidate countries (Latvia, Lithuania, Malta, Poland and Slovak R), with national policies that meet all four criteria. The Czech Republic is currently revising its 1992 and 1995 national policies to include the four criteria. Bulgaria, Denmark, Germany, Estonia, Spain, Greece, Netherlands, Norway and Sweden have national policies covering three out of the four criteria (Denmark has a policy "for about six months", as opposed to "for six months"). France, Luxembourg, Ireland and England issued policy statements recommending "EBF for six months" after the questionnaires were completed and while this report was being written. Austria, Belgium, Switzerland, Czech R, Finland, Hungary, Iceland, Italy, Portugal, Romania and Slovenia lack national policies. Existing policies mostly concern "BF after birth" and the "10 Steps", closely followed by the "duration of EBF", while relatively little consideration is given to the "continuation of BF up to two years".

Most countries have national recommendations that meet at least one of the above four criteria. In the majority of cases these have been developed by professional associations, in other cases by national BF committees. The WHO Global Strategy on Infant and Young Child Feeding, adopted by all WHA Member States in 2002 (recommending, inter alia, EBF for the first six months), has so far only been adopted as policy by a minority of countries, though in many it is a best practice recommendation. The wording of some of the national recommendations does not allow for them to be rated as fully meeting the above four criteria.

Policies and recommendations, where they exist, are usually (19 countries) well disseminated through journals, newsletters and booklets, mostly to health professionals, less often to the public. However, there is almost no public monitoring of adherence to, or implementation of, policies and recommendations, except in Iceland, Poland, Slovak R, Slovenia, Sweden and parts of the United Kingdom (Scotland).

National plans have been developed in about 50% of countries (15); in some of the others a national plan is being developed or drafted. In some of the countries where the health system is decentralised local plans are available. Plans including specific objectives and targets have been drafted in Bulgaria, Estonia, Hungary, Latvia, Lithuania, Netherlands, Norway, and the United Kingdom. Not all plans, however, are fully implemented. Greece, Luxembourg, Malta, Austria, Poland, Slovak R, Finland and Sweden do not have national and/or local plans and are not envisaging drafting them. The fact that there is no plan does not mean that there are no activities to protect, promote and support BF; they are just less likely to be part of a coordinated effort.

2. Management

Table 3 shows the number of countries with a National BF Committee and a National Co-ordinator and the type of funding they receive. Switzerland, Finland, France, Iceland, Italy and Sweden are the countries lacking both a national co-ordinator and a national committee.

Table 3. Countries with BF committee and coordinator, and their funding (n=29)		
Countries with a national co-ordinator		16
Countries with a national committee		21
Funds available to the national committee	regular	6
	irregular	8
	no funds	7

Many countries have already appointed a National BF Co-ordinator, as recommended in the 1990 Innocenti Declaration, and reiterated in the Global Strategy. National Committees, where they exist, generally have an advisory, as opposed to decision-making role. Membership of these Committees usually includes representatives from the major stakeholder groups involved in BF promotion,

protection and support, eg. representatives from relevant health professional groups, academic research organisations, NGO members and mother-to-mother support groups. Some of the National Committees do not meet regularly, or do so infrequently. With changes in governments following elections, or when re-shuffles of health portfolios occur, especially in the accession and candidate countries, National Committees can be put on hold or disbanded.

National Co-ordinators and Committees are mostly active in advocacy, policy, planning, development of guidelines and other written materials; some Committees are responsible for training and/or the development of training materials, including curricula for pre-service training. In Lithuania, a national committee exists but has no legal status and works on a voluntary basis. In some countries, national committees largely overlap with BFHI committees.

There is no national co-ordinator in Sweden, but there is an effective informal co-ordination among all the actors involved in BF. This may bear some relation to the fact that 100% of Swedish hospitals are certified as BFHs. However, the 10% decline in BF rates recorded between 1996 and 2000 may reflect some difficulties with the management of the activities.

3. Training

Some countries have national boards that certify the quality of pre-service training. Only five countries, however, have some form of certification of courses on BF; mostly this involves curricula for midwives and nutritionists. In the other countries with such boards, certification refers more generally to subjects, such as nutrition, paediatrics or child health, and not specifically to BF. An evaluation of the quality of the pre-service training available would need further investigation. Very little BF education occurs in health care training colleges (at either undergraduate or postgraduate level), except in Bulgaria, Ireland (midwifery), Austria (midwifery), Sweden, Slovenia (midwifery, registered nursing), and the United Kingdom (where it is just starting). In most countries, there are few skilled trainers in this sector.

Regarding in-service training, the 18-hour UNICEF/WHO course on the BFHI has been introduced in 17 countries, mostly with low to medium coverage. The 40-hour WHO/UNICEF course on BF counselling has been introduced in 12 countries, also with low to medium coverage. Most countries (25) have introduced locally adapted/developed courses with duration ranging from a few hours to a few days. Some of these courses, in Germany for example, are officially endorsed and lead to a recognised certificate or credits. However, there is little assessment of the quality and effectiveness of these courses, except in Denmark. In-service training coverage is generally higher for nurses and midwives than for doctors; among the latter, paediatricians are more likely to undergo BF training than obstetricians.

There is widespread support for training in Bulgaria, Czech R, Greece, Ireland, Norway, Romania, Slovenia, Sweden, and the United Kingdom. In Italy there is a Continuing Medical Education programme which awards credits to health professionals attending BF courses. Information meetings, newsletters, journals and web-sites are available in many countries.

The IBLCE is available in many countries. There are IBLCE certificants in Switzerland, Germany, France, Ireland, Italy, Iceland, Netherlands, Norway, Austria, Sweden, Luxembourg, Belgium, Hungary, Slovenia, Estonia, Spain, Poland, Greece and the United Kingdom. The number of IBCLC by country is shown in Annex 2. A high number of IBCLCs does not necessarily mean better promotion and support for BF. This can only be measured by the percentage of relevant personnel who have received training and by their levels of competency in providing high standards of BF support.

4. Baby Friendly Hospital Initiative

There are national BFHI co-ordinators in 20 countries. Some of them are appointed by governments, some by UNICEF, some by national NGOs. The government supports the BFHI in some countries, but not in others. UNICEF national organisations in Greece, France and Ireland have virtually no involvement in the BFHI. The implementation of the BFHI has been very difficult and slow in many countries.

Some countries have no baby friendly teaching hospitals but may have other hospitals with the BFH designation. There are teaching hospitals with the BFH designation in Bulgaria, Switzerland, Czech R, Denmark, Germany, Spain, Hungary, Luxembourg, Netherlands, Norway, Austria, Poland, Romania, Slovak R, Slovenia, Sweden, and the United Kingdom.

Table 4 shows the number of BFHs by country, as well as the national percentage of births in BFHs. The data from the Netherlands includes home care organisations providing maternity care in the mother's own home. Three countries in particular show very high percentages of births in BFHs (Sweden 100%, Slovenia 85% and Norway 75%). Seven countries (Switzerland, Czech R, Denmark, Luxembourg, Slovak R, the Netherlands and United Kingdom) range at intermediate level (15-50%), while 19 countries display low percentages of births in BFH (0-15%).

The Global Criteria of the BFHI are not fully applied in all countries. For example, the criteria for Step 4 often allow initiation of BF more than one hour after birth. Similarly, with regards to Step 6, some countries (those with a very low initiation rate) give the BFH designation to some hospitals with less than 75% EBF at discharge; some other countries, such as Switzerland, are relatively liberal with pre-lacteal feeds. Finally, some countries are not very strict with Step 9 (avoid the use of teats and pacifiers). In other countries, Steps 4, 6 and 7 (on rooming-in) in the United Kingdom for example, some of the Global Criteria have been strengthened

The BFHI is one of the possible approaches to changing hospital practices. Where the BFHI is implemented, the number and percentage of BFHs is an indicator of the extent of BF promotion and support in hospitals. It is not, however, the only possible indicator and may not fully reflect the quality of care provided to BF mothers. In some countries, the BFHI may not have been promoted vigorously, yet hospital practices may be improving. In Germany for example, nationally adapted recommendations on the implementation of the 10 Steps have been sent to all hospitals, endorsed by the national committee and by professional societies, and practices may be improving even if the number of BFHs is low.

Reassessment of BFHs is scheduled to happen every 2-6 years. It is already being done or is a permanently ongoing process in Denmark, Germany, Luxembourg, Netherlands, Norway, Sweden and the United Kingdom. The reassessment process will start in 2003 in Estonia, Spain and Romania. Ceasing the acceptance of free formula donations by hospitals is a challenge to the expansion of the BFHI in some countries, as is the fact that the BFHI is generally under-funded.

Community Baby Friendly Initiatives, based on the adaptation of the 10 steps of the BFHI to primary health care services, are planned and/or implemented in Bulgaria, Czech R, Denmark, Hungary, Lithuania, Netherlands, Norway, Slovak R, Slovenia, Sweden, and the United Kingdom. BF supportive paediatric hospital initiatives, for older infants and children admitted to hospitals, are in place in Slovenia and Ireland; in Ireland there is also a BF supportive health service workplace project as part of the BFHI.

Table 4. Number of BFHs by country and percentage of births in BFHs.		
Country	BFH/Hospitals	% births in BFH
Austria	14/110	12
Belgium	0/107	0
Bulgaria	5/127	8
Switzerland	53/155	51
Czech Republic	30/116	23
Germany	18/1100	3
Denmark	11/35	22
Estonia	1/17	2
Spain	8/498	1.5
Finland	4/35	7
France	2/800 *	0.3
United Kingdom	44/305	15 **
Greece	0	0
Hungary	9/100	11
Ireland	0/22	0
Iceland	0/15	0
Italy	7/700	1
Lithuania	3/54	12
Luxembourg	2/6	35
Latvia	4/30	8
Malta	0/3	0
Netherlands	25/200	24
Norway	36/57	75
Poland	50/434	12
Portugal	0/60	0
Romania	10/237	5
Sweden	52/52	100
Slovenia	10/14	85
Slovak Republic	11/72	30

* self-assessed using global BFHI criteria

** 8% (England) 34% (Wales) 38% (Scotland) 20% (Northern Ireland)

5. International Code and subsequent relevant WHA resolutions

All EU member states voted in favour of the International Code on Marketing of Breastmilk Substitutes in 1981; they followed a similar course of action also for subsequent relevant WHA resolutions. In 1991, the EU adopted many provisions of the Code in its Directive for the internal market of infant and follow-on formulae (91/321/EEC). The following year an export Directive (92/52/EEC) and Council Resolution (92/C172/01) were adopted. These Directives, however, have not been revised to take into consideration relevant WHA resolutions approved after 1991. In addition, a number of products mentioned in and covered by the Code are not included in the scope of the Directives; therefore, the parts of the Code related to these products have not been implemented in national legislation. The Directives are binding acts. In most EU countries they have been transposed into national legislation that has had some positive effect on the marketing of BM substitutes, which had previously been largely unregulated.

In accession and candidate countries, marketing of BM substitutes is not yet regulated. For this reason, infringements to the International Code are probably more common in these countries than

in EU member states. The situation will hopefully improve with full EU membership and the adoption of the EU Directives.

The differences between the EU Directives and the Code can be summarised as follows. The EU Directives:

- Only apply to infant and follow-on formulae. Only the former, however, is considered a BM substitute by the EU Directives. The latter is defined as "foodstuffs intended for particular nutritional use by infants aged over four months and constituting the principal liquid element in a progressively diversified diet of this category of persons".
- Do not apply to preterm and other special formulae.
- Do not apply to other BM substitutes, including complementary foods when these are represented as a suitable replacement for BM.
- Do not apply to feeding bottles and teats, which are covered by the Code.
- Permit certain forms of promotion that are prohibited under the Code, namely advertising in specialist baby care and scientific publications.
- Do not define "health care system" and "institutions and organisations"; this can lead to ambiguity in interpretation with regard to donations of infant formula or provisions of low-cost supplies. The EU Directives, therefore, do not achieve the aim of the Code, i.e. to prevent donations of free and low cost supplies to health care systems.
- Restrict the ban of "point-of-sale advertising, giving of samples or any other promotional device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales", as well as the provision "to the general public or to pregnant women, mothers or members of their families, of free or low-priced products, samples or any other promotional gifts, either directly or indirectly via the health care system or health workers" to infant formula, since it is considered as the only BM substitute.

EU member states have for the most part adopted the EU Directives, with few providing any additional protection. No EU country has given full legislative backing to the International Code and subsequent WHA Resolutions. It has to be noted, however, that member states (as well as accession and candidate countries that achieve full membership status) are bound to adopt the EU Directives as a minimum standard, but they are free to provide additional legislative protective measures at national level in order to safeguard infant and young child health.

The enforcement and monitoring of compliance with the national laws based on the EU Directives, and with any additional aspect of the International Code enshrined in law, is the responsibility of different government sectors in different countries. The monitoring of compliance with the International Code and subsequent WHA Resolutions is, so far, not the responsibility of national legislation. This is done by NGOs and consumer associations in some countries. Whenever such monitoring has been conducted, violations of the Code have been disclosed. Infringements of the Code are normally reported to governments, but even proven infringements are rarely prosecuted or punished.

There is a general lack of awareness of the Code among the general public and health professionals. Limited official dissemination of information about the Code and its implementation has taken place in Norway, Finland and Sweden; more information has been circulated in many countries, including accession and candidate countries, by NGOs.

Manufacturers of BM substitutes interact regularly with health professionals and health professional associations (especially paediatric and nutrition/dietetic associations), as well as health facilities in many countries, through sponsorship of events, congresses, research and publications. Some of these companies also have direct contact with mothers through mail, internet, telephone help lines, discharge packets and baby clubs. All these activities, when promoting products covered by the

Code (broader than just infant formulae), should be considered as violations of the International Code.

6. Legislation for working mothers

The ILO standards (convention MPC 183) for protecting and supporting BF among working mothers involve the provision of:

- minimum of 14 weeks of paid maternity leave (Note: the minimum leave is shorter than the recommended six months of EBF, which means that working mothers will have difficulties to breastfeed exclusively for six months); maternity leave payment should be at least two-thirds of previous earnings;
- entitlement to one or more paid BF breaks daily or daily reduction of hours of work to breastfeed, without loss of pay;
- job protection and non-discrimination for BF workers.

In many countries, the legislative provisions facilitating BF in the workplace go beyond the ILO recommendations. Only four governments (Bulgaria, Italy, Romania, Slovak R), however, have ratified the ILO convention so far. The ILO recommendations have been fully implemented in most countries and partially implemented in those remaining. The standard regarding paid BF breaks during working time is not frequently met. The United Kingdom seems to be the EU country with the least compliance with ILO standards, though it has recently extended its paid maternity leave to 6 months. In Scotland, there is no specific legislation but BF mothers are protected under a series of acts and regulations (a booklet on BF and Returning to Work is available to women), and can individually negotiate BF breaks with employers and union's support. Virtually none of the ILO standards are met in Switzerland, but some cantonal laws do meet the standards.

Fathers can often share the maternity protection benefits granted to mothers under national legislation. There are groups of women workers not covered by protective legislation in some countries, e.g.: women employed for less than 6-12 months at the time of application for maternity leave, those who are self-employed, contract workers, irregular or illegal workers, working students. In some countries there are differences between women employed in the private and the public sector, especially with regards to the duration of full and/or partial salary, and the provision of paid BF breaks.

7. Community outreach, including mother support

Mother-to-mother support groups are present in most countries (27 out of 29). In many cases they were involved in the promotion and support of BF long before any concerted public health initiative/activity on BF started. Where institutional support is well developed, mother-to-mother support groups seem to be less active, probably because they are less needed.

The coverage of these groups is reported as low to medium in most countries, except in France where it is rated as high (probably because of the low level of support for BF within the health care system) and Scotland. In the Netherlands, mother-to-mother support groups have national coverage. In some countries there are good links with the health care services, in others peer counsellors, defined as lay (non-health professional) women adequately trained to provide individual support to mothers, and mother-to-mother support groups are funded and otherwise supported by the health care services. In many countries volunteer mother-to-mother support organisation members get some training in BF management and support.

A certain level of co-ordination between groups is present in some countries. Women are made aware of the availability of these groups through newsletters, health services (during antenatal care or at discharge after delivery), telephone directories and internet. Mothers who need information or

support usually attend group meetings, or get in touch by phone and increasingly by e-mail and through the internet. Support is usually provided via the same channels, but sometimes also through home visits, written materials, and videos.

8. Information, Education, Communication

In many countries, governments allocate some funds for the promotion of BF (Belgium, Czech R, Germany, Greece, France, Ireland, Italy, Iceland, Luxembourg, Malta, Netherlands, Norway, Poland, Romania, Finland, United Kingdom). Funds are usually used for the production of booklets, leaflets, flyers, posters, stickers, videos, TV spots, and for workshops. Local funds and initiatives are also common in some countries.

These materials are reviewed and revised as necessary. They are widely and regularly disseminated in some countries, irregularly in others. No provisions are made to audit their results, in terms of both coverage and effectiveness, except in Iceland (showing that mothers usually comply with the written advice), Malta, Norway, Romania and the United Kingdom (England and Scotland).

WBFW activities are implemented in all countries except Iceland, Portugal and Romania. In most countries the WBFW takes place in October, but also in May (Poland, Northern Ireland and Scotland), August (the Flemish speaking region of Belgium, Luxembourg, and most accession and candidate countries), and November (Denmark, Greece). Activities are mostly organised by NGOs, with some UNICEF involvement (Germany, Greece, Spain and some accession and candidate countries) and in some cases - i.e. Denmark, Hungary, Ireland, Malta, Northern Ireland and Scotland – with Government support.

The number of web-sites devoted to BF is increasing; they are developed by Government departments, individuals, interest groups, NGOs, and BFHI committees. Currently available government websites on BF are:

- Belgium www.health.fgov.be/vesalius/startf.htm
- Estonia www.perekool.ee
- Greece www.mohaw.gr
- Ireland www.healthpromotion.ie
- Latvia www.esi-vesels.lv
- Norway www.rikshospitalet.no\ammesenteret
- United Kingdom www.doh.gov.uk/infantfeeding
- Scotland www.show.scot.nhs.uk/breastfeed
- Wales www.wales.gov.uk
- Northern Ireland www.healthpromotionagency.org.uk

9. Monitoring

Monitoring of BF rates is almost always funded by governments, within the budget assigned to health care systems. Monitoring is population-based in Belgium (initiation and duration up to 12 months), Greece (metabolic screening), France (initiation), Ireland (discharge from hospital), Iceland, Sweden, Scotland (initiation and discharge from hospital, metabolic screening, child health surveillance programme), Wales (child health system), and in all accession and candidate countries with the exception of Romania. Population-based means that data are routinely gathered by health care providers during contacts with users (delivery, discharge from hospital, immunisation, well-baby clinics). This routine collection of data achieves differing degrees of completeness and accuracy.

Monitoring is sample-based in Denmark, Spain, Italy, Luxembourg, Netherlands, Norway, Austria, Portugal, Romania, Finland, and the United Kingdom, at different and often irregular intervals. Local surveys are conducted in many countries and are often not reported. No regular monitoring takes place in Switzerland and Germany. Each country and monitoring group seems to apply a different definition and method; WHO definitions and methods are frequently not applied.

Reports of monitoring are usually available (but not always) with a 6-month to 3-year time lag. Dissemination of results is low and so is feedback to health professionals and decision makers, except in Iceland, Netherlands, Finland, Sweden, United Kingdom and in most accession and candidate countries (except Poland and Slovenia). Dissemination to the general public is even poorer.

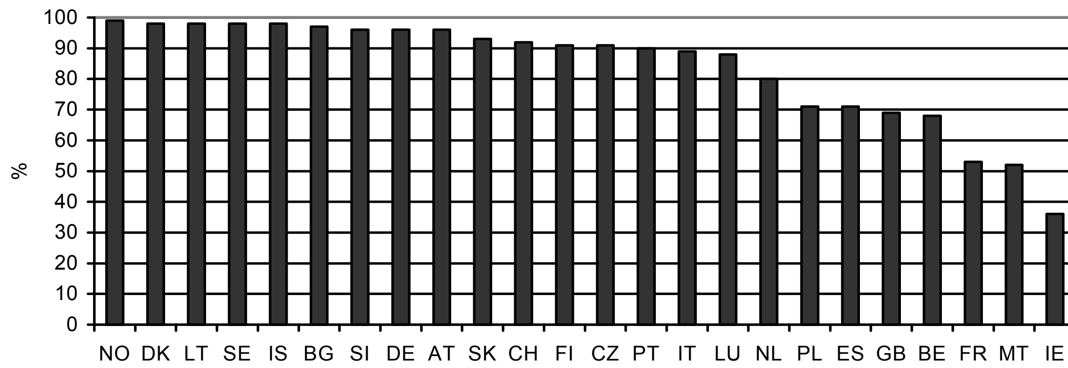
Table 5 shows the available information on BF rates. Figures 1-3 show how countries could be ranked by some rate. Great care is needed when making comparisons due to the lack of standard methods of data collection and of application of definitions.

Table 5. Some BF rates by country.

Country	(y)	Initiation	Discharge	3 months	6 months	12 months
AT	(1998)	**A** 96	**E** 95	**E** 79	**E** 46	**A** 10
BE	(1998/00)	**A** 63-72		**A** 30-37	**A** 10	**A** 4
BG	(2001)	**A** 97		**E** 49	**A** 36	
CH	(1994)	**A** 92		**A** 73 **E** 62	**A** 41 **E** 11	
CZ	(1999)		**E** 91 (2001)		**A** 53 **E** 23	
DE	(1997/98)	**A** 96	**A** 86 **E** 73	**A** 60 **E** 33 (4 m)	**A** 48 **E** 10	**A** 13
DK	(2000)	**A** 98		**A** 75 **F** 60 (4 m)		
EE	(2001)			**A** 61	**A** 40	
ES	(2001)	**A** 71	**E** 61 (6 w)	**A** 58 **E** 42	**A** 40 **E** 23	
FI	(2000)		**A** 91 **E** 65	**A** 74 **E** 41	**A** 51 **E** 1	
FR	(2000)		**A** 53	**A** 15		
GB	(2000)	**A** 69		**A** 28 (4 m)	**A** 21	**A** 13 (9 m)
GR	(2001)*	**A** 86	**E** 24		**A** 54 **E** 28	
HU	(2001)			**E** 62 (4 m)	**E** 35	
IE	(1999)		**E** 36			
IS	(2000)		**A** 98 **E** 93	**A** 75 **E** 47 (4 m)	**A** 65 **E** 13	**A** 13
IT	(2000)	**A** 89	**F** 78		**A** 62 **F** 45	
LT	(2000/02)	**A** 98		**A** 46	**A** 26 **E** 14	**A** 7
LU	(2001)	**A** 88	**E** 65 (84 in BFH)	**A** 58 **E** 40 (4 m)	**A** 42 **E** 4	
LV	(2000)	only the proportional distribution of ABF by duration is available				
MT	(2002)		**E** 52			
NL	(2002)	**E** 80	**E** 72	**A** 47 **E** 35	**A** 34 **E** 17	
NO	(1998)	**A** 99	**E** 94	**A** 90 **E** 70	**A** 80 **E** 7	**A** 36
PL	(1997)		**E** 71 (2002)	**E** 31 (4 m)	**E** 9	
PT	(1998/99)	**A** 90	**A** 85	**A** 63	**A** 34	**A** 16
RO		no information available				
SE	(2000)		**A** 98 **F** 93	**A** 83 **F** 68 (4 m)	**A** 72 **F** 33	
SI	(2000)		**F** 96 **E** 90			
SK	(2000)	**E** 93		**E** 55	**E** 30	

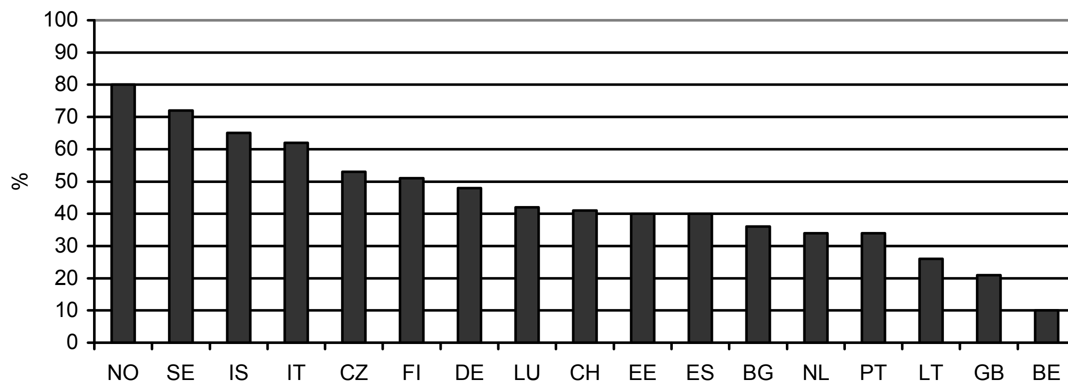
Legend: **A** = ABF, **F** = FBF, **E** = EBF. * Data from maternity hospitals in Athens

Figure 1. Rate of initiation of breastfeeding.



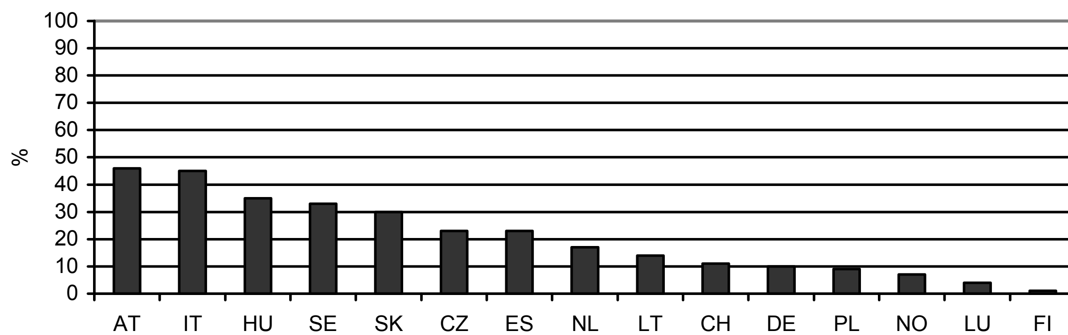
- Data missing from EE, GR, HU, LV and RO.
- Data from CZ, IE, MT, SE and PL represent EBF at discharge, for ES at 6 weeks.
- Data from FR, IS, SI, and FI represent ABF at discharge, for SE at 1 week.

Figure 2. Rate of any breastfeeding at six months.



- Data missing from DK, GR, FR, HU, IE, LV, MT, AT, PL, PT, RO, SK, SI.

Figure 3. Rate of exclusive breastfeeding at six months.



- Data missing from BE, BG, DK, EE, FR, GB, IE, IS, LV, MT, RO, SI.
- Data from IT, PT and SE represent FBF.

10. Disadvantaged groups

In most countries, there is no specific policy or plan addressing the poor up-take of BF by mothers from disadvantaged groups. Some specific policy and action plans have been developed and implemented in Czech R, Denmark, Germany, Greece, Spain, Hungary, Norway, Portugal, Romania, Slovak R, Sweden (proposed), and the United Kingdom. They address smokers, teenagers, less educated families, lower socio-economic groups, immigrant women or ethnic minority groups. In the Netherlands, bilingual leaflets for immigrants are produced and disseminated by NGOs; such leaflets are produced and disseminated by the National BF Committee in Germany.

There are also local activities carried out by health authorities and NGOs. These activities generally focus on reducing inequalities in health and do not specifically address BF. In some countries, free formula is given to low-income mothers as a financial support to child rearing.

Where there is a degree of monitoring of BF rates, data is sometimes available by age, education, residence, occupation, but less often by family income, employment status and ethnicity. In the Netherlands such data are gathered by an NGO.

Conclusions

The current situation in the 29 countries surveyed is extremely heterogeneous. However, a number of common conclusions may be drawn:

- Most countries are collecting some data. However, data collection on BF rates is generally inconsistent and incomplete. Definitions and methods are different in many countries. A single standard system for data collection (basic rates and basic practices) does not exist. Whilst this might not be easy to establish, the creation of a common EU-wide population-based monitoring system is urgently required. The responsibility to establish this monitoring system lies with individual EU governments working together to bring it about.

- Despite difficulties in interpreting available data, it is clear that BF rates and practices fall short of WHO and UNICEF recommendations, of many national policies, and of recommendations published by many professional organisations. In some countries, initiation rates are very low. In other countries, there is a marked decline of BF rates in the first six months despite high initiation rates. The rates of EBF at six months are low everywhere.

- Health care systems in most countries have the resources and the potential to fully protect, promote and support BF. Inter-sectoral and inter-disciplinary co-operation across the whole of society is vital to achieve this. This is happening in some countries but to a much lesser extent in others. The level of national commitment, coordination and cooperation has been shown to have a direct bearing on BF rates and best practice.

- Some countries have national policies as well as local policies, while others have only got local policies. In many cases, however, these policies do not meet current best practice standards as set out in the latest WHO evidence-based-recommendations (see WHA Resolution 55/15 of 2002 “Global Strategy on Infant and Young Child Feeding”), as well as recommendations from UNICEF and other univerally acclaimed professional and scientific bodies. Common EU recommendations are lacking.

- Many countries have yet to achieve the goals and the objectives set for 1995 by the Innocenti Declaration. Some countries have advanced more than others and have a national coordinator

and committee (but often without the financial means to carry out activities), an active BFHI, and some legislation on maternity protection and marketing of BM substitutes. Other countries are lagging behind. There is little funding made available for BF activities in many countries.

- The BFHI (or a similar initiative that promotes changes in hospital practices) is implemented in many countries, but only a few countries have achieved widespread BFHI participation across the whole maternity care sector . In some countries, none of the maternity hospitals have, as yet, achieved the standard for BFH designation. Baby Friendly Community and other Initiatives are being developed in some countries, but these need further evaluation of their effectiveness before they are standardised and officially adopted.

- There is a lack of effective pre-service BF course curricula to ensure the adequate training of all health care professionals and nutritionists. Those courses that do exist need to be assessed as to their quality and effectiveness, and revised or revamped as necessary. In most countries there are few skilled pre-service trainers.

- The use of quality-assessed WHO/UNICEF courses for in-service training is low. An assessment of the effectiveness of locally adapted/developed courses has not been carried out. IBCLCs are found in many countries, which may indicate increased awareness of the need for specialist health workers, particularly where general health worker education for BF is low.

- The legislation that regulates the marketing of BM substitutes falls short of the International Code and subsequent relevant WHA resolutions in the majority of countries. Most EU, accession and candidate countries apply the EU Directive of 1991, which only covers some provisions of the Code and has not been updated. The Code itself is not sufficiently known by health professionals and the general public, nor is it adequately monitored, except by NGOs.

- In many countries, the legislation on maternity protection with relevance to BF goes beyond the recommendations of the ILO 183 Convention, even though only four countries ratified this Convention. In some countries, national legislation does not meet the ILO Convention standards, especially with regard to BF/lactation break provisions. In addition, many working mothers (e.g., women employed for less than 6-12 months at the time of application for maternity leave, women who are self-employed, contract workers, irregular or illegal workers and working students) are not protected by legislation even in countries where it meets the ILO standards for other workers.

- Mother-to-mother support groups and peer counsellors are present in most countries but their coverage is generally low to medium. The degree of co-ordination among the various support groups is weak in most countries. Links with the health care system are often too loose to achieve an effective degree of integration and cooperation.

Please note that in the questionnaire used for this survey it was not possible to include questions on other important influencing factors relating to BF promotion, protection and support. For example, questions on the role of the media, BF awareness in primary education, gender issues, the role of fathers, and general community attitudes were not included. All these points will however, be taken into consideration in the development of the Blueprint for Action.

Annex 1
Promotion of breastfeeding in Europe
Questionnaire on national activities for the promotion of breastfeeding

The purpose of this questionnaire is to gather information on what is currently being done in each of the countries of the EU. All participants will receive copies of all the questionnaires during the first meeting. The information you provide will be used to produce the first project document. During the meeting, we shall compare what is currently being done with what should be done, based on a document on effective and feasible interventions.

Country: Date:

Person in charge of the questionnaire:

Qualification:

Position:

Full address:

Phone: Fax: E-mail:

Use the most recently available information to fill in the questionnaire; whenever possible, specify the period to which the information refers. Send the completed questionnaire and any other relevant document to cattaneo@burlo.trieste.it or to Adriano Cattaneo, Unit for Health Services Research and International Health, IRCCS Burlo Garofolo,Via dell'Istria 65/1, 34137 Trieste, Italy, by 31 January 2003.

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2. Management
3. Training
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5. International Code
6. Legislation for working mothers
7. Community outreach, including mother support
8. Information, education, communication
9. Monitoring
10. Disadvantaged groups

Please list the people/organisations you consulted to get the information:

1.

2.

3.

4.

5.

Use this box to briefly outline (the) features of your national health system that you think might have a bearing on the promotion of breastfeeding.

1. Policy and planning

Some definitions:

- Legislation: laws passed by national or local parliaments, decrees issued by ministries.
- Policy: short statements on what providers and/or users of health services should do.
- Recommendations: long referenced documents on what health professionals should do.

1.1. In the table below, tick (the box on) what is available in your country for the promotion of breastfeeding and roughly rate it against the stated criteria. Write any other comment you might have in the box at the end of this section.

Please attach a copy (or insert internet address) of any national (not local) document.

Criteria	Legislation	National policy	Local policies	Recommendations
Start breastfeeding immediately after birth	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:
Breastfeed exclusively for about six months	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:
Continue breastfeeding up to two years and beyond	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:
Implement the Ten Steps for Successful Breastfeeding	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:	Yes ☐ No ☐ Rating:

1.2. Are these laws, policies and recommendations routinely communicated to those managing and implementing relevant activities? Yes ☐ No ☐

1.2.1. If yes, how and by who?

1.3. Is adherence to these laws, policies and recommendations routinely monitored and enforced? Yes ☐ No ☐

1.3.1. If yes, how and by who?

1.4. Is there a national government plan to promote breastfeeding? Yes ☐ No ☐

If yes, please attach a copy or insert internet address

1.4.1. If yes, what are the main objectives and targets for 2002 (or the most recent year)?

Observations and comments:

2. Management

2.1. Is there a national coordinator for breastfeeding? Yes □ No □

2.2. Is there a national breastfeeding committee? Yes □ No □

2.2.1. If yes, does the committee have an advisory □ and/or a decision-making □ role?

2.3. Does the government provide regular □ or irregular □ funds to support the activities of the national committee (if any)?

2.3.1. If yes, what is the latest figure?

2.4. Which national bodies and/or institutions are represented on the national committee (if any)?

□ government departments	□ health professional associations
□ medical schools	□ nursing/midwifery schools
□ women/mothers support groups	□ breastfeeding support groups
□ infant food manufacturers	□ NGOs
□ public health experts	□ UNICEF
□ nutritionists	□ other ....……….............................

2.5. What are the main recent accomplishments of the national committee (if any)?

Please attach a list of the current members of the national committee (if any), including name and full address of the national coordinator (if any).

Observations and comments:

3. Training

3.1. Is there a National Board that certifies the quality of pre-service curricula of medical □, public health □, nutrition □, nursing □, and midwifery □ schools?

3.1.1. If yes, does it have criteria for training on breastfeeding? Yes □ No □

3.1.2. If yes, describe.

3.2. Has the 18-hour UNICEF course on Breastfeeding promotion and practice been introduced? Yes □ No □

3.2.1. If yes, rate the coverage: high □ medium □ low □

3.3. Has the 40-hour WHO course on Breastfeeding counselling been introduced? Yes □ No □

3.3.1. If yes, rate the coverage: high □ medium □ low □

3.4. Have other courses on breastfeeding been introduced? Yes □ No □

3.4.1. If yes, give details.

3.5. Are trained health professionals kept informed on new research findings through newsletters or other means? Yes □ No □

Observations and comments:

4. Baby Friendly Hospital Initiative (BFHI)

4.1. Is there a national BFHI coordinator? Yes ☐ No ☐

If yes, give name and full address

4.2. Approximate number of hospitals providing maternity services:

4.3. Number of hospitals designated as Baby Friendly:

4.4. Is there any teaching hospital among them? Yes ☐ No ☐

4.5. Are BFHI universal criteria used for designation? Yes ☐ No ☐

4.5.1. If not, state differences.

4.6. Number of hospitals and facilities that have a Certificate of Commitment:

4.7. Approximate number of annual deliveries in the country:

4.8. Percentage of deliveries in Baby Friendly Hospitals:

4.9. Is there a plan to reassess designated Baby Friendly hospitals? Yes ☐ No ☐

4.9.1. If yes, how often?

4.10. Is there a Baby Friendly Community Initiative? Yes ☐ No ☐

Observations and comments:

5. International Code

5.1. Is the WHO International Code on Marketing of Breastmilk Substitutes in effect?
Yes ☐ No ☐

5.2. Are national measures being drafted in this sense, i.e. legislation, regulations, etc?
Yes ☐ No ☐

5.3. Does the legislation that puts the Code into effect cover all its provisions?
Yes ☐ No ☐

5.3.1. If not, what provisions are not covered?

5.4. Are the World Health Assembly (WHA) Resolutions reinforcing the Code taken into account in the revision of laws and/or policies? Yes ☐ No ☐

5.5. Is the implementation of the Code and/or national legislation regularly monitored by a public and/or private non-for-profit independent organisation? Yes ☐ No ☐

5.6. What action is taken in case of confirmed infringement of the Code and/or national legislation?

Observations and comments:

6. Legislation for working mothers

6.1. Has the International Labour Organization (ILO) maternity protection convention (MPC138) been ratified? Yes ☐ No ☐

6.2. Is there a legislation that meets the ILO standards for protecting and supporting breastfeeding among working mothers? Yes ☐ No ☐

6.2.1. If yes, please specify standards:

- Minimum 14 weeks of paid maternity leave ☐
- Paid maternity leave (at least two-thirds of previous earnings) ☐
- Entitlement to one or more paid breastfeeding breaks daily
- or daily reduction of hours of work to breastfeed ☐
- Job protection and non-discrimination for breastfeeding workers ☐

6.3. Are there any groups of women not covered by this legislation? Yes ☐ No ☐

6.3.1. If yes, give details:

Observations and comments:

7. Community outreach, including mother support

7.1. Are voluntary organisations for mother-to-mother support established?

Yes ☐ No ☐

7.1.1. If yes, describe:

7.1.2. Rate the likely/estimated coverage of these groups:

high ☐ medium ☐ low ☐

7.1.3. Rate the linkage of these groups with the health care services:

high ☐ medium ☐ low ☐

7.1.4. How do mothers get in touch with these groups?

7.2. Does the health care system organise mother-to-mother support groups?

Yes ☐ No ☐

7.2.1. If yes, describe:

7.2.2. If yes, rate the likely/estimated coverage of these groups:

high ☐ medium ☐ low ☐

7.3. Is there training of peer counsellors? Yes ☐ No ☐

7.3.1. If yes, rate the likely/estimated coverage:

high ☐ medium ☐ low ☐

Observations and comments:

8. Information, Education and Communication (IEC)

8.1. Is there any government budget for IEC? Yes ☐ No ☐

8.1.1. If yes, how is it used?

8.2. What are the main government IEC products?

8.3. Is there any assessment of results? Yes ☐ No ☐

8.3.1. If yes, give details.

8.4. Are there national activities for the World Breastfeeding Week? Yes ☐ No ☐

8.4.1. If yes, in August ☐ or October ☐?

8.4.2. Supported by government ☐ and/or UNICEF ☐ and/or NGOs ☐?

8.5. Is there a government breastfeeding website? Yes ☐ No ☐

If yes, give internet address

Observations and comments:

9. Monitoring

9.1. Is there any government collection of data on breastfeeding rates? Yes ☐ No ☐

9.1.1. If yes, is it sample ☐ or population ☐ based?

9.1.2. What is the periodicity?

9.2. What are the main indicators used for initiation, duration and exclusivity of breastfeeding?

Indicator	Definition	Latest value (year)

9.3. Is the information reported regularly? Yes ☐ No ☐

9.3.1. If yes, how often?

9.3.2. What is the time lag?

9.4. Is the information fed back regularly to health professionals? Yes ☐ No ☐

9.4.1. If yes, can they relate it to their local needs? Yes ☐ No ☐

9.4.2. Is it given to policy and decision makers? Yes ☐ No ☐

Observations and comments:

10. Disadvantaged groups

10.1. Is there a government policy targeting disadvantaged groups? Yes ☐ No ☐

10.2. Is information on breastfeeding gathered by:

☐ age of the mother ☐ area of residence
☐ income of the family ☐ occupation of the mother
☐ education of the mother ☐ employment status
☐ etnicity ☐ other ....

10.3. What action is taken to target disadvantaged groups?

Observations and comments:

Annex 2: the answers (closed or short answers) from each country to some of the items of the questionnaire

	AT	BE	BG	CH	CZ	DE	DK	EE	ES	FI	FR	GB	GR	HU	IE	IS	IT	LT	LU	LV	MT	NL	NO	PL	PT	RO	SE	SI	SK
Policy and planning																													
Help mothers to start BF soon after birth (legislation)																													
BF exclusively for 6 months (legislation)																													
Continue BF up to two years and beyond (legislation)																													
Implement the Ten Steps to successful BF (legislation)																													
Help mothers to start BF soon after birth (national policy)																													
BF exclusively for 6 months (national policy)																													
Continue BF up to two years and beyond (national policy)																							1 year						
Implement the Ten Steps to successful BF (national policy)																													
Help mothers to start BF soon after birth (local policy)																													
BF exclusively for 6 months (local policy)																													
Continue BF up to two years and beyond (local policy)																													
Implement the Ten Steps to successful BF (local policy)																													
Help mothers to start BF soon after birth (recommendation)																													
BF exclusively for 6 months (recommendation)																													
Continue BF up to two years and beyond (recommendation)																													
Implement the Ten Steps for successful BF (recommendation)																													
Are these laws, policies and recommendations routinely communicated to those managing and implementing relevant activities?																													
Is adherence to these laws, policies and recommendations routinely monitored and enforced?																													
Is there a national government plan to promote BF?															?														
Programme management																													
Is there a national coordinator for BF?																													
Is there a national BF committee?												3/4																	
Does the government provide funds to support the activities of the national committee?																													
Does the government provide regular funds to support the activities of the national committee?																													
Does the government provide irregular funds to support the activities of the national committee?																													

Annex 2: the answers (closed or short answers) from each country to some of the items of the questionnaire

	AT	BE	BG	CH	CZ	DE	DK	EE	ES	FI	FR	GB	GR	HU	IE	IS	IT	LT	LU	LV	MT	NL	NO	PL	PT	RO	SE	SI	SK
Training																													
Is there a national board that certifies the quality of pre-service curricula for training on BF?																													
Has the 18-hour UNICEF/WHO course on BF promotion and practice been introduced?															?														
Rate the coverage	mid	low	mid	high	low	low		low	low	low		mid		low	?		mid	low	mid	low				low		low		high	
Has the 40-hour WHO/UNICEF course on BF counselling been introduced?																													
Rate the coverage	low		mid			low		low	low			low	high				low	low		low						low			mid
Have other courses on BF been introduced?																													
Are trained health professionals kept informed on new research findings through newsletters or other means?																													
International Board Certified Lactation Consultants (IBCLC) by country on 31 December 2002	187	3	0	220	0	642	0	1	2	0	37	138	3	2	109	23	65	0	3	0	0	194	9	3	0	0	3	3	0
BFHI																													
Is there a national BFHI coordinator?																													
Approximate number of hospitals providing maternity services	110	107	127	155	116	1100	35	17	498	35	800	305		100	22	15	700	54	6	30	3	200	57	434	60	237	52	14	72
Number of hospitals designated as BFH	14	0	5	53	30	18	11	1	8	4	2	44	0	9	0	0	7	3	2	4	0	25	36	50	0	10	52	10	11
Percentage of BFH	13%	0%	4%	34%	26%	2%	31%	6%	2%	11%	0%	14%	0%	9%	0%	0%	1%	6%	33%	13%	0%	13%	63%	12%	0%	4%	100%	71%	15%
Is there any teaching hospital among them?																													
Are BFHI universal criteria used for designation?																													
Number of hospitals and facilities with a Certificate of Commitment	0	0	15	0	0	?	12	1	10		0	90		9	6	0	5	1	0	4	0	40	0	5	15	0	52	0	17
Approximate number of annual deliveries in the country (x 1000)	76	110	70	75	89	800	67	13	300	45	750	583	100	90	60	4	540	29	5	19	5	200	55	350	112	250	100	18	56
Percentage of deliveries in BFH	12%	0%	8%	51%	23%	3%	22%	2%	2%	7%	1%	15%	0%	11%	0%	0%	1%	12%	35%	8%		24%	75%	12%	0%	5%	100%	85%	30%
Is there a plan to reassess designated BFH?																													
Is there a Baby Friendly Community Initiative?																													

Annex 2: the answers (closed or short answers) from each country to some of the items of the questionnaire

	AT	BE	BG	CH	CZ	DE	DK	EE	ES	FI	FR	GB	GR	HU	IE	IS	IT	LT	LU	LV	MT	NL	NO	PL	PT	RO	SE	SI	SK
International Code																													
Is the WHO International Code in effect?																													
Are national measures being drafted in this sense, i.e. legislation, regulation, etc.?																													
Does the legislation that puts the Code into effect cover all its provisions?																													
Are the WHA resolutions reinforcing the Code taken into account in the revision of laws and/or policies?																													
Is the implementation of the Code and/or national legislation regularly monitored by a public and/or private non-for-profit independent organisation?																													
Are actions taken in case of confirmed infringement of the Code and/or national legislation?																													
Working mothers																													
Has the ILO maternity protection convention (MPC183) been ratified?																													
Is there a legislation that meets the ILO standards for protecting and supporting BF among working mothers?																													
Minimum 14 weeks of paid maternity leave																													
Paid maternity leave (at least 2/3 of previous earnings)																													
Entitlement to one or more paid BF breaks daily or daily reduction of hours of work to BF											often not paid				propo sed														
Job protection and non-discrimination for BF workers																													
Are there any groups of women not covered by this legislation?																													
Community outreach																													
Are voluntary organisations for mother-to-mother support established?																													
Rate the likely/estimated coverage of these groups	low	low	mid	mid	low	mid	low	low	mid	low	high	low	low	low	low		low	low	mid	low	mid	mid	mid	low	mid		mid	mid	mid
Rate the linkage of these groups with the health care services	low	low	mid	mid	low	mid	low	high	mid	low	mid	mid	low	low	mid		low	low	mid	mid	low	high	mid	low	mid		high	mid	mid
Does the health care system organise mother-to-mother support groups?																													
Rate the likely/estimated coverage of these groups	mid				low	low	mid	mid	low	high	mid	mid		low	low					low				low			high	mid	mid
Is there training of peer counsellors?															?														
Rate the likely/estimated coverage of these groups		low			low	mid	low		low			low			?		low	low			low			low			low	mid	mid

Annex 2: the answers (closed or short answers) from each country to some of the items of the questionnaire

	AT	BE	BG	CH	CZ	DE	DK	EE	ES	FI	FR	GB	GR	HU	IE	IS	IT	LT	LU	LV	MT	NL	NO	PL	PT	RO	SE	SI	SK
IEC																													
Is there any government budget for IEC?												2/4																	
Is there any assessment of results?						sporadic																							
Are there national activities for the WBW?												1/4																	
When?	Oct	Aug/ Oct	Aug	Oct	Aug	Oct	Oct	Oct	Oct	Oct	Oct	May	Nov	Aug	vary		Oct	Aug/ Oct	Aug/ Oct	Oct	Aug/ Oct	Oct	Oct	May/ Jun			Oct	Oct	Aug
WBW supported by	N	N	UN	N	UN	UN	G		GUN	N	GN	GUN	GUN	GN	GN		UN		GUN	GUN	G	N	N	N			N	U	UN
Is there a government breastfeeding website?																													
Monitoring																													
Is there any government collection of data on breastfeeding rates?																													
Data collection modality	sam	pop	pop		pop	pop		pop	sam	sam	pop	sam		pop	pop	pop	sam	pop	sam	pop	pop	sam	sam	pop	sam	sam	pop	pop	pop
Is the information reported regularly?																													
Is the information fed back regularly to health professionals?																													
Is yes, can they relate it to their local needs?																													
Is it given to policy and decision makers?																													
Disadvantaged groups																													
Is there any government policy targeting disadvantaged groups?																													
Information on BF gathered by age of the mother																													
Information on BF gathered by income of the family																													
Information on BF gathered by education of the mother																													
Information on BF gathered by ethnicity																													
Information on BF gathered by area of residence																													
Information on BF gathered by occupation of the mother																													
Information on BF gathered by employment status																													
Information on BF gathered by other variable																						BFHI							

sam = sample based
pop = population based

G = Government
N = NGO
U = Unicef

yes
no

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