

**BREASTFEEDING SURVEILLANCE IN THE EU AND EFTA;
Recommendations adopted at the Breastfeeding Surveillance Conference, Stockholm
May 4-5, 2001**

Introduction

Breastfeeding is recognized as a unique process that contributes to children and women’s health in a long term as well as in a short term perspective, and reduces infant morbidity and mortality. Breastfeeding also provides social and economic benefits to the family and the nation. Despite overwhelming scientific support for a widespread use of human milk, it does not seem to be practiced to any satisfactorily extent in most, if not all, Member States of the EU and EFTA. Improved promotion of breastfeeding at a local, national and international level is therefore needed.

Effective promotion of breastfeeding, and evaluation of the promotion programmes, requires reliable and valid prevalence data, comparable across the countries. A monitoring system, common to all EU Member States, should provide these data. Such a system has to be developed. This document describes indicators possible for use in such a system, adopted at an expert meeting on Breastfeeding Surveillance held in Stockholm, May 2001.

Background

A number of initiatives to protect, promote and support breastfeeding have been taken worldwide by international and national authorities as well as non-governmental organisations.

In 1981 the *International Code of Marketing of Breast-milk Substitutes* was adopted by the World Health Assembly (WHA) at WHO, with the main aim to protect breastfeeding by regulating the marketing of breast-milk substitutes (Annex I) (1).

A joint statement from the WHO and UNICEF in 1989, ‘Protecting, promoting and supporting breastfeeding: The special role of maternity services’, was the basis for the *Baby Friendly Hospital Initiative (BFHI)*, which was launched in 1991 (2).

The Innocenti Declaration summarises recommendations from a meeting held in 1990 by the WHO/UNICEF in co-operation with USAID, the Swedish SIDA and other organisations and countries (Annex II) (3). These recommendations stress the importance of exclusive breastfeeding during the first 4 to 6 months of life, and call on governments to draw up strategies for protecting, promoting and supporting breast-feeding, and to monitor and evaluate the strategies.

In 1996 the WHO in Geneva initiated the ‘*Global Data Bank on Breast-feeding*’ with the aim to establish a base for a global strategy on promoting breastfeeding (4).

A recent resolution about breastfeeding was adopted at the 54th World Health Assembly at WHO in May 2001 (5). Findings of an expert consultation on optimal duration of exclusive breastfeeding were taken into account. In the resolution the member states are urged

a) to strengthen activities and develop new approaches to protect, promote and support *exclusive breastfeeding for six months* as a global public health recommendation, and

b) to provide safe and appropriate complementary foods, with *continued breastfeeding for up to two years of age or beyond*, emphasizing channels of social dissemination of these concepts in order to lead communities to adhere to these practices.

A number of policy statements do exist regarding breastfeeding and the use of human milk, published by professional bodies such as the *American Academy of Pediatricians* (6), the *American Dietetic Association (ADA)* (7), and the *Standing Committee on Nutrition of the British Paediatric Association* (8). These statements have all in common an emphasis on the benefits of exclusive breastfeeding for the first 6 months of life and strong recommendations for breastfeeding promotion.

The International Labour Organization (ILO) adopted a revised convention and recommendation on maternity protection in June 2000 (9).

EU and EFTA

The breastfeeding situation in Europe is difficult to survey. The available national data on breastfeeding prevalence have different characteristics, and are collected in different ways, and are therefore difficult to compare (10). The data indicate vast differences in breastfeeding rates within and between countries. Many countries have no regular assessment of breastfeeding practice at all.

The *EURODIET* reports conclude that efficient, national breastfeeding surveillance systems need to be developed across Europe (10, 11, 12). These need to give comparable data, using common definitions and methodology. During the French EU Presidency (Autumn 2000), the so called “*French Initiative*” suggested urgent action on breastfeeding, including harmonising of the definitions as well as assessment of the actual situation, and on this basis the preparation of a recommendation to the Member States for breastfeeding surveillance and promotion (13). The *EU Council* resolution of December 14th 2000 on health and nutrition states the importance of breastfeeding promotion (14).

The European Commission’s Health Monitoring Programme has requested indicators, amongst others, regarding breastfeeding, in order to measure health status, its determinants and the trends herein throughout the European Community. One project within that programme considers public health nutrition monitoring including breastfeeding. This project invited European experts to a conference on breastfeeding surveillance in Stockholm May 4th and 5th, 2001 (Annex III). Some of these experts, including a representative from WHO, Geneva, also participated at a preparative meeting (May 2nd and 3rd).

