Interim Report of the National Committee on Breastfeeding

May 2003

Health
Promotion
Unit

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Health Promotion Unit

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Membership of the National Committee on Breastfeeding

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Ms. Claire Allcutt,	Cuidiú-Irish Childbirth Trust Representative, Family Development Nurse, Community Mothers Programme.
Ms. Genevieve Becker,	Coordinator, Baby Friendly Hospital Initiative in Ireland, Network of Health Promoting Hospitals, c/o James Connolly Memorial Hospital, Blanchardstown, Dublin 15.
Dr. Méabh Ní Bhuinneáin,	Institute of Obstetrics & Gynaecology Representative, Consultant Obstetrician, Mayo General Hospital, Western Health Board
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Dr. Lucia Gannon,	Irish College of General Practitioners (ICGP) Representative, GP Surgery, Killenaule, Co. Tipperary.
Ms. Rosa Gardiner,	Director of Public Health Nursing Representative, Association of Irish Nurse Managers (AINM), South Eastern Health Board, Clonmel, Co. Tipperary
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Ms. Catherine Murphy,	Health Promotion Managers Representative, Southern Health Board, Western Road, Cork.

Ms Emma O'Donoghue,	Women's Health Council Representative, Women's Health Council, Abbey Court, Lr. Abbey Street, Dublin 1.
Ms Margaret O'Driscoll,	Ministerial nominee, Staff Midwife, Erinville Maternity Hospital, Cork, Southern Health Board.
Ms. Mary Robinson,	Ministerial nominee.
Ms. Pauline Treanor,	Director of Midwifery Services Representative, Association of Irish Nurse Managers, Rotunda Hospital, Dublin 1.
Dr. Tessa Greally,	Representative of the MWHB Breastfeeding Strategy Group, Public Health Specialist, Mid-Western Health Board, Catherine St., Limerick. Joined the Committee in July 2002.
Mr. David Simpson,	Representative of NWHB Breastfeeding Strategy Group, Men's Health Promotion Coordinator, North Western Health Board. Joined the Committee in November 2002.

Secretariat:

Ms. Sinead Bromley,	Executive Officer, Department of Health and Children, previously
Ms. Margaret McDonnell,	Higher Executive Officer, Department of Health and Children.

Foreword

A review of the 1994 National Breastfeeding Policy is an important component of the Terms of Reference under which the National Committee on Breastfeeding was established in March 2002 and this Interim Report from the Committee to the Minister for Health and Children, Mr. Micheál Martin TD, represents an important advancement towards the fulfilment of this objective.

This review has been informed by the broad range of expert opinions represented within the membership of the Committee, together with submissions. In addition to providing information on the impact of the targets and recommendations in the 1994 Policy, proposals for future action have been put forward and these will inform the next stage of the Committee's work.

All contributors to this review process considered the 1994 National Breastfeeding Policy an excellent template for action that has stood the test of time in its continued relevance. While the impact of the targets and recommendations set down in the 1994 Policy are shown to have fallen short of expectations in some areas, its very existence provided a new focus on breastfeeding that has generated many valuable opportunities to highlight breastfeeding issues. This new focus has also had a major impact on the quality of breastfeeding support for mothers and babies within the health services and a greater respect for the value of voluntary mother-to-mother support services offered by organisations like La Leche League of Ireland and Cuidiú-Irish Childbirth Trust.

Ireland now has a National Breastfeeding Coordinator and a Baby Friendly Hospital Initiative. Most maternity units have a breastfeeding policy. Clinical midwife specialists in breastfeeding are being appointed in relevant areas of the health services and these are coordinating and spearheading changes in breastfeeding practices in accordance with the best available research evidence. Many health professionals attend update courses in breastfeeding. These and many other positive initiatives have come about as a direct result of the advancements enabled by the 1994 National Breastfeeding Policy.

The fundamental changes advocated in the 1994 Policy take time to have effect and regrettably Ireland still has the lowest breastfeeding initiation rates in Europe. The latest available figures[a] show that only 36.97% of Irish mothers currently commence breastfeeding which is indicative of the challenge presented by the objective of ensuring that the majority of babies born in Ireland enjoy the great benefits offered by breastfeeding.

I would like to extend my thanks to the many people who contributed generously of their time to the production of this report which constitutes a valuable contribution to the work of the National Committee on Breastfeeding. Together with all members of the Committee we now look forward to building on the very substantial foundations laid down by the 1994 Policy in formulating a new Strategic Action Plan to tackle the barriers to breastfeeding in Irish society at all levels.

Professor Miriam Wiley

Chairperson

[a] *Report on Perinatal Statistics for 1999. HIPE & NPRS Unit, ESRI. December 2002.*

Section 1.

The work of the National Committee on Breastfeeding

Introduction

This section gives the context and rationale for the review of the 1994 Policy. It explains the background of the Policy and the formation and guiding principles of the National Committee on Breastfeeding. The methodology for the review process is outlined. The evidence-based cost implications of a decision not to breastfeed are given in summary -a more detailed elaboration of this research evidence is given in Appendix B.

Terms of Reference

The terms of reference given to the Committee by the Minister for Health and Children, Mr. Micheál Martin TD were to:

1. Review the 1994 National Breastfeeding Policy and,
    - identify recommendations not yet implemented;
    - identify those organisations charged with responsibility for implementation;
    - engage with such organisations to establish commitment and advise on best practice.
2. Provide recommendations to the Minister on what further action is required at National, Regional and Local level to improve and sustain breastfeeding rates.
3. Identify other relevant areas requiring support e.g. research, data collection, monitoring etc. and recommend measures for their implementation.
4. Report to the Minister on its findings.

Background

The Department of Health and Children has always promoted breastfeeding as the ideal for infants and young children. In 1992, the then Minister for Health, appointed a committee to develop a national policy to promote breastfeeding. The outcome of the committee's work was *A National Breastfeeding Policy for Ireland* (1994). This Policy detailed a series of recommendations and targets aimed at improving breastfeeding rates in Ireland.

In the intervening period, there has been a small increase in breastfeeding rates. However, the majority of Irish children are still not breastfed and significant numbers of mothers who start breastfeeding cease doing so very early in the post-natal period. These infants and their mothers are thereby deprived of the major nutritional, immunological and psychological benefits that breastfeeding confers.

To further address this issue, Mr. Micheál Martin TD, Minister for Health and Children, appointed The National Committee on Breastfeeding in March 2002. A major part of the work of the Committee under its Terms of Reference is to undertake a review of the 1994 Policy. While the National Committee on Breastfeeding was not given a finite period of existence, at its inaugural meeting on the 20th March 2002, the members decided to produce a Strategy document for the Minister for Health and Children after 2 years and this Interim Report after its first year.

To date the work of the Committee has focussed on examining the extent to which the recommendations of the 1994 Policy have been acted on in the intervening period and what impact this has had on breastfeeding rates as well as on breastfeeding supportive and promotional practices. Account has also been taken of any changes in breastfeeding 'best practice' in the intervening period.

Organisation of the work of the Committee so far

In organising its work under the Terms of Reference, the Committee broke into three sub-groups, employing the classification used by the Innocenti Declaration[b]. The Committee allocated each sub-group the responsibility to examine more efficient and effective ways to PROMOTE, SUPPORT or PROTECT breastfeeding in Ireland. The Committee members selected sub-groups based on their particular expertise and/or area of interest. Whilst there are areas of overlap in this approach, the plenary meetings provide opportunities to formulate ideas based on the interdependence between efforts to better promote, protect and support breastfeeding.

The Committee also decided to focus on a 'Settings Approach' and a 'Population Approach' in its deliberations:

- The **Settings** identified include, inter alia: GP surgeries; maternity hospitals/ units/antenatal education clinics/classes; homes; schools/colleges; workplaces; youth clubs; community centres; recreational areas; public areas generally.

- The **Populations** identified include, inter alia: women; mothers/expectant mothers; men; fathers/expectant fathers; grandmothers/grandparents; midwives/PHNs/ paediatric nurses/practice nurses; general practitioners/obstetricians/paediatricians; other health professionals; students in primary/post-primary /3rd level and their teachers; legislators/policy makers; employers/employer representatives; trade unionists/ workers representatives; media personnel; artificial formula manufacturers/ allied products manufacturers/retailers of these products.

In order to maintain a goal-directed focus it was also decided that proposals for action should meet the **SMART** criteria –**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imebound.

While these criteria are considered important for evaluation purposes, the Committee believe the major emphasis needs to be on bringing about system changes rather than being too initiative driven.

[b] *WHO/UNICEF "Breastfeeding in the 1990s: A Global Initiative", 1990*

Membership of the Sub-Groups

PROMOTE SUB-GROUP	SUPPORT SUB-GROUP	PROTECT SUB-GROUP
Ms. Janet Calvert	Ms. Claire Allcutt	Ms. Maureen Fallon
Ms. Sarah McEvoy	Ms. Genevieve Becker	Dr. Lucia Gannon
Ms. Catherine Murphy	Ms. Mary Bird	Ms. Mary Healy
Dr. Méabh Ní Bhuinneáin	Ms. Ann Ellis	Mr. Jeffrey Moon
Ms. Mary Robinson	Ms. Rosa Gardiner	Ms. Emma O'Donoghue
Mr. David Simpson	Dr. Tessa Greally	
Ms. Pauline Treanor	Dr. Ann Leahy	
	Ms. Margaret O'Driscoll	

Review process

Members of the Committee include those in key positions in statutory and voluntary services related to expectant parents and breastfeeding families as well as representatives of women's / men's organisations and the general public. The members' views were therefore, along with the public submissions[c], the main source of information in undertaking the review of the 1994 Policy. Where further verification was required, information was sought from the relevant key stakeholders.

Between March 2002 and January 2003, the committee met on four occasions as a full committee with additional meetings at sub-group level.

Many positive developments have taken place in the area of breastfeeding since 1994, which were not included in the recommendations of the 1994 Policy, e.g. the appointment of a National Breastfeeding Co-ordinator and Clinical Midwife Specialists in Breastfeeding. Also some innovative breastfeeding supportive projects/research have been undertaken. The contribution of these is acknowledged. However, this review, under the Terms of Reference, will only address the impact of the targets and recommendations in the Policy. Very few of the targets and recommendations were met in the timeframe set by the 1994 Policy. Consequently it was decided to evaluate their status up to the time of writing this Report in January 2003. It is not possible to verify in absolute terms the level of achievement of all the Policy's recommendations. The current review will therefore give an overview of their impact.

The breastfeeding rate targets are first examined, followed by an assessment of the targets/ recommendations as they applied to the four key areas for action identified in the 1994 Policy:

- Maternity Hospitals/Units
- Community Care Level
- Training of Health Professionals
- The Wider Community

[c] *A list of organisations that made submissions can be found in Appendix A.*

Before proceeding to the review of the targets and recommendations put forward in 1994, a short summary is provided here of our current knowledge of the importance of breastfeeding. This is intended to provide some perspective on the factors motivating the drive to increase breastfeeding levels in Ireland to at least those prevailing in the international context.

Why Breastfeed? [d]

The scientific evidence for the importance of breastfeeding was recognised in the 1994 National Breastfeeding Policy for Ireland, which included a section on the "Protection afforded by breastfeeding against acute infectious diseases." In the intervening years, research data on the importance of breastfeeding to the short and long term health of children and their mothers has grown immensely. Breastfeeding is also important for economic reasons.

Costs of ill-health

Compared to the baby who is fully breastfed for more than 13 weeks, the baby who does not receive breast milk is:

- 5 times more likely to be admitted to hospital with diarrhoea[1] and more likely to be ill for longer[2]
- 2 times more likely to be admitted with respiratory disease[1-3] and more likely to have severe wheezy illness[2]
- 2 times more likely to suffer from otitis media[4,5,]
- 2 times more likely to develop eczema or a wheeze if from a family with a history of atopic disease[6,7,8]
- 5 times more likely to develop a urinary tract infection[9]
- 6 times more likely to experience illness resulting in three times as many maternal absences from work[10]
- premature infants of 30-36 weeks' gestation fed formula are 10 times more likely to get necrotising enterocolitis (NEC) than breastfed infants – a costly condition to treat which also carries a 25% mortality rate.[11]

In addition, babies who do not breastfeed may have

- reduced ability to produce antibodies;[12]
- increased risk of developing juvenile onset insulin dependent diabetes mellitus;[13,14] higher blood pressure at age seven[15,16] and increased risk of obesity in childhood,[17] markers of later heart disease;[18]
- lower developmental performance and educational achievement, [18] thus reducing earning potential.

[d] *A more detailed review of the importance of breastfeeding can be found in Appendix B.*

Compared to women who breastfeed, not breastfeeding may increase the risk of:

- breast cancer [19]
- hip fractures in older age[20]
- retention of fat deposited during pregnancy[21] which may result in later obesity

Costs of provision of artificial formula

- Formula feeds for newborn infants while in maternity hospitals/units cost the health service at least €317,500 per year and there is a waste disposal cost for the more than 635,000 teats and bottles used.
- Free infant formula provided for some low-income families cost one health board over €114,000 in 1996.[22]
- For an individual family, to formula feed for 6 months, requires them to purchase 22 kg of powdered formula milk, feeding bottles, teats, cleaning and sterilising equipment plus the cost of boiling the water to make up the feeds, the cost of heating water for washing the equipment and the time needed for preparation.

Summary

In Section 1, the basis for the Interim Report has been set out. The organisation of the work of the National Committee was given and the approach taken in carrying out the review of the 1994 Policy's targets and recommendations was set down. Section 2 will review the breastfeeding rate targets set by the 1994 Policy.

Section 2.

Review of the breastfeeding rate targets

Introduction

This section addresses the targets for breastfeeding initiation and duration rates set by the 1994 Policy, with reference to available national and regional data. The importance of data collection initiatives is outlined, the sources for current data are given and other potential sources of data are considered.

1994 Policy Targets:

An overall breastfeeding initiation rate of 35% by 1996 and 50% by 2000

A breastfeeding initiation rate of 20% among lower socio-economic groups by 1996 and 30% by 2000.

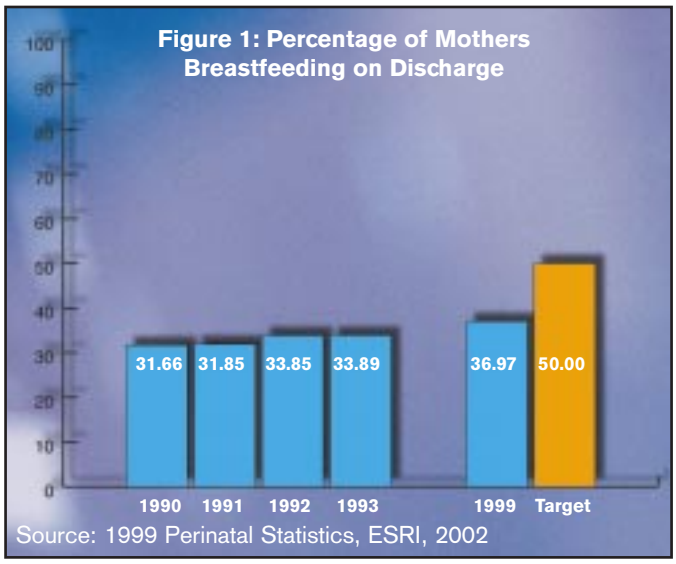
A breastfeeding rate of 30% at 4 months by the year 2000

National data

Breastfeeding rates on discharge

The National Perinatal Reporting System (NPRS) is at present the **only** Irish national infant feeding data source (it should be noted however that the introduction of National Performance Indicators in 2002 would be expected to constitute an important future source of data on breastfeeding). The NPRS records infant feeding method on discharge from maternity hospital/unit/domiciliary midwife care. A discharge rate (at approx. 3-4 days) is not the same as an initiation rate (at birth) however, it is sufficiently close to use as a yardstick for the breastfeeding initiation target set in the Policy.

The Report on the Perinatal Statistics for 1999[23] represents the most recent data available from this source. The report has 100 per cent coverage of all births in Ireland in 1999. This report gives a breastfeeding rate at discharge of 36.97% (36.21% exclusive + 0.76% combined). In 1993, the hospital with the lowest breastfeeding rate was 17.8% and the highest 54.3%. In 1999 the range was 24.6% to 59.1%. Though the 1999 rates show an increase on previous rates, this rate is well below the 50% breastfeeding initiation target set for achievement by the year 2000 in the 1994 Policy *(Figure 1)*. While the Perinatal Statistics are a good data source, the interval between collection and publication of reports has, to date, been relatively long and their effectiveness as a dynamic evaluative tool is therefore somewhat reduced.

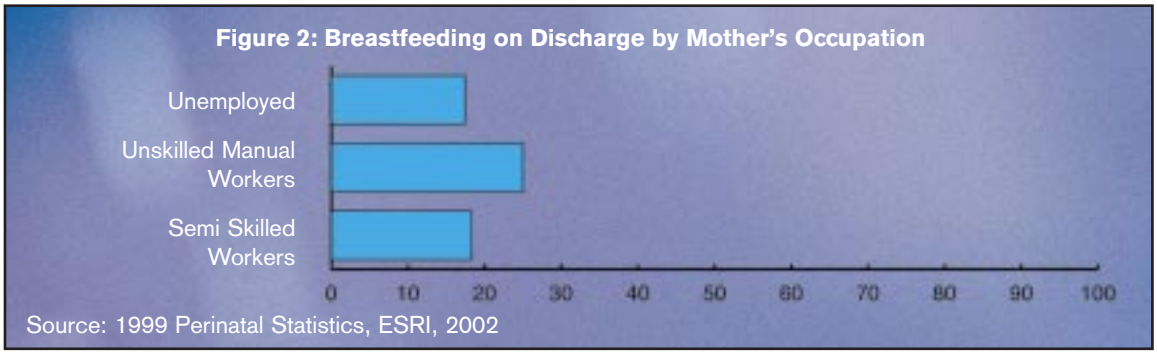


Source: 1999 Perinatal Statistics, ESRI, 2002

Prior to 1999, the data from this source was collected as breast or artificial feeding. In 1999, an attempt was made to establish if the breastfeeding was exclusive or partial and the categories used were breast, artificial or combined, though these were not clearly defined. From 1st January 2003, the NPRS[e] is defining the category 'BREAST' according to the WHO definition for exclusive breastfeeding/breast milk feeding.

Taking the occupation of the mother as an indication of her socio-economic status, the breastfeeding on discharge rate for lower socio-economic group women (unemployed, unskilled or semi-skilled manual workers) at 20% overall for these groups, also falls short of the 1994 Policy target of 30% by 2000 *(Figure 2)*, though it is a rise from 13% which was the baseline at the time of setting the target.

Figure 2: Breastfeeding on Discharge by Mother's Occupation



Source: 1999 Perinatal Statistics, ESRI, 2002

Breastfeeding initiation rate data are also collected as part of the Baby Friendly Hospital Initiative (BFHI), and by La Leche League of Ireland and Cuidiú-ICT via their support services.

Breastfeeding duration rates

Currently national data on breastfeeding duration rates are not collected in Ireland. However, given that the rate of breastfeeding on discharge from maternity unit/hospital for 1999 was 36.97% it can be reasonably assumed that the 1994 Policy's 4-month duration rate target of 30% by 2000 was not achieved.

Local data

In the years 1994 - 2002 the Policy recommendations did lead to some Health Boards commissioning regional breastfeeding research surveys to establish baseline data, as well as to gain insights into the influencing factors or barriers that dissuade women in their particular areas from breastfeeding and/or impact negatively on the duration of breastfeeding. Valuable insights were also gleaned from qualitative surveys undertaken regionally.[24] However, as this section is addressing the breastfeeding rate targets, the research examples cited are from quantitative surveys only.

Breastfeeding in the North Eastern Health Board

In 1995, the North Eastern Health Board (NEHB) studied a one month cohort of all singleton births in the region (n=308).[25] This survey estimated the breastfeeding initiation rate for the region at 34.8% with 10.1% still breastfeeding at approximately 16 weeks.

[e] *NPRS-National Perinatal Reporting System*

Breastfeeding in the Mid-Western Health Board

In 1997, the Mid-Western Health Board published the results of their research survey of all live births to women living in their health board region in August 1996 (n=339).[26] For the 339 women surveyed for the study, a breastfeeding initiation rate of 34.2 per cent was estimated while the breastfeeding rate at four months was estimated at 12.7 per cent *(Table 1).* A clear gradient in this rate by age at completion of full time education was observed. For women who had completed full time education at less than 17 years of age, just around 10 per cent choose breastfeeding while for women whose age at finishing full time education exceeded 23 years, a breastfeeding initiation rate in excess of 60 per cent was estimated. An important finding of this study was that 54.3 per cent of breastfeeding mothers and 48 per cent of bottle-feeding mothers had made their infant feeding decision prior to becoming pregnant. This does not diminish the important role health professionals play in promoting and supporting breastfeeding but it does suggest the promotion of breastfeeding should start much earlier at a general societal level. The initiation and duration rates in both the NEHB and the MWHB surveys were remarkably similar *(Table 1).*

Breastfeeding in the North Western Health Board

Between October 1998 and February 2000, the NWHB carried out a three-stage Infant Feeding Survey.[27] Three hundred (300) women attending booking clinics in the region's two maternity hospitals and four women planning home births were recruited. Some differences in the findings for the NWHB study compared with the studies undertaken in the other Health Boards are in evidence and are summarised below *(Table 1).* In the NWHB study, it was reported that half of the respondents who had stopped breastfeeding 6-12 weeks after birth would like to have continued breastfeeding for longer.

Table 1: Breastfeeding rates in three health boards

	NEHB	MWHB	NWHB
Year	1995	1996	1998-2000
At birth	34.8%	34.2%	44%
At discharge	29.6%	30.1%	34%
At approx. 6 weeks	20.2%	21.8%	23%
At approx. 16 weeks	10.1%	12.7%	6%

Breastfeeding in the Eastern Health Board (Community Care Area 1)

As part of a comprehensive programme to increase breastfeeding rates, Community Care Area One in the former Eastern Health Board undertook an intervention breastfeeding project between

mid 1998 to mid 2001.[28] The post programme breastfeeding rates were collected on a cohort of all live births born to mothers living in the area from 1st March – 1st May 2001 (n= 320).

The results estimate a breastfeeding initiation rate of 57.4 per cent plus 4.4 per cent combined feeding, resulting in an overall estimate of 61.8 per cent. These rates are considerably higher than in the studies cited earlier. A social class effect was in evidence in this study as 39.2 per cent of mothers in SE 1-3 were still breastfeeding at three months compared to 10.3 per cent of mothers in SE 4-6. The relatively high breastfeeding rates in this study may also reflect changes in breastfeeding support in the intervening years, as the data pertains to 2001, whereas the health board data cited earlier dates from 1995 to 2000.

The initiation and duration rate targets set by the 1994 Policy were National Targets and the evidence available shows that neither the overall targets, nor the target set for women from the lower socio-economic groups, were achieved in the timeframe stipulated or indeed since.\

Data Collection

The accurate collection, analysis and timely publication of breastfeeding data are essential for monitoring and evaluating the on-going effectiveness of promotion and support strategies. Electronically generated data should also form an integral part of maternity service provision. There is also a growing EU imperative to develop these data systems for trans-national comparative purposes.

A necessity in developing breastfeeding data collection systems is a universally accepted standard system for defining breastfeeding. The 1994 Policy targets used 'breastfeeding' as the undefined criterion for measurement. Since 1994, research has shown that many of the health advantages from breastfeeding are 'dose related' and can be maximised by exclusively breastfeeding for longer durations. This and other research evidence from developing and developed countries has led to UNICEF and WHO changing their best practice recommendations on infant and young child feeding. The new recommendations adopted at the World Health Assembly in May 2002 state that mothers should be encouraged to exclusively breastfeed for the first six months of life and to continue breastfeeding thereafter in combination with suitably nutritious semi-solid and solid complementary foods for up to two years of age or beyond. The Department of Health and Children has adopted this recommendation as policy.

Any future targets would need to use an exclusive breastfeeding rate up to six months of age as the main yardstick. Another imperative to ensure the accuracy and reliability of any new data collection system is to link its introduction with an information/training programme on the new collection process for staff responsible for in-putting/collecting the data, together with a validation or audit process to regularly check the accuracy and completeness of the data set.

Of vital importance also is the ability to link breastfeeding data with denominator data that provide a breakdown of crucial demographic variables, such as socio-economic status and other factors known to impact on infant feeding choice and duration. This would be a pre-requisite for target setting and for evaluating future initiatives aimed at addressing the breastfeeding needs,

particularly of lower socio-economic groups and others where breastfeeding as an option is especially endangered.

National Performance Indicators

In 2002, The National Performance Indicators Project Team devised an interim standard template for a quarterly submission to the Department of Health and Children on specific overall health indicators from each health board area. The set of Performance Indicators include the percentages of babies who are:

- exclusively breastfed on discharge from maternity hospital/unit
- partially breastfed on discharge from hospital/unit
- exclusively breastfed at three months
- partially breastfed at three months.

The data on discharge rates are sourced from the maternity units in the Health Board's catchment area and the 3-month rates are based on mainly manual data collected by public health nurses during the scheduled 3 months infant surveillance check. The WHO definition for exclusive breastfeeding is used and partial breastfeeding is defined as breastfeeding / breast milk feeding in combination with other fluids/formula/solids. A number of health boards are not yet returning breastfeeding data for the 3 months stage due to difficulty with collating the manual data from large numbers of public health nurses.

Parent-Held Child Health Record

A Best Health for Children Project in the Mid-Western Health Board has recently developed a parent-held child health record ('My Personal Health Record') that will generate aggregate computer infant feeding data for the region. Data is collected using the following categories: Breast; Formula; Mixed. So far there are no definitions stipulated for these categories. Another category 'Ever Breastfed' will provide estimates of the breastfeeding duration profile for the region. At the time of writing, this model was being piloted and it may be recommended for use throughout the region and also in other health board areas.

Feeding Data from the National Metabolic Screening Card

The Metabolic Screening (Guthrie) card is another potential source of data on breastfeeding. Electronic access to the infant feeding data on the Guthrie card would achieve a complete or near complete data set of all infants breastfeeding on day 4-5. The Guthrie generated data in Scotland is considered their best source of early breastfeeding data.[29] Communication with the National Metabolic Screening Unit in Ireland regarding access to this data has highlighted problems related to incompatibility of computer systems and level of non-completion of feeding data on these cards.

Summary

This section has shown that the 1994 Policy targets for breastfeeding initiation and duration were

not achieved. While the Perinatal Statistics provide a national data source for breastfeeding at time of discharge from maternity hospital/unit, there are currently no national data sources for duration rates beyond this stage. Evidence for the achievement/non-achievement of the breastfeeding target at 4 months therefore, relied on available regional survey data.

The pivotal importance of accurate, comparable and up-to-date breastfeeding initiation and duration data, using universally accepted and understood breastfeeding definitions, was highlighted. It was noted that the recent introduction of quarterly National Breastfeeding Performance Indicators could become an important future source of duration rate data. The next section will look at the 1994 Policy's other targets and recommendations as they pertain to the Health Sector.

Section 3.

Review of the targets and recommendations for the Health Services

Introduction

This section explores the main targets and recommendations relating to the health services. Apart from separately examining the effect of the recommendations relating to the protection of breastfeeding from the marketing of breast milk substitutes, the review process used the same format as the 1994 Policy. That is, it individually explored the main recommendations as they applied to the hospital setting, the community health care setting and health professional education.

Maternity Hospital/Unit Setting

Target: All maternity hospitals and units have a breastfeeding policy and a lactation team in place by early 1995

Eighteen of the 22 maternity hospitals/units report they have a breastfeeding policy. Fifteen of these report their policy is displayed in all areas of the health facility serving mothers and babies. Compliance with the hospital policy is compulsory for all health care staff in 15 units/hospitals. In 4 maternity facilities, there is an audit procedure to ensure compliance.

Eleven units/hospitals have a lactation team/breastfeeding committee in the hospital. In addition, 9 maternity facilities have a Clinical Midwife Specialist in Breastfeeding or a similarly designated person in post. These committees/teams meet regularly and most are multi-disciplinary and include members of the voluntary mother-to-mother breastfeeding support groups such as La Leche League of Ireland, Cuidiú – ICT and others, and staff from other health sectors.

Target: By early 1995, the national structures necessary for Ireland's participation in the Baby Friendly Hospital Initiative should be in place

The Baby Friendly Hospital Initiative is a global project of WHO/UNICEF started in 1991. In April 1998, the Irish Network of Health Promoting Hospitals (HPH) agreed to put these structures in place as one of its key projects. Current research evidence worldwide still supports this initiative as the best evidence-based approach to breastfeeding supportive hospital practices.

At present 19 of the 22 maternity hospitals/units in the country are participating in the BFHI with an additional one in the process of applying to do so. Six of the 19 units/hospitals participating have achieved the level of a Certificate of Commitment. To date **no** maternity hospital/unit in the Republic of Ireland has achieved national or global 'Baby Friendly' designation. Two hospitals in Northern Ireland have BFI UK National 'Baby Friendly' awards.

Virtually all of the individual 1994 Policy recommendations pertaining to maternity hospitals/units involve implementing the Baby Friendly Hospital Initiative (BFHI), therefore these recommendations are discussed together with the BFHI.

Self-appraisals by individual maternity hospitals/units are integral to participating in the BFHI. These self-appraisals estimate the stage at which the Unit is at in implementing the '10 Steps to Successful Breastfeeding', upon which the Initiative is based. Similar self-reported information was obtained from the maternity units not participating in the BFHI by means of a telephone questionnaire to their midwifery managers and this information has been incorporated into the review of this target.

Overview of implementation of recommendations:

- All hospitals/units state that they show mothers how to breastfeed and maintain lactation, even if separated from their baby, and that they give information on support services after discharge.
- Skin to skin contact is facilitated in most hospitals/units.
- Encouraging breastfeeding on demand is the norm in most hospitals/units.
- Policies are common but are not always displayed. There are very few hospitals/units auditing their policy.
- Most hospitals/units state they arrange for specialised training for specific staff members.
- Few provide orientation for all new staff or training in assisting breastfeeding for all relevant staff.
- Antenatal information and discussion, protection from marketing of breast milk substitutes, use of supplements, use of dummies and teats and rooming-in all need attention in addition to training and auditing.
- Breastfeeding (any) initiation at time of completing the appraisal forms ranged from 26% to 57%

Further details are provided in Appendix C.

Breastfeeding ill or pre-term infants

Two recommendations in the 1994 Policy stress the importance of reassuring mothers that having an ill or pre-term infant does not preclude breastfeeding and that extra breastfeeding support will be available. Since the Policy was published, the body of research evidence for the special advantages of breastfeeding for these babies has grown.

A Breastfeeding Supportive Paediatric Unit Project was started in 2002 and currently there are 8 paediatric units/hospitals participating in it. This Project is a further development within the main BFHI/HPH Project.

Additional information to establish what breastfeeding supportive practices were in place in this sector of the health services was gathered by means of a telephone questionnaire to managers in 10 neonatal units, (2 of these were combined neonatal-paediatric units) and 2 infant/young child units in paediatric hospitals.

Of the units contacted:

- 4 collect breastfeeding/breast milk feeding data on babies in their unit;
- 10 reported they use tubes or cups either occasionally or routinely to give expressed breast milk (or other medically indicated supplements) to breastfeeding/breast milk feeding babies instead of bottles/teats;
- 3 have an identified staff member in the unit with responsibility for breastfeeding support and the remainder have access to a breastfeeding support person/specialist in the maternity section of the hospital;
- 10 neonatal units report they inform parents of the *special* advantages of breastfeeding for ill or pre-term infants. One of the paediatric units said they did not see a role for themselves in giving this information as the majority of mothers of babies admitted to their units had already made their infant feeding decision before admission.
- 11 of the units reported their hospital provides breastfeeding education for nursing/midwifery staff –18 hour breastfeeding course/2 day course/study days- but no data was available on the percentage of the staff who have attended these. Although doctors and other staff were not excluded from attending these courses only 2 units reported that another discipline, i.e. doctors/dietitians attended.

A donor breast milk bank exists in Northern Ireland that is run in accordance with international guidelines for milk banking. Its use by neonatal/paediatric units in Northern Ireland is widespread. Donated breast milk is sent from the Republic to this bank. However, despite evidence of its benefits, the use of breast milk from the bank by units/hospitals in the Republic is minimal.

Protection from the Marketing of Breast Milk Substitutes

There are three recommendations in the Policy relating to the protection of breastfeeding from the marketing practices of breast milk substitute manufacturers and distributors. These relate to not using/giving free samples, literature and other gifts promoting infant formulae to the general public, pregnant women, mothers and their families through the health services. In addition, it recommends that health care staff only use approved literature on breastfeeding produced/approved by the Health Promotion Unit of the Department of Health and Children or breastfeeding support groups and that information on the Codes of Marketing should form part of education programmes.

Issues in relation to the Codes also apply to the wider community but the recommendations in the Policy relate to the health sector only. At the time the 1994 Policy was written there was a voluntary Code of Practice for the Marketing of Infant Formulae in Ireland.

A Code Monitoring Committee, comprised of representatives from the various manufacturers and distributors of infant formulae and a number of medical, nursing, midwifery and other interested professional bodies, monitored compliance with the Voluntary Code. In the intervening period, this

process has been replaced as a result of the transposing into Irish law of the European Communities (Infant Formulae and Follow-on Formulae) Regulations, 1998-2000. The monitoring and investigation of possible infringements of this legislation has devolved to the Food Safety Authority of Ireland through its agents the Health Boards, specifically the environmental health officers. The Irish legislation does not include all the provisions of the WHO International Code of Marketing of Breast Milk Substitutes and subsequent World Health Assembly Resolutions.

Marketing gift packs/materials are distributed to pregnant women, new mothers and mothers of young children via the health services. Members of the Committee have been made aware of, or have direct knowledge of, breaches of the International Code by the companies producing these packs/materials. The Health Promotion Unit uses one of these commercial packs to distribute health promotion/information materials. The marketing gift packs are supposed to be distributed by employees of the marketing company. However, in an audit conducted among new mothers in the Midland Health Board area in 2002[30], 34% of the respondents interviewed reported that these packs were given to them by a hospital staff member. Eighty-one percent of all the respondents interviewed said their names and addresses were taken by or for the company in question. This audit cited a review [31] of randomised control trials which showed that the distribution of commercial discharge bags, with or without formula samples, appears to decrease the number of women who breastfeed exclusively at all times, but their use did not seem to have any effect on earlier termination of non-exclusive breastfeeding. A 1999 survey[32] found that 16% of antenatal education teachers said they involved formula company representatives in their programmes. This contact between pregnant women and formula company representatives constitutes a breach of the International Code.

All the Chief Executive Officers of the Health Boards were contacted for information about procedures for monitoring adherence to the marketing Codes/legislation, as well as how they investigate possible infringements. They were also asked how this information/ responsibility is conveyed to staff.

From the responses of the 8 (out of 10) health board replies received, there was a general misunderstanding about the process of monitoring, and procedures for reporting a possible infringement. Only one health board respondent identified the environmental health officers as the agents responsible for investigating infringements. In their responses, education and monitoring appeared to be linked with breastfeeding courses and committees. One health board did however have a system in place for auditing compliance and a procedure for investigating breaches.

The 1994 Policy recommendations protecting breastfeeding have had an impact. There is an increased awareness of the ethical issues around health service employees accepting gifts, education sponsorship or other items from manufacturers and distributors of products that can compromise breastfeeding. Many maternity hospitals/units/health boards have put procedures in place to monitor the contents/information in promotional gift packs/commercial information materials. Public health nurses in many health centres have withdrawn from dispensing free formula under the Free Milk Scheme. This has led to more protection of clients from exposure to the marketing of breast milk substitutes as well as bottles, teats, soothers and other products covered under the International Code.

Community Care Setting

Target: All Community Care Areas to have an identified Breastfeeding Resource Person by early 1995.

Directors/ Assistant Directors of Public Health Nursing from 20 Community Care Areas nationwide (20 out of a possible 33) - representing all of the health board areas - completed a telephone questionnaire on the recommendations pertaining to public health nursing in the 1994 Policy.

Fourteen Directors/Assistant Directors of Public Health Nursing reported there were breastfeeding resource public health nurses (PHNs) working in their areas. Asked if these resource PHNs had any extra qualification in breastfeeding, 4 Directors/Assistant Directors reported having PHNs on staff that were International Board Certified Lactation Consultants (IBCLC) but these were not necessarily the staff identified as the breastfeeding resource PHN.

One community care area has a Breastfeeding Resource Person with a full time working commitment to breastfeeding. This post was initially created as part of a Pilot Project to promote, protect and support breastfeeding in a maternity hospital and in the surrounding community care area. This project contributed to a significant increase in the breastfeeding discharge rate and had a positive impact on breastfeeding duration rates.[33] These and other positive outcomes provided the justification for the continuation of the post beyond the duration of the project's timeframe.

Another health board has recently appointed a PHN as Regional Project Officer for the Promotion of Breastfeeding. None of the remaining staff identified by their managers as being breastfeeding resource persons/PHNs, had any dedicated working time allotted to breastfeeding.

Fifteen of the 18 National Health Trusts in Northern Ireland have appointed breastfeeding coordinators. Their role is to promote the implementation of best practice standards, develop peer support programmes and support groups, provide training to all relevant health professionals and develop resources for parents and professionals ie. leaflets, policies, guidelines etc.

Recommendation: Every health board should have a written breastfeeding policy. This should be consistent with that recommended for hospital as well as incorporating elements specific to community care at local level.

Six of the 10 Health Boards have a regional breastfeeding policy and a further 3 are at varying stages of formulating one. The existing policies do contain service commitments in line with the implementation of WHO/UNICEF's 10 Steps to Successful Breastfeeding. Two of the policies have linked action plans or strategies to monitor progress toward implementing Policy commitments within a stated time frame.

Most of the Health Board Breastfeeding Policies were formulated by multidisciplinary and multi-sectoral teams, in line with recommendations in the 1994 Policy. The communication of breastfeeding policies to all disciplines in the community care services has largely been done on an ad hoc basis.

Recommendation: At a minimum, health professionals should ensure that during the ante-natal period all women have information on the advantages and management of

breastfeeding and are assured that pre- and post-natal support will be available from health professionals and voluntary groups.

Research evidence shows a strong correlation between attendance at antenatal education classes and subsequent breastfeeding. This might be partly explained by the fact that while antenatal education is offered to parents as part of antenatal care, the social class profile of those who attend is skewed toward the higher socio-economic groups. While the imparting of this information on the importance of breastfeeding is integral to antenatal education classes, it is also the responsibility of GPs, obstetricians and midwives as part of the provision of routine antenatal check-ups. In addition, the provision of information and opportunities to discuss breastfeeding might be more effectively carried out in a less formal setting than a class setting and on a one-to-one basis.

In the non-statutory sector, Cuidiú-Irish Childbirth Trust provide antenatal education programmes that cover all breastfeeding issues very comprehensively. However, these programmes are availed of by only a small number of pregnant women/couples. Cuidiú-ICT and La Leche League report that women antenatally are frequently not encouraged to attend their support groups during pregnancy, even though contact with breastfeeding mothers has been shown to improve both initiation and duration rates.

Participation by most hospitals/units in the Baby Friendly Initiative has meant that information about local mother-to-mother support is routinely given to the majority of breastfeeding mothers on discharge.

Information on the advantages of breastfeeding also needs to be literacy-proofed so that it meets the needs of those in society who, at present, are least likely to breastfeed and arguably have the most to gain from the advantages that breastfeeding confers. Methods of imparting information need also to take account of Ireland's growing multiculturalism.

Recommendation: There should be regular meetings and on-going liaison between health professionals and voluntary support groups …Adequate resources should be made available to these groups to enable them to participate in these programmes.

Voluntary support groups, such as La Leche League of Ireland and Cuidiú – ICT, among others, are an important community resource available to assist health professionals in supporting breastfeeding mothers. When good collaboration is established, voluntary support groups and health professionals mutually reinforce each other's value to breastfeeding mothers.

Most of the Maternity Hospitals and Health Boards report having voluntary support group representation on their Breastfeeding Teams/Committees/Strategy Groups.

Of the 20 Directors/Assistant Directors of Public Health Nursing contacted, 7 said there was some level of contact between public health nurses and breastfeeding support volunteers at local level. None of those interviewed however, knew of any formal meetings at local level between statutory and voluntary breastfeeding supporters. Most said public health nurses would speak to volunteers on the phone, if contact were needed.

While some health boards and hospitals reimburse travel expenses for volunteer support

representatives on their Regional Breastfeeding Committees, this is by no means universal.

Recommendation: A breastfeeding clinic to which mothers can come with their babies should be held weekly in each health centre.

Currently, there are no community care areas in the country holding breastfeeding support clinics (either weekly or less often) in all their health centres, according to the 20 public health nurse managers contacted. In one community care area, 7 out of 8 of their health centres have breastfeeding support clinics-but some of these are held less often than weekly. This is by far the best ratio in the country, the next best being 4 out of 18 health centres. Three directors of Public Health Nursing reported there were no breastfeeding support clinics in their areas.

An examination of the evidence for the effectiveness or current relevance of this recommendation may be necessary for a number of reasons. Breastfeeding clinics may give the perception that breastfeeding is problematic as there is a commonly held association between clinics and health problems. The location of health centres may not always be suitable. Questions were raised about the feasibility of providing these clinics in every health centre. Duplication was reported in a few areas, with statutory and voluntary support organisations running breastfeeding support clinics serving the same client group. Closer linkages between the statutory and voluntary sectors could improve efficiency and widen the availability of support clinics by allowing the statutory services concentrate on areas where no other breastfeeding support services are available. The importance of home visits with one-to-one support should not be neglected.

Health Professional Education

Target: From 1995 all courses for health professionals should incorporate the recommendations on professional training contained in this Report.

The appropriate training of health professionals in breastfeeding promotion, protection and support is one of the key steps in the BFHI. Health care professionals should be able to access best evidence based information in breastfeeding management. Health professionals, and other health care staff, are well placed to provide information on breastfeeding and to support mothers. This is particularly important in Ireland, where breastfeeding rates have been low over a number of generations, with a consequent lack of breastfeeding ability in families and kinship networks. Irish breastfeeding parents are therefore heavily reliant on health professional knowledge, expertise and support.

Many health professionals in diverse work settings may encounter pregnant women, mothers and their infants and young children, therefore all need a general awareness of the importance of breastfeeding and their role in supporting breastfeeding policies and initiatives.

In 1997, the Centre for Health Promotion Studies, University College Galway, developed and published a breastfeeding self-study training pack for health professionals.[34] The pack consists of 12 units of written material and 2 videos. The Health Promotion Unit of the Department of Health and Children funded the development of the materials to provide a research-based model for

health professional education that incorporated learning outcomes.

Seventy-five colleges/departments/hospitals providing undergraduate, postgraduate and in-service training to health and allied professionals routinely caring for pregnant women, mothers and infants in Ireland were contacted for information on how breastfeeding is addressed in their curricula. The colleges from whom information was requested are listed in Appendix D.

Apart from the specialist areas of midwifery, public health and neonatal nursing, the overall impression gleaned from the 42 responses received, is that sessions on breastfeeding are very variable, with input incorporated into, for example, biology, anatomy, behavioural sciences, nutrition, and during clinical attachments in undergraduate general health professional training (nursing, medicine, dietetics). Practical skills acquisition may be dependent on the clinician the students are assigned to for their clinical training. Most of the replies received did not address the issue of breastfeeding in specialist training courses for general practitioners, paediatricians and obstetricians. In the midwifery, public health nursing and paediatric nursing education, some courses aim to provide knowledge and skills to a level at which their graduates can provide practical assistance and support to mothers – a level similar to that of three-day courses attended by existing staff. However, competency to assist with breastfeeding is not assessed as a registration requirement.

All maternity hospitals, all but 1 of the neonatal/paediatric units and 17 of the 20 Public Health Nursing managers of Community Care Areas contacted, reported that the majority of their current midwifery/paediatric/public health nursing staff had been offered or completed an 18 hour breastfeeding course. Opportunities for new staff to do this course were however dependent on the numbers involved and the cost. The need for refresher/up-dates on breastfeeding was raised by 14 of the Public Health Nursing managers contacted.

With one or two exceptions, in-service courses on breastfeeding are generally offered to midwives, public health nurses and paediatric nurses with some available to dieticians, practice nurses and health promotion officers. Hospital doctors and GPs are offered places on some courses, though up-take is low. Continuing Medical Education programmes for GPs occasionally have a module related to breastfeeding. Most in-service courses provide a list of topics covered but not the learning outcomes, evaluation or assessment methods.

Though most of the replies from employers/health boards stated they offer their relevant employees 'the 18 hour breastfeeding course' there is no recognised content for this course in Ireland and the content may vary depending on the course facilitator. Most courses have the majority of the content delivered by International Board Certified Lactation Consultants (IBCLC), however this is not a training qualification of itself. Some IBCLCs have done additional courses in training /adult education. Nevertheless, there is no common standard for those providing breastfeeding training in Ireland.

There is a need for the development of a recognised course content, evaluation system and suitably qualified course providers to ensure consistency of information and up-to-date information on best practice. In developed countries, this is of general concern and the Education Committee of the International Lactation Consultant Association is developing curricula, learning outcomes,

competencies and assessment methods for breastfeeding courses. There is an Irish representative on this committee.

At present (January 2003), there are 121 International Board Certified Lactation Consultants in Ireland from a variety of backgrounds including midwifery, nursing, medicine, nutrition, social work and peer support. This internationally accredited examination has been held in Ireland since 1989. More than 121people have passed the IBCLC exam, however IBCLCs are required to continue their education in order to remain accredited and not all people remain accredited. Most Clinical Midwife Specialists in Breastfeeding currently in post have this qualification.

The Association of Lactation Consultants in Ireland (ALCI) holds regular accredited continuing education events for their members, which are open to anyone with an interest in supporting and promoting breastfeeding.

Established peer support groups such as Cuidiú–ICT, La Leche League of Ireland, Community Mothers and the mother-to-mother support groups in Sligo and Dungarvan, have systems of training their breastfeeding counsellors, which vary between organisations. For example, La Leche League leaders are accredited in accordance with La Leche League International's policies governing accreditation practices. The duration of training for members of mother-to-mother support groups may take anything from a few days to two years or more and includes theoretical knowledge, practical skills and communication/ counselling practice. Most groups also have continuing education for their counsellors and a mentoring system for new counsellors. Further information on La Leche League of Ireland Leader Accreditation and Cuidiú-ICT can be obtained from www.lalecheleague.org and www.cuidiu-ict.ie

Summary

The recommendations and targets relating to the Health Sector in the 1994 Policy were very extensive. This Section has shown that much progress was made in addressing these recommendations in the maternity hospital setting. Many of the health sector recommendations involved the implementation of the WHO/UNICEF research-based '10 Steps to Successful Breastfeeding', upon which the 'Baby Friendly' Hospital Initiative (BFHI) is based. The establishment of the national structures for the BFHI in late 1998 did meet one of the main recommendations of the 1994 Policy. The vast majority of Irish maternity hospitals/units were found to be participating in this Initiative, although none so far have achieved a 'Baby Friendly' award.

Improvements were also identified in health professional breastfeeding education, although mainly within a few, albeit important, health disciplines. The review also found that regional and local breastfeeding policies have been drawn up for the majority of hospitals and health boards and these give commitments to the implementation of BFHI and better cooperation between the statutory and voluntary sectors. The review process in relation to recommendations covering community care settings revealed less progress. For example, an important recommendation was to appoint community breastfeeding resource persons with dedicated time to provide breastfeeding education and support. This has largely not happened. In the next section the impact of the recommendations relating to the Wider Community are examined.

Section 4.

Review of the targets/recommendations in the wider community

Introduction

In this section, the 1994 Policy's targets and recommendations aimed at the wider community outside the health sector are reviewed. These cover breastfeeding promotion and protection initiatives in schools, the workplace, in public areas generally and in the media. The provision of a national resource centre for breastfeeding was also advocated in the 1994 Policy as well as recommending longer paid maternity leave.

Target: The Health Promotion Unit (HPU) Budget Plan should include provision for the designation of the Unit as a National Breastfeeding Resource Centre.

The HPU of the Department of Health and Children has had a dedicated breastfeeding budget for the last number of years. This budget has been utilised to develop and produce materials on breastfeeding and to support specific voluntary organisations. More recently funding has been earmarked for the appointment of the National Breastfeeding Coordinator as well as for the servicing of the National Committee on Breastfeeding. In addition to this, the Unit continues to provide resources for the development and production of information materials and for the support of the voluntary groups.

Workplace

Target: At the 1996 review of the EU Directive on Maternity Leave, Ireland should support the extension of such leave to 16 weeks.

In the interim, this recommendation was not only achieved, but exceeded. When the 1994 Policy was published, maternity leave entitlement was 12 weeks. Since March 2001, Maternity Leave provision in Ireland is 18 weeks paid leave and two months unpaid leave. There is further unpaid leave available under the Parental Leave Act. During pregnancy, employees are also entitled to time off without loss of pay for all antenatal medical visits.

Target: By 1998, the public sector and in particular the health sector should be giving a lead in the provision of workplace crèche facilities and lactation breaks.

This recommendation is particularly important if the very low breastfeeding duration rates are to be addressed. Irish survey data cited earlier in this Report shows that returning to work is a disincentive to initiating breastfeeding and a major reason for early cessation.

Following on from the Report of the Working Group on the Review and Improvement of the Maternity Protection Legislation[35] the Department of Justice, Equality and Law Reform referred a bill for drafting in July 2002 that will give legislative backing to the provision by employers of paid breastfeeding/lactation breaks or a reduction of working hours (without loss of pay) for their

employees up to 4 months following the birth of a child – this accords with the Working Party recommendation. The Maternity Protection (Amendment) Bill 2003 is due to come before the Oireachtas towards the latter half of 2003. Some lobbying is taking place to have no time limit on the provision of these breaks or at least to extend the entitlement to 6 months or longer after the birth as the vast majority of new mothers intending to return to paid work will still be on maternity leave up to 4 months and possibly beyond this time.

The Chief Executive Officers of all 10 Health Boards were contacted to determine whether they make provisions for breastfeeding/lactation breaks for their employees. A reply was received from nine. Four health boards provide lactation breaks for breast milk expression and offer facilities for these. Two further health boards reported that informal arrangements were made with the cooperation of colleagues. A further 2 were examining the feasibility of offering lactation breaks, but this would be dependent on funding being made available. Three of the four health boards providing breaks give 15-minute breaks for every four hours worked, as part of the working day. The fourth reported that a 'short period' of time was added to official breaks to allow for breast milk expression. One health board stated their only obligation currently to breastfeeding employees applied to provisions under the Health and Safety regulations.[36] A BFHI/HPH Breastfeeding Supportive Workplace project (for health facilities) is to commence this year.

Currently there is no civil/public service-wide policy on the provision of breastfeeding/ lactation breaks. Civil service human resource sections are awaiting pending legislation on the issue. It was indicated that individual Government departments might facilitate these breaks through their Personnel Units.

Contact was made with the Personnel Unit of the Department of Health & Children to enquire whether any provisions are made to facilitate these breaks. It was indicated that the issue had been discussed. Consideration was being given to adapting the existing restroom as a lactation facility. Consultation regarding the duration of breaks and the length of time these are facilitated is also awaiting legislation on the matter.

Dublin City Council provides paid lactation breaks for their employees. The Council is flexible about the number, duration and length of time breaks are given, so long as these are within reasonable limits. Monitoring and facilitation of these breaks are the responsibility of the employees' line managers. While there is no designated room for breast milk expression, each department has a range of rooms that can provide privacy e.g. rest rooms, first aid rooms and conference rooms. If there is any difficulty in gaining access to suitable facilities, Human Resources takes responsibility for organising this. Lactation break provisions are communicated to staff via leaflets and intranet information channels.

Schools

Target: By the year 1997, the social and health education programme in primary and secondary schools should contain a component on breastfeeding along the lines recommended in this Report.

From September 2003 all primary and post primary (junior cycle) schools will be making provision for the implementation of Social, Personal and Health Education Curriculum.

At primary level the Social, Personal and Health Education (SPHE) curriculum addresses issues through Strands and Strand Units including 'Knowing about My Body', 'New Life', 'Health and Well-being', and 'Birth and New Life'. Each of these topics is explored in a developmental way that is appropriate to the age and stage of development of the children and consistent with the characteristic ethos of the school.

The SPHE curriculum for the Junior Cycle at Post-Primary level is an enabling curriculum and is therefore a framework to assist schools, rather than prescriptive. Schools have the discretion to address issues considered important to their cohort of students within this framework.

School programme content is at the discretion of the teacher / school so information is at individual classroom level. Teachers, who are aware of the value of breastfeeding and comfortable with it, may include mention of breastfeeding in various subjects without consciously recording it as a 'breastfeeding class'. To attempt to collect accurate data on the inclusion of breastfeeding in schools may be difficult. An excessive focus on breastfeeding might serve to highlight it as an unusual activity.

Small breastfeeding projects have been undertaken in some schools with varying levels of success. Some projects involved art, some involved discussions and some were talks by visiting Public Health Nurses. Members of the voluntary breastfeeding groups were involved in a number of school health promotion/breastfeeding information sessions. Breastfeeding appears in projects of the Young Scientist Exhibition on a regular basis.

A Northern Ireland survey[37] of 419 teenagers (aged 14-16 years) from 7 schools indicated that 71% of respondents had not received any infant feeding or breastfeeding information in school. Forty-five percent of the overall respondents believed babies should be breastfed or 58% of those answering the question, as 22% of the students did not express a view. There was considerable agreement/strong agreement (76%) that breastfeeding should form part of the main school curriculum and that it was important for young people to have contact with breastfeeding mothers.

A 1996 study[38] of 177 boys and girls, aged 16-19 in three Co. Galway schools, found 80% believed breastfeeding was best and, of those who expressed a view, 78% intended the practice for their children. However, there were negative attitudes expressed in the focus groups towards the actual practicalities of breastfeeding including embarrassment, perceptions of inconvenience, the role of the father and practical difficulties. Forty percent of the girls and 14% of the boys replied that they learned about breastfeeding at school. The author concludes that a structured and practical educational programme at school could significantly influence future self-efficacy in relation to the practice of breastfeeding.

In looking to the future, it is appropriate that the focus needs to be on breastfeeding as the normal way to nurture a baby and positive body image related to breasts, rather than a focus on the physiology of the breast as stated in the 1994 Policy. Breastfeeding materials for schools exist in many other countries and include information on statutory and voluntary organisations.

Public Places

Recommendation: There should be no discrimination against breastfeeding over bottle-feeding babies in public places.

Currently, it is difficult to get definitive data on the prevalence of discrimination. There is anecdotal evidence that discrimination against breastfeeding mothers in public still occurs on a regular basis. Nearly half the respondents in a recent study[39] of West African refugee mothers in Ireland, did not breastfeed in public because they perceived there was a negative attitude towards breastfeeding in Ireland. Almost one fifth of the study group stated they thought it was against Irish culture to do so.

Most respondents in a Midland Health Board Survey[40] subjectively felt people get embarrassed when they see a mother breastfeeding, however, the majority did not feel breastfeeding mothers should stay out of sight. It is notable that those mothers who were artificially feeding indicated more concern regarding potential embarrassment (*Table 2).*

Table 2: MHB mother's views on breastfeeding away from home

	'I think that people get embarrassed when they see a mother breastfeeding'	'Breastfeeding mothers should stay out of sight'
Breastfeeding respondents	91% agreed	99% disagreed
Mixed feeding respondents	100% agreed	100% disagreed
Artificially feeding respondents	84% agreed	84% disagreed

The Dublin Community Care Area 1 Survey,[41] found that when members of the general public were asked how they would feel if a woman was breastfeeding near them, 84% said they would 'be delighted/happy/comfortable or have no problem' with a woman breastfeeding nearby. It may be that the mother's concerns that others would be embarrassed are unfounded and other people actually are more positive about breastfeeding than mothers believe.

However, rather worryingly, 63% of the teenage respondents in the Northern Ireland survey[37] of secondary school students expressed the opinion that breastfeeding should be prohibited in public, and boys were less likely than girls to favour it. In this Northern Ireland study, prior exposure to breastfeeding was associated with positive attitudes toward breastfeeding in public.

If public/recreational service providers discriminate against breastfeeding mothers there may be redress under the Equal Status Act, 2000 –on 'gender' and 'family status' grounds. It may also be deemed to be harassment as defined under this Act too. The Equality Authority (set up in 1999) provides advice, assistance and legal representation to those who may have a grievance under the Equal Status Act.

Media

Recommendation: The media should support and promote breastfeeding and portray it as the norm.

As the media generally reflect current public opinion and given that public opinion is at present based on a bottle-feeding culture, it is not surprising that breastfeeding is frequently portrayed in negative terms. Recent research undertaken at University College Cork– as part of a larger study due to be completed/published in late 2003[42] – analysed all the media portrayals of infant feeding in Ireland during March 2002. The researchers found that in all types of media, bottle-feeding is associated with normal ordinary lives. On television and in newspapers they found that bottle-feeding was portrayed as part of the 'scene' while breastfeeding was part of the story line, with far fewer images of breastfeeding being shown. When breastfeeding is mentioned, problems with it are discussed, while problems with bottle-feeding are rarely mentioned. Problems raised ranged from guilt at not breastfeeding, incompatibility of breastfeeding with work, sore nipples/breasts and the association of mothers who breastfeed with 'cows' was also made.

The Midland Health Board survey[40] also addressed this by asking respondents did they agree/disagree with the following statement - 'I think that the media is supportive of breastfeeding'. Mothers who were exclusively breastfeeding were least likely to feel the media was supportive of breastfeeding.

Table 3: MHB mother's views on breastfeeding and the media

'I think that the media is supportive of breastfeeding'

Breastfeeding respondents	42% agreed
Mixed feeding respondents	50% agreed
Artificially feeding respondents	63% agreed

Summary

This section evaluated the impact of the 1994 Policy's recommendations addressing breastfeeding issues outside the realm of the health sector. Overall the influence of these recommendations was shown to be disappointing. Within the Irish school system no concerted efforts were identified which addressed the need to incorporate breastfeeding information into the SPHE or other curricula or extra-curricular models. This was identified as a key necessity to counter negative societal attitudes to breastfeeding.

Some evidence was obtained from within the health employer/public sector of efforts to provide breastfeeding/lactation breaks to employees on return to paid work. But this was not extensive. Some public service employers stated they were awaiting pending legislation before addressing any obligations they may have in this area. Some research and much anecdotal evidence confirmed the perception by mothers of discrimination against breastfeeding mothers in public areas. Discrimination in the media was also identified. On a more positive note the recommendation to increase paid maternity leave to 16 weeks was not only achieved but surpassed.

Section 5

Conclusion

All the sources for this Interim Report considered that the 1994 Policy has stood the test of time in its continuing relevance. Those who contributed to the writing of the Policy are to be commended for their far-sightedness. However, it is clear that no strategic approach was taken toward achieving the targets and recommendations contained in the 1994 Policy. Once the original Committee was disbanded, there was no designated body to drive policy initiatives forward to implementation. Many of the targets and recommendations have therefore not been achieved either within the timeframe or subsequently. This has undoubtedly contributed to Ireland's continuing low breastfeeding rates by comparison with other countries.

Nevertheless, some things have changed for the better as a result of the impetus generated by having a National Breastfeeding Policy for Ireland. There is now a firm basis for progress in the Baby Friendly Hospital Initiative within the health sector, although no maternity hospital or unit has yet reached the standard necessary to achieve 'Baby Friendly' status.

The 1994 Policy rightly focussed on breastfeeding practices within the health services environment. At that time, WHO/UNICEF had identified breastfeeding practices by health workers as having been a major contributor to the global decline in breastfeeding rates. Recommendations pertaining to the wider community were also addressed but not so comprehensively. The positive impact of the 1994 Policy can therefore be seen most forcibly within the health sector. The high level of breastfeeding skills and commitment of the majority of health professionals within the maternity and allied services can, to some extent, be justifiably attributed to the impact of the 1994 Policy. Some changes in the wider community's attitude to breastfeeding can also be seen. However, major cultural and societal shifts in favour of breastfeeding take longer to establish. The climate for breastfeeding promotion, protection and support in Ireland is certainly more favourable as a result of the influence of the 1994 Policy and it provides a good foundation on which to build.

A wide range of proposals for future action have been put forward by the organisations and individuals who responded to the Committee's call for public submissions and these will inform the next stage of the work of the Committee. In its second year of operation, the Committee will proceed towards the development of a strategic framework for breastfeeding in pursuit of the goal of creating a truly breastfeeding supportive culture in Ireland. For this to happen, support needs to come from all sectors of government and all areas of public life in order to re-establish breastfeeding as the universally accepted natural progression following birth. One step towards achieving this objective would be ensuring that strategies, programmes and policies are subjected to mother-baby proofing to ensure that barriers are not put in the way of normal mother-baby relationships such as breastfeeding.

Appendix A:

Respondents to the Public Call for Submissions

The Health Promotion Unit received 40 responses to its public call for submissions, which was advertised at the National Conference on Breastfeeding (October 4th 2002) and in the national newspapers the following week. The public call asked that respondents address the Terms of Reference of the National Committee on Breastfeeding in their submissions.

13 submissions came from individuals. The remaining submissions came from the following bodies or institutions:

Rotunda Hospital, Dublin

Maternity Unit, Waterford Regional Hospital

Baby Friendly Hospital Initiative in Ireland

National Midwifery Advisory Forum

La Leche League of Ireland

La Leche League, Tralee & Killarney

La Leche League, Carlow

La Leche League, Clonakilty

La Leche League, Trim/Summerhill

La Leche League, Arklow

Midwives Association of Ireland

National Maternity Hospital, Holles Street, Dublin

Regional School of Midwifery, Drogheda

Maternity Unit, Wexford General Hospital

Association of Lactation Consultants of Ireland (ALCI)

Breastfeeding Co-ordinator, South Eastern Health Board

Cuidiú Breastfeeding Panel

Our Lady's Hospital for Sick Children, Crumlin

Clinical Midwife Specialists, Mid-Western Health Board

Public Health Nursing Team, South West Area Health Board, Area 4

South West Area Health Board, Breastfeeding Sub-group

Best Health for Children

Community Mothers Programme, Coolock

Public Health Nurses, Community Care Area 1, East Coast Area Health Board

Southern Branch, Institute of Community Health Nursing

Northern Area Health Board's Breastfeeding Steering Group

Appendix B:

The importance of breastfeeding in Ireland

Breastfeeding has nurtured the world's children for thousands of years. The scientific evidence for the importance of breastfeeding in the health and well-being of children, mothers and society is widely available and was recognised in the 1994 National Breastfeeding Policy for Ireland.

In Ireland, information on the importance of breastfeeding often is directed at parents. Breastfeeding is seen in the context of a mother's personal decision and in short-term health effects. However, in countries with high breastfeeding rates, a wider view is taken and breastfeeding is seen as an investment in the future of the society and thus important to the entire country. Ireland has started along this path with a goal in the National Health Strategy (2001) to strengthen the support and promotion of breastfeeding.

Breastfeeding is important for many reasons including the health and well-being of the child and mother, its value to society and for economic reasons. Circa 80% of the cost of the Irish health service is borne by the tax payer[43] so the health costs that may be associated with a decision not to breastfeed are relevant to most of the population. Therefore breastfeeding initiatives are a wise investment.

Costs related to infant feeding can be looked at from two perspectives; the cost of the formula and the cost of ill health. Costs of ill health accrue from acute illnesses in infancy, long-term or chronic health effects in later life and health costs for the mother, as well as costs in relation to employment.

Acute infant illness

Two similar prospective cohort studies from Dundee, Scotland (n=644) and Tucson, Arizona (n=944) determined the excess cost of health service use by artificially fed infants compared with exclusively breastfed infants, for three common illnesses in the first year of life, i.e. lower respiratory tract infection, otitis media, and gastrointestinal illness. Compared with infants who were exclusively breastfed for 3 months or more, there was an excess use of health care services attributed to not breastfeeding which was estimated to cost between $331 and $475 per infant never breastfeed, in the Tucson study[44] There are approximately 35,000 infants born in Ireland each year who are never breastfed.

The Dundee study[1] found that infants who were not breastfed were five times the risk of developing gastrointestinal illness (GI) compared to those who were exclusively breastfed for 13 weeks or more. The economic consequences of this for Scotland were calculated by Broadfoot.[45] Applying these calculations to the Irish birth rate results in a cost of €6.1 million per year for hospitalisations due to GI illness for infants who are not breastfed. This only includes the cost of managing cases of gastroenteritis that require hospitalisation, and does not take account of the financial or emotional costs to the family and the baby. If the breastfeeding rate at 13 weeks increased by 5%, there could be a saving of €300,000 per annum. If the breastfeeding rate at 13 weeks increased to 30% in line with the target of the 1994 Policy, there could be a saving of €1.2million per annum (at 1993 Scottish costs).

Neonatal necrotising entrocolitis (NEC) is a critical illness to which pre-term infants are particularly vulnerable. A 1996 study[46] involving three major Dublin hospitals, found a rate of NEC of 11% in their preterm infants (54/503) with 6 of the 54 affected infants dying of the condition. The disease has been found to be 6-10 times more common in infants who receive no breast milk. In 1990 in the UK it was estimated to cost £5,000 per infant, to treat this condition in the acute stage (there are also long term costs from the resultant damaged bowel).[11] If pre-term infants who were not receiving their own mother's milk, routinely received donor breast-milk from a milk bank run in accordance internationally accredited milk banking guidelines (e.g. the donor breast-milk bank in Co. Fermanagh) the risk of NEC for these infants would be greatly reduced. At present, the only cost to an Irish hospital to receive this donor breast milk is the transport cost.

Breastfeeding is often described as the baby's first immunization giving protection against gastrointestinal and respiratory illness. The breastfed baby's enhanced active immune system is demonstrated when babies who breastfeed are shown to produce a better response to vaccines such as BCG, Hib, and MMR.[12] Therefore increasing breastfeeding rates can contribute to better immune responses to immunisations.

Not breastfeeding is also associated with higher levels of respiratory illness,[3] recurrent wheezing,[2] otitis media[4,5] urinary tract infections[9], atopic disease[6,7,8] as well as lower levels of educational achievement.[18] The importance of breastfeeding in relation to these conditions and other infectious and allergic conditions in childhood continues to be researched. However, attention has increased in relation to the effects of early nutrition on adult health. There may be higher risks associated with not breastfeeding for a number of the conditions that reduce the quality of life and productivity of many Irish people. These conditions include hypertension, obesity, diabetes, some forms of cancer and osteoporