

Protection, promotion and support of breast-feeding in Europe: current situation

Adriano Cattaneo¹, Agneta Yngve^{2,*}, Berthold Koletzko³ and Luis Ruiz Guzman⁴
on behalf of the 'Promotion of Breastfeeding in Europe' project

¹Unit for Health Services Research and International Cooperation, Istituto per l'Infanzia, Trieste, Italy: ²Unit for Preventive Nutrition, Department of Biosciences at Novum, Karolinska Institute, SE 146 57 Huddinge, Sweden:

³Metabolic Diseases and Nutrition, Dr von Hauner Children's Hospital, University of Munich, Germany: ⁴Baby Friendly Hospital Initiative, Barcelona, Spain

Submitted 24 January 2004: Accepted 30 June 2004

Abstract

Objective: To describe the current situation regarding protection, promotion and support of breast-feeding in Europe, as a first step towards the development of a blueprint for action.

Design and setting: A questionnaire was completed by 29 key informants and 128 other informants in the EU, including member states, accession and candidate countries.

Results: EU countries do not fully comply with the policies and recommendations of the Global Strategy on Infant and Young Child Feeding that they endorsed during the 55th World Health Assembly in 2002. Some countries do not even comply with the targets of the Innocenti Declaration (1990). Pre-service training on breast-feeding practice is inadequate and in-service training achieves only low to medium coverage. The Baby Friendly Hospital Initiative is well developed only in three countries; in 19 countries, less than 15% of births occur in baby-friendly hospitals. The International Code of Marketing of Breastmilk Substitutes, endorsed in 1981 by all countries, is not fully applied and submitted to independent monitoring. The legislation for working mothers meets on average the International Labour Organization standards, but covers only women with full formal employment. Voluntary mother-to-mother support groups and trained peer counsellors are present in 27 and 13 countries, respectively. Breast-feeding rates span over a wide range; comparisons are difficult due to use of non-standard methods. The rate of exclusive breast-feeding at 6 months is low everywhere, even in countries with high initiation rates.

Conclusions: EU countries need to revise their policies and practices to meet the principles inscribed in the Global Strategy on Infant and Young Child Feeding in order to better protect, promote and support breast-feeding.

Keywords
Breast-feeding
Europe

The need to protect, promote and support breast-feeding is unquestionable. It represents a public health priority everywhere, as confirmed by the Global Strategy on Infant and Young Child Feeding unanimously approved by the 55th World Health Assembly (WHA) in 2002¹. In Europe, the EC-supported expert report EURODIET was initiated in 1998 with the aim of contributing to a co-ordinated EU and Member State programme on nutrition, diet and healthy lifestyles. The final report from the EURODIET project strongly recommended a review of existing activities and the development and implementation of an action plan for the promotion of breast-feeding^{2–4}. As a follow-up on EURODIET, France during its Presidency of the Council chose to concentrate on the nutrition situation in Europe.

The so-called French Initiative on nutrition highlighted the need for action on breast-feeding surveillance and promotion⁵. The French Initiative led to the Council Resolution on Nutrition and Health in December 2000, where breast-feeding was officially identified as a priority⁶. The EU-funded project 'Promotion of Breastfeeding in Europe' arose as a consequence of EURODIET, the French initiative and the Council resolution. Its objective is to develop a Blueprint for Action on Breastfeeding that countries can use as a model for planning initiatives at national and local level. The present article on the current situation in 29 countries is based on the first official project document. It was followed by a review of interventions and by the blueprint for action.

*Corresponding author: Email agneta.yngve@prevnut.ki.se

Methods

Data were gathered through a questionnaire completed during January and February 2003. The questionnaire was originally sent to key people in the 15 EU member states, Iceland, Norway and Switzerland. Through the European Office of the World Health Organization (WHO), the questionnaire was also sent to 10 accession (Estonia, Latvia, Lithuania, Poland, Hungary, Czech Republic, Slovak Republic, Malta, Slovenia, Cyprus) and two candidate countries (Bulgaria, Romania). Cyprus was the only country contacted that did not respond and Turkey was the only candidate country not contacted by WHO for this project. The UK completed four separate questionnaires for England, Wales, Scotland and Northern Ireland. The key informants represented different sectors within the participant countries: eight informants were employed by governmental bodies, 11 by other public institutions (universities, hospitals, institutes of public health) and 10 by non-government organisations (NGOs), including national committees for the United Nations Children's Fund (UNICEF). Key informants gathered data from a total of 128 other informants from governments, public institutions and NGOs. In 10 countries, key informants were national breast-feeding co-ordinators or members of national breast-feeding committees.

The questionnaire was split into the sections used to report the results. There was room for additional comments at the end of each section; some of the reported results derive from these comments and may not reflect the situation in all countries. The quality of the data is not uniform, reflecting the different development of health information systems in Europe. When data are missing it means that key and other informants, the best possible sources of data in each country, were unable to find the information. The compiled results are the outcome of revisions/suggestions supplied by key informants on drafts circulated via email.

Results

Policy, planning and management

Table 1 shows the number of countries with a national and/or local policy (i.e. a series of simple statements on what is recommended) and/or a national recommendation (i.e. a more detailed and referenced document) for each of the criteria stated in the first column. Only five countries (Latvia, Lithuania, Malta, Poland and the Slovak Republic) have policies that meet all four criteria. Policies in Bulgaria, Denmark, Germany, Estonia, Spain, Greece, The Netherlands, Norway and Sweden meet three out of four criteria. France, Luxembourg, Ireland, Sweden and the UK issued policy statements recommending 'exclusive breast-feeding for 6 months' subsequent to the collection of data. All the other countries have no national policies at all or have policies that do not meet the stated criteria.

Table 1 Countries with policies and recommendations meeting stated criteria ($n = 29$)

Criterion	National policy	Local policy	National recommendation
Help mothers to start breast-feeding soon after birth	14	15	23
Breast-feed exclusively for 6 months	17	11	20
Continue breast-feeding up to 2 years and beyond	4	7	10
Implement the Ten Steps for Successful Breastfeeding	14	14	23

The Czech Republic is currently revising its 1992 and 1995 policies. All countries, except Malta and The Netherlands, have national recommendations that meet at least one of the four criteria. In the majority of cases these recommendations were developed by professional associations; in other cases by national breast-feeding committees. 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 Republic, Slovenia, Sweden and Scotland.

National plans including general objectives and recommended strategies have been developed in 15 countries; in some of the others a plan is being developed or drafted. Where the health system is decentralised, local plans are available. Action plans including specific objectives, targets and activities have been developed in Estonia, Hungary, Ireland, Latvia, Lithuania, The Netherlands, Norway and the UK; not all plans, however, are fully implemented. Greece, Luxembourg, Malta, Austria, Poland, Slovak Republic, Finland and Sweden do not have national and/or local plans and do not envisage developing them.

Sixteen countries have a national co-ordinator, 21 a national committee; Switzerland, Spain, Finland, France, Iceland, Italy and Sweden (now both installed in Sweden) lack both, 13 years after the Innocenti Declaration⁷. The amount and type of funding available to national committees and co-ordinators vary greatly. National committees, where they exist, generally have an advisory role. Membership usually includes representatives from relevant health professional groups, academic research organisations, NGOs 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 government portfolios occur, national committees have been suspended or disbanded. National co-ordinators and committees are mostly involved in advocacy, policy, planning and 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.

Training

Several countries have national boards that set standards and certify pre-service education. Only Austria, Bulgaria, Romania, Slovak Republic and the UK, however, have some form of certification of courses on breast-feeding and/or set curricula for breast-feeding education of midwives and nutritionists. In the other countries with such boards, certification and standard setting apply to the generality of pre-service education, and not specifically to breast-feeding. In most countries, there are few skilled breast-feeding trainers at either undergraduate or post-graduate level.

Regarding in-service training, the 18-hour UNICEF/WHO course on the Baby Friendly Hospital Initiative (BFHI)⁸ has been introduced in 17 countries, mostly with low to medium coverage. The 40-hour WHO/UNICEF course on breast-feeding counselling⁹ has been introduced in 12 countries, also with low to medium coverage. Twenty-five countries have introduced locally adapted/developed courses with duration ranging from a few hours to a few days. Some of these courses are officially endorsed and lead to a recognised certificate or credits. However, there is little assessment of the quality and effectiveness of training. In-service training coverage is generally higher for nurses and midwives than for doctors; among the latter, paediatricians are more likely to undergo breast-feeding training than obstetricians.

The examination leading to the certificate of International Board Certified Lactation Consultant (IBCLC) is available in 10 countries. In total, 1647 IBCLCs were certified up to the end of 2002; 86% of them in only six countries: Austria, Switzerland, Germany, Ireland, The Netherlands and the UK.

Baby Friendly Hospital Initiative

There are national BFHI co-ordinators in 20 countries, some appointed by governments, some by UNICEF and NGOs. National committees for UNICEF in Greece, France and Ireland have virtually no involvement in the BFHI. The implementation of the BFHI has been difficult and slow in many countries. Table 2 shows the number of baby-friendly hospitals (BFHs) and the percentage of births they cover by country; it also indicates if there is at least one teaching hospital among accredited BFHs. The data from The Netherlands includes home care organisations, providing maternity care in the mother's own home, that are assessed using BFHI criteria. Three countries, Sweden, Slovenia and Norway, report very high percentages of births in BFHs; seven countries – Switzerland, Czech Republic, Denmark, Luxembourg, Slovak Republic, The Netherlands and the UK – fall within an intermediate range (i.e. 15–50%), while 19 countries report lower percentages (i.e. 0–15%). Ceasing

Table 2 Baby-friendly hospitals (BFHs) by country and coverage of births (2003)

Country	BFHs/total hospitals	% of births in BFHs	Teaching BFHs
Austria	14/110	12	✓
Belgium	0/107	0	
Bulgaria	5/127	8	✓
Switzerland	46/150	40	✓
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	24/200	25	✓
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	✓

* England 8%; Wales 34%; Scotland 38%; Northern Ireland 20%.

of acceptance of free formula donations is a challenge to the expansion of the BFHI in some countries, as is general under-funding of the initiative with overall cost charged to participating hospitals, and a less than desirable strength of collaboration between the BFHI and health professionals in some places.

International Code and subsequent relevant WHA resolutions

All 29 countries voted in favour of the International Code of Marketing of Breastmilk Substitutes¹⁰ and of subsequent relevant WHA resolutions (referred to hereafter as the Code). In 1991, the EU adopted many provisions of the Code in its Directive for the internal market of infant and follow-on formulae¹¹. The following year an export Directive and Council Resolution were adopted^{12,13}. These Directives, however, have not been revised to take into consideration relevant WHA resolutions approved after 1991. In addition, a number of products covered by the Code are not included in the scope of the Directives and hence in national legislation. The Directives are binding acts; in most EU countries they have regulated the marketing of infant formulae. In accession and candidate countries, this marketing is not yet fully regulated and serious infringements to the Code are reportedly more common^{13,14}.

The enforcement and monitoring of compliance with national laws is the responsibility of different government sectors in different countries. Governments, however, have not, in the main, taken responsibility for enforcement and monitoring of the Code. In countries where compliance with the Code is monitored, this is mainly undertaken by NGOs and consumer associations; where monitoring has been conducted, violations have been reported¹⁴. 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 are rarely aware of their responsibilities under the Code. 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 breast milk substitutes have direct contact with mothers through mail, the Internet, telephone help lines, commercial discharge packs and baby clubs. Many of these activities, when promoting products covered by the Code, should be considered as violations. Companies interact regularly also with health professionals and their associations through sponsorship of events, courses, conferences, research and publications; some of these activities may lead to a conflict of interest.

Legislation for working mothers

Convention 183 on Maternity Protection of the International Labour Organization (ILO) set standards for protecting and supporting breast-feeding among working mothers, including:

- The provision of a minimum of 14 weeks of paid maternity leave (i.e. shorter than the recommended 6 months of exclusive breast-feeding);
- Entitlement to one or more paid breast-feeding/lactation breaks daily or daily reduction of hours of work to promote the longer duration of breast-feeding, without loss of pay;
- Job protection and the non-discrimination of breast-feeding workers¹⁵.

The ILO recommendations also state that maternity leave payments should be at least two-thirds of previous earnings. The legislative provisions facilitating breast-feeding in the workplace go beyond the ILO recommendations in many countries and are partially implemented in others. Fathers can often share part of the maternity protection benefits granted to mothers under national legislation. Only four governments (Bulgaria, Italy, Romania, Slovak Republic), however, have ratified ILO Convention 183 so far. The standard regarding paid breast-feeding breaks during working time is not frequently met. The UK was the EU country with least compliance with ILO standards, but it has recently extended its paid

maternity leave to 6 months. Virtually none of the ILO standards are met in Switzerland, although legal provisions in some cantons do meet the standards. There are groups of women workers not covered by protective legislation in all 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 or irregular workers, and working students. In some countries there are differences between women employed in the private and the public sector, especially with regard to the duration of full and/or partial salary during maternity leave and the provision of paid breast-feeding breaks.

Community outreach, including voluntary mother-to-mother support

Voluntary mother-to-mother support groups are present in 27 countries. Some of these groups were involved in the promotion and support of breast-feeding long before any concerted public health initiatives/activities started. The geographical coverage of these groups is reported as low to medium in all countries, except in France and Scotland where it is rated as high, and in The Netherlands where mother-to-mother support groups have national coverage. In 16 countries these groups have good links with the health-care services and their members have some training in breast-feeding management and support. In 13 countries, 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/grant-aided and/or otherwise supported by providers of regional or national health-care services. Women are made aware of the contact details and services provided by these groups through newsletters, information sheets, telephone directories, the Internet and contacts with health-service providers (during antenatal care or at discharge after delivery). Mothers who need information and/or support usually attend group meetings, or get in touch by phone and increasingly by email and through the Internet. Information and support is usually provided via these channels, but may also be provided through home visits, written materials and videos.

Information, education, communication

In 16 countries, governments allocate funds for the production of booklets, leaflets, flyers, posters, stickers, videos, TV spots and for workshops; local funds and initiatives are also common. 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 coverage and effectiveness, except in Iceland (where it has been shown that mothers usually comply with the written advice), Malta, Norway, Romania and the UK. World Breastfeeding Week activities are implemented in all countries except Iceland, Portugal and Romania. Activities

are mostly organised by NGOs, with some UNICEF involvement (Bulgaria, Czech Republic, Germany, Estonia, Greece, Latvia, Lithuania, Slovenia, Spain) and government support (Denmark, Hungary, Ireland, Malta, UK). The number of websites devoted to breast-feeding is increasing, developed by government departments, individuals, interest groups, NGOs and BFHI committees.

Monitoring

Monitoring of breast-feeding rates is generally funded by governments, within the budgets assigned to health-care systems. Monitoring is population-based in Belgium, Greece, France, Ireland, Iceland, Sweden, Scotland, Wales, and in all accession and candidate countries except Romania. Population-based means that data are gathered routinely by health-care providers during contacts with users (delivery, discharge from hospital, metabolic screening, immunisation, well-baby clinics). This routine collection of data achieves differing degrees of completeness. Monitoring is sample-based in Denmark, Spain, Italy, Luxembourg, The Netherlands, Norway, Austria, Portugal, Romania, Finland and the UK (Scotland and Wales also collect population-based data, as stated above), at different and often irregular intervals. Local surveys are conducted in many countries and are often not widely reported. No routine collection/monitoring of breast-feeding data takes place in Switzerland and Germany. Analysis/publication of data usually (but not always) involves a 6-month to 3-year time lag. Dissemination of results is low, as is feedback to health professionals and decision-makers, except in Iceland, The Netherlands, Finland, Sweden, the UK, and in most accession and candidate countries (except Poland and Slovenia). Dissemination to the general public is even poorer. Table 3 shows the available information on breast-feeding rates. The key informants were asked to report data using, as far as possible, the WHO/UNICEF definitions of exclusive, full (exclusive plus predominant) and any breast-feeding^{16,17}. The respondents' sources were from published reports in only a small number of cases; in most cases the sources belonged to the so-called 'grey literature', available only within health institutions. Due to varying degrees of incompleteness and inaccuracy, i.e. use of non-standard methods of data collection and breast-feeding definitions, great care is needed when making comparisons.

Disadvantaged groups

In 18 countries, there is no specific policy or plan addressing the poor up-take of breast-feeding by mothers from disadvantaged groups. Some specific policy and action plans have been developed and implemented in Czech Republic, Germany, Denmark, Greece, Hungary, Norway, Portugal, Romania, Slovak Republic, Sweden (proposed) and the UK. These address smokers, teenagers, less educated families, lower socio-economic

groups, immigrant women or ethnic minority groups, and generally focus on reducing inequalities in health and do not specifically address low breast-feeding rates. Some local projects/activities involve NGOs. In some countries, free formula is given to low-income mothers as an in-kind financial support to child rearing. Where there is monitoring of breast-feeding rates, data are sometimes available by age, education, residence and occupation, but less often by family income, employment status and ethnicity.

Discussion

Breast-feeding rates in the 29 countries span over a wide range. This may be partly due to varying degrees of accuracy, consistency and completeness in data collection. The WHO breast-feeding definitions are also not widely applied³. Inconsistencies are common, even within countries¹⁸. The establishment of a common EU monitoring system is urgently required. Different social and cultural determinants, as well as flawed policies and unequal support among and within health-care systems, could also explain differences in breast-feeding rates¹⁹. But it is definitely difficult to understand why initiation and duration of breast-feeding vary so much, and more comparative research is needed. Meanwhile, the only possible conclusion is that breast-feeding rates fall short of the recommended targets set by many national policies, international agencies¹ and professional associations^{20–23} everywhere, even in countries with a high initiation rate.

A possible explanation is that policies on infants and young child feeding are just beginning to accept universally recognised best practice criteria for breast-feeding protection, promotion and support. Some professional associations have also started to develop or update their recommendations using these criteria. What is missing is a commonly agreed EU document that can function as a template for individual countries. Many countries have yet to achieve the goals and objectives set for 1995 by the Innocenti Declaration⁷. Some countries have advanced more than others and have a national co-ordinator and committee in place, but these are often under-funded and cannot implement much-needed changes. The BFHI, or a similar initiative that promotes changes in hospital practices, is generally implemented but only a limited number of countries have achieved good coverage, despite evidence of effectiveness²⁴. Moreover, the BFHI is not usually integrated within national policies and is often regarded as a stand-alone scheme. None of the countries has fully revised its policies in view of the Global Strategy on Infant and Young Child Feeding; yet all European countries, and in fact all WHO Member States, endorsed it at the 55th WHA in 2002 and made a commitment to implement it¹.

Adequate competency-based training is needed for optimal breast-feeding promotion and support.

Table 3 Rates (%) of breast-feeding by age and country

Country	Year	Initiation			Discharge			3–4 months			6 months			12 months	
		Any	Full	Exclusive	Any	Full	Exclusive	Any	Full	Exclusive	Any	Full	Exclusive	Any	
Austria	1998	96													10
Belgium	1998–2000	63–72					95								46
Bulgaria	2001	97													4
Switzerland	1994	92													11
Czech Republic	1999–2001						91								23
Germany	1997–1998	96			86		73								10
Denmark	2000	98								60†					13
Estonia	2001									75†					
Spain	2001	71								61					
Finland	2000				91		65			58					23
France	2000				53					74					1
UK	2000	69								15					
Hungary	2001									28†					13‡
Ireland	1999														35
Iceland	2000				98					75†					13
Italy	2000	89													
Lithuania	2000–2002	98					78			46					7
Luxembourg	2001	88								58†					
Malta	2002														4
Netherlands	1998														
Norway	1997–2002	99			80					47					17
Poland	1998–1999									90					7
Portugal	2000														9
Sweden	2000				98*		85			63					34
Slovenia	2000						93*			68†					33
Slovak Republic	2000				93		90								30

No information available from Greece and Romania. Data from Latvia are not included, since they do not allow estimation of age prevalence.

* Data at 1 week.

† Data at 4 months.

‡ Data at 9 months.

Undergraduate and postgraduate curricula for all health-care professionals should be revised. This process, while urgently needed, will take a long time to have a positive impact on the competencies of newly qualified health and allied professionals. In the mean time, quality-assessed courses involving clinical competency testing should be used for in-service training²⁵. The coverage of such training is currently low. IBCLCs are found in many countries, which may indicate increased awareness of the need for specialist consultants. Mother-to-mother support groups and peer counsellors are present in most countries but their coverage is low to medium. It should be high, given their proven effectiveness in the promotion and support of breast-feeding, especially among disadvantaged groups^{26–28}.

The legislation that regulates the marketing of breast milk substitutes falls short of the provisions in the Code in all of the 29 countries. Most EU countries apply the EU Directive of 1991¹¹, which covers only some provisions of the Code and has not been updated since. The Code itself is not sufficiently known by health professionals and the general public, nor is it adequately monitored²⁹. Accession and candidate countries must adopt the EU Directive to achieve full EU membership. EU member states, however, are bound to adopt the EU Directives as a minimum standard, but they are free to provide additional legislative protective measures to safeguard infant and young child health. The EU Directive only applies to infant and follow-on formulae; it does not apply to preterm and other special formulae or to feeding bottles and teats. It permits certain forms of marketing that are prohibited under the Code, namely promotion to the general public of follow-on formulae, advertising in specialist baby-care magazines and scientific publications, and the donation or low-price sale of supplies for infants fed on infant formula. An updated EU legislation is required, along with a statutory framework for independent monitoring and enforcement.

In many countries, the legislation on maternity protection with relevance to breast-feeding goes beyond the ILO standards¹⁵; in some countries, however, it does not meet them, especially with regard to breast-feeding/lactation break provisions. Because legislation intended to protect working mothers can only cover employed women and does not cover women who are self-employed, women with short-term or irregular work and working students, special measures are needed to ensure that these mothers receive appropriate care and funds to enable breast-feeding, even in countries where the legislation meets the ILO standards. It is clear that labour market policies are important and need to be improved, if high rates of breast-feeding among working women are to be achieved³⁰.

Acknowledgements

Collection of the information used to write this paper was carried out within the project 'Promotion of Breastfeeding

in Europe', financed by the European Commission, Health and Consumer Protection Directorate-General, Directorate G – Public Health (EU Project Contract No. SPC 2002359), and co-ordinated by Adriano Cattaneo. Information from EU accession and candidate countries was gathered through the European Regional Office of WHO in Copenhagen, Denmark, and was analysed by Joceline Pomerleau at the London School of Hygiene and Tropical Medicine.

Members of the 'Promotion of Breastfeeding in Europe' project who provided information: Bichler I (Austria), Moyersoen F (Belgium), Petrova S (Bulgaria), Schneidrová D (Czech Republic), Vinther Jerris T (Denmark), Deikina J (Estonia), Hasunen K (Finland), Ollivier-Diers F and Roques N (France), Koletzko B and Przyrembel H (Germany), Benetou V and Zachou T (Greece), Sarlai K (Hungary), Gunnlaugsson G (Iceland), Becker G and Fallon M (Ireland), Cattaneo A, Di Mario S, Macaluso A and Ronfani L (Italy), Brazneva V, Kondrate I and Pudule I (Latvia), Bartkeviciute R (Lithuania), Lehnert-Arendt M (Luxembourg), Ellul M (Malta), de Reede A (The Netherlands), Bergljot Bærug A (Norway), Mikiel-Kostyra K (Poland), Loureiro I (Portugal), Parvan C (Romania), Hal'amová V (Slovak Republic), Gabrijelcic-Blenkus M (Slovenia), Ruiz Guzman L (Spain), Holmström U, Kylberg E, Sjöström M and Yngve A (Sweden), Bucher C (Switzerland), Calvert J, Carson C, Reddy S, Sky S and Warren J (UK), Radford A (UK Baby Friendly Hospital Initiative), Lhotska L (International Baby-Food Action Network), Fleischer Michaelsen K (International Society for Research on Human Milk and Lactation), Pomerleau J (ECHOHOST, London School of Hygiene and Tropical Medicine, UK), Robertson A (WHO European Regional Office).

Contributors: A.C. and A.Y. wrote the first draft of the paper, based on the project report submitted to the European Commission. B.K. and L.R.G., as members of the project steering committee, revised the draft and contributed to the final text. All the other project participants and key informants read, commented and approved the manuscript.

References

- 1 Global Strategy on Infant and Young Child Feeding. *55th World Health Assembly*. Geneva: World Health Organization, 2002.
- 2 Nutrition & diet for healthy lifestyles in Europe: science & policy implications. *Public Health Nutrition* 2001; **4**(2A): 265–73.
- 3 Yngve A, Sjöström M. Breastfeeding in countries of the European Union and EFTA: current and proposed recommendations, rationale, prevalence, duration and trends. *Public Health Nutrition* 2001; **4**(2B): 631–45.
- 4 Yngve A, Sjöström M. Breastfeeding determinants and a suggested framework for action in Europe. *Public Health Nutrition* 2001; **4**(2B): 729–39.
- 5 *Health and Human Nutrition: Elements for European Action*. Brussels: European Commission, 2000.

- 6 Resolution on Health and Nutrition. Brussels: EU Council, 2000.
- 7 Innocenti Declaration. Florence: United Nations Children's Fund/World Health Organization, 1990.
- 8 Breastfeeding, management and promotion in a baby-friendly hospital: an 18-hour course for maternity staff. New York: United Nations Children's Fund/World Health Organization, 1993.
- 9 Breastfeeding counselling: a training course. Geneva: World Health Organization/United Nations Children's Fund, 1993.
- 10 International Code of Marketing of Breastmilk Substitutes. Geneva: World Health Organization, 1981.
- 11 Directive 91/321/EEC. Brussels: European Commission, 1991.
- 12 European Commission Directive 92/52/EEC. Brussels: European Economic Community, 1992.
- 13 European Council Resolution 92/C 172/01. Brussels: European Economic Community, 1992.
- 14 International Baby-Food Action Network (IBFAN). *Breaking the Rules, Stretching the Rules 2001*. Penang: IBFAN, 2002.
- 15 Maternity Protection Convention C183. Geneva: International Labour Organization, 2000.
- 16 *Indicators for Assessing Breast-feeding Practices*. Geneva: World Health Organization, 1991.
- 17 *Indicators for Assessing Health Facility Practices that Affect Breastfeeding Practices*. Geneva: World Health Organization, 1993.
- 18 Cattaneo A, Davanzo R, Ronfani L. Are data on the prevalence and duration of breastfeeding reliable? The case of Italy. *Acta Paediatrica* 2000; **89**(1): 88–93.
- 19 Nicoll ATB, Newell ML, Rundall P. Breastfeeding policy, promotion and practice in Europe. Results of a survey with non-governmental organizations. *Journal of Nutrition and Environmental Medicine* 2002; **12**: 255–64.
- 20 ESPGAN. Committee on Nutrition: Guidelines on infant nutrition. III. Recommendations for infant feeding. *Acta Paediatrica* 1982; (Suppl. 302): 1–27.
- 21 American Academy of Pediatricians. Work Group on Breastfeeding: Breastfeeding and the use of human milk. *Pediatrics* 1997; **100**: 1035–9.
- 22 Neonatologia Sid. Raccomandazioni sull'allattamento materno per i nati a termine, di peso appropriato, sani. *Medico e Bambino* 2002; **21**: 91–8.
- 23 Agence Nationale d'Accreditation et d'Évaluation en Santé (ANAES). *Allaitement maternel: mise en oeuvre et poursuite dans les six premiers mois de vie de l'enfant*. Paris: ANAES, 2002.
- 24 Kramer MS, Chalmers B, Hodnett ED, Sevkovskaya Z, Dzikovich I, Shapiro S, *et al.* Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the Republic of Belarus. *Journal of the American Medical Association* 2001; **285**(4): 413–20.
- 25 Cattaneo A, Buzzetti R. Effect on rates of breast feeding of training for the baby friendly hospital initiative. *British Medical Journal* 2001; **323**(7325): 1358–62.
- 26 Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Sowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technology Assessment* 2000; **4**(25): 1–171.
- 27 McInnes RJ, Love JG, Stone DH. Evaluation of a community-based intervention to increase breastfeeding prevalence. *Journal of Public Health Medicine* 2000; **22**(2): 138–45.
- 28 Dennis CL, Hodnett E, Gallop R, Chalmers B. The effect of peer support on breast-feeding duration among primiparous women: a randomized controlled trial. *Canadian Medical Association Journal* 2002; **166**(1): 21–8.
- 29 Waterston T, Tumwine J. Monitoring the marketing of infant formula feeds. *British Medical Journal* 2003; **326**(7381): 113–4.
- 30 Galtry J. The impact on breastfeeding of labour market policy and practice in Ireland, Sweden, and the USA. *Social Science & Medicine* 2003; **57**(1): 167–77.