The Conference

The aim of the conference was to agree on a set of indicators on the prevalence of breastfeeding to be recommended for use in the health monitoring or health surveillance system currently under development in the EU and the EFTA Member States. The collected data will make it possible to define the current situation within the countries. They will also be comparable to enable comparison of the breastfeeding prevalence between the countries, and to direct the design and the evaluation of breastfeeding promotion programmes also at community level.

The Recommendations

Definitions

The WHO definitions on infant feeding categories should be used (15):

- *Exclusive breastfeeding*. The infant receives breast milk (including expressed milk or from wet nurse) and is allowed to receive drops and syrups (vitamins, minerals, medicines). The infant may not receive anything else.
- *Predominant breastfeeding*. The infant receives breast milk and is allowed liquids (water and water-based drinks, fruit-juice, ORS), ritual fluids and drops or syrups (vitamins, minerals, medicines). The infant is not allowed to receive anything else (in particular non-human milk, food-based fluids).
- *Complementary feeding*. The infant receives breast milk and solid or semi-solid foods. It is allowed to receive any food or liquid, including non-human milk.
- *Breastfeeding*. The infant receives breast milk. The infant is allowed any food or liquid including non-human milk.

An additional *definition* is needed which is derived from above definitions:

- *Partial breastfeeding*. The infant receives breastmilk and non human milk or food based fluids.

Indicators

Core indicators should be designed to follow-up on recent recommendations on breastfeeding duration and exclusiveness (5, 11, 12), and should cover

- initiation of breastfeeding or breastfeeding at birth,
- prevalence of breastfeeding and exclusive breastfeeding at 6 months, and
- prevalence of breastfeeding at 12, 18 and 24 months of age.

An expanded set of indicators and determinants on breastfeeding should be used to support and enable countries to monitor progress in achieving their own national and local targets, and also to enable the design of promotion programmes.

Data

The collected data should

- reflect the current situation, defined as the last 24 hrs,
- be based on a representative sample from the population,

- normally be the information reported by the mother (if necessary, health records can be used to collect this information to complement the information supplied by the mother),
- be reported regularly, e.g. annually or bi-annually, to a European collective body, together with information on how the data was collected.

Manual

For assessing breastfeeding on a national level, a comprehensive European manual needs to be developed.

The core indicators

Breastfeeding and exclusive breastfeeding rates at birth, i.e. throughout the first 48 hrs of age
This indicator will enable a comparison between countries reflecting hospitals routines.

Breastfeeding and exclusive breastfeeding rates at 6 months of age

This is a later indicator of continued breastfeeding. The data can be collected when mothers have a routine contact with the healthcare system as closely as is feasible and practical to six months of life, giving the range of data collection.

Breastfeeding rates at 12, 18 and 24 months of age

These are later indicators of the prevalence or the duration of breastfeeding. Data can be collected at 12-15, 18-21 and 24-27 months of age respectively, during any scheduled contacts e.g. for immunisation, always giving the range of data collection.

Expanded data collection

These indicators and determinants may support and enable countries to monitor progress in achieving their own national and local targets. The data will also enable to direct the design of promotion programmes. The data collection may require creative solutions depending on local circumstances.

Recommended indicators and determinants are:

- Undisturbed skin-to-skin contact following birth for at least one hour, initiation of breastfeeding within the first 2 hours of birth, timing of the first breast feed;
- Exclusive, predominant and partial breastfeeding rates on discharge from healthcare facility;
- Exclusive, predominant and partial breastfeeding rates at one or more intermediate ages such 1, 2, 3, 4 or 5 months;
- Breastfeeding at 9 months;
- Breastfeeding prevalence by population group (e.g. demographic details, poverty index, age and education of mother) and marginalized groups;
- Percentage of babies born in a Baby Friendly Hospital (BFH) and number of BFH in comparison with total number of birth clinics.
- Annual proportion of professional staff receiving breastfeeding education with a certified course (minimum length n days/weeks) by professional group during the last 5 years.

- Percentage of universities or colleges (medical, nursing, midwifery etc) with a breastfeeding curriculum.
- Implementation of the operational targets of the Innocenti Declaration.
- Monitoring of the International Code of Marketing of Breast-milk Substitutes.
- Maternity leave, parental leave and breastfeeding rights.

On an individual level, a number of issues can be assessed in order to further identify risk groups and design targeted measures. For example the level of social support for breastfeeding mothers in different social settings, the level of readiness to change behavior (“stage of change”) and the level of self-efficacy. Tools for this type of assessment need to be identified and/or developed for European use and included in a comprehensive European manual.

Summary

There is an urgent need for an efficient surveillance system, which gives reliable, valid and comparable prevalence data across Europe. The WHO definitions on infant feeding categories should be used. The suggested core indicators should cover initiation, continuation and duration of breastfeeding. Breastfeeding (exclusive breastfeeding and breastfeeding where appropriate) prevalence at 6, 12, 18 and 24 months should be reported. The collected data should reflect the current situation of the mother, defined as the last 24 hrs, based on a representative sample from the population. The core indicators must be reported regularly together with information on how the data was collected, to a European body. An expanded data set can optionally be used at a national or local level including additional indicators and determinants on breastfeeding.

References

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Annex I

The International Code of Marketing of Breastmilk Substitutes

- No advertising of breast milk substitutes to the public;
- No free samples to mothers;
- No promotion of products in health care facilities;
- No company “mothercraft” nurses to advise mothers;
- No gifts or personal samples to health workers;
- No pictures idealising artificial feeding, including pictures of infants on the products;
- Information to health workers should be scientific and factual;
- All information on artificial feeding, including the labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial breastfeeding;
- All products should be of a high quality and take into account the climatic and storage conditions of the country where they are used.

Annex II

The Innocenti Declaration

All governments by the year 1995 should have:

- Appointed a national breastfeeding co-ordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, NGOs, and health professional associations;
- Ensured that every facility providing maternity services fully practices all ten of the Ten Steps to Successful Breastfeeding set out in the joint WHO/UNICEF statement “Protecting, promoting and supporting breastfeeding: the special role of maternity services”;
- Taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

The document also calls upon international organisations to:

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

Annex III

Participant list

Name	City, Country	WG	TFG
Clara Aarts	Uppsala, Sweden		
Eva Adem	Ystad, Sweden		
Biljana Ancevska	Skopje, Macedonia	x	
Anne Baerug	Oslo, Norway	x	x
Genevieve Becker	Galway, Ireland	x	x
Ilse Bichler	Pfaffstaetten, Austria		
Astrid Broberg Ströberg	Västerås, Sweden		
Adriano Cattaneo	Trieste, Italy	x	x
Nicky Clarke	Dublin, Ireland		
Randi-Elisabeth Dalhaug	Bergen, Norway		
Maureen Fallon	Dublin, Ireland		
Agneta Grönros	Vårby, Sweden		
Olöf Gudny Geirsdottir	Reykjavik, Iceland		
Geir Gunnlaugsson	Reykjavik, Iceland	x	x
Lars Å Hanson	Göteborg, Sweden		
Kerstin Hedberg Nyqvist	Uppsala, Sweden		
Elisabet Helsing	Oslo, Norway		x
Charlotte Hillervik	Falun, Sweden		
Agneta Hörnell	Umeå, Sweden		
Ulla Idenstedt	Stockholm, Sweden	x	
Edgar Iglesias	Huddinge, Sweden		
Maud Johansson	Mora, Sweden		
Rosemary Johnson	Cardiff, Wales	x	x
Kolbrun Jonsdottir	Reykjavik, Iceland		
Ewa Karlberg Åberg	Växjö, Sweden		
Ann-Marie Karlsson	Jönköping, Sweden		
Kerstin Karlsson	Jönköping, Sweden		
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Mathilde Kersting	Dortmund, Germany	x	x
Ewa Kolskog	Stockholm, Sweden		
Elisabeth Kylberg	Huddinge, Sweden	x	x
Britt Lande	Oslo, Norway		
Maryse Lehnert-Arendt	Oberpallen, Luxembourg	x	
Kerstin Lilja	Östersund, Sweden		
Karin Loodus	Uddevalla, Sweden		
Kath McGrath	Cardiff, Wales		

Sonja Merten	Basel, Switzerland		
Kjerstin Perlman	Västerås, Sweden		
Sofia Quintero-Romero	Trieste, Italy	x	
Sheela Reddy	London, England		
Pedro Ribeiro	Portugal		
Sylvia Rickard	Mold, Wales	x	
Helena Rissanen	Wårby, Sweden		
Randa Saadeh	WHO, Geneva, Switzerland	x	
Elisabet Sandén	Mora, Sweden		
Felicity Savage King	Leeds, England		x
Michael Sjöström	Huddinge, Sweden	x	x
Marini Smith	Östersund, Sweden		
Gudmund Stintzing	Stockholm, Sweden		x
Monica Svensson	Kalmar, Sweden		
Kristin Svensson	Stockholm, Sweden		
Catharina Tennerfors	Stockholm, Sweden		
Ann Tiits	Tungelsta, Sweden		
Björk Tryggvadottir	Gardabae, Iceland		
Chariklia Tzachrista	Athens, Greece		
Jenny Warren	Lanarkshire, Scotland		
Lena Weimers	Tumba, Sweden		
Marianne Velandia	Stockholm, Sweden		
Katerina Venovska	Skopje, Macedonia	x	
Helena Wennborg	Huddinge, Sweden		
Mia Westlund	Göteborg, Sweden		
Christina Wilbacher	Vårby, Sweden		
Pirjo Väyrynen	Helsingfors, Finland		
Agneta Yngve	Huddinge, Sweden	x	x
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WG: Working Group
 TFG: Task Force Group

Response from the European Breastfeeding Promotion Project Network regarding the suggested indicators:

Denmark:

Data regarding breastfeeding at birth are not registered regularly in our country. However, the 15 Baby-friendly hospitals in Denmark are collecting data one month every year on supplementation during the first days. On the rest of the hospitals, around 30, data might be available in the hospital records but not easily collected.

Breastfeeding at six months of age has not yet been registered. The Danish Board of Health only recently (October 2000) decided to follow the WHO recommendation and therefore we only have data on breastfeeding at 4 months, to follow up on the old recommendation.

Italy:

Breastfeeding at discharge is collected in some regions on a routine basis.

Breastfeeding is collected at 2,4 and 6 months in some regions. However in some regions only at 4 months.

Switzerland:

No official data are collected, only local projects have collected some data on initiation and breastfeeding at 6 months.

Ireland:

Feeding data at time of discharge are collected on all infants as part of the perinatal statistics forms. No national reporting of breastfeeding takes place at any point after discharge. Data is collected in the childhealth record by the community nurse but there is no system for collating these and the definitions are unclear. From January 2003, data are collected at the 3 month infant health check and reported nationally.

France:

There are national figures on total breastfeeding at birth, collected during the stay at the maternity hospital. There is a bf duration indication in the health certificate that is completed at nine months for all children. However, definitions are unclear and the results are not collated.

Spain:

National survey was started in 1995. Data came from a sample of families, asking only about duration of breastfeeding. Another survey came in 1997 and another one will take place in 2003. There are possibilities of gathering data on bf in maternity hospital. In a form for blood test regarding congenital diseases, there is a question about bf. These could be collated on autonomic government level (16 districts), and this has taken place in some cases. The definitions for exclusive bf and other parameters are not well described.

Netherlands:

A representative survey is done, where children from all over the country are followed up until the age of 6/7 months. Data on bf on Day 1, 3 months and 6 months are collected on exclusive and any breastfeeding.

Belgium:

Bf data are collected by regional authorities, in mother’s file at the maternity ward, in the child’s file only for those attending postnatal consultations. Difficulties to identify exclusive bf. National bf committee interested in improving the quality of data and has designed a working group on the issue.

Luxembourg:

No national collection of data on either initiation or bf at 6 months. Data on initiation are collected but reporting to a central source is not legally binding. Some bf data checked in irregular surveys on representative samples of the population.

Austria:

Hospitals are asked to report their data on breastfeeding, both initial and at discharge to the county health authorities, but few respond. Representative surveys take place on an irregular basis, where 6 month data on bf and exclusive bf can be found.

Norway:

Data on initiation of breastfeeding are not included in the national birth registry. The well-baby clinics have different journal systems and most register bf, but how and for which period varies. The definitions vary as well. Data on bf are collected as a part of the national dietary surveillance system in Norway. These cover bf at birth, as well as bf and exclusive bf at 6 months.

Sweden:

Data on breastfeeding at discharge are collected but not collated. Data on bf and exclusive bf is collected and collated at 1 week, 2 months, 4 months and 6 months through the child care centers.

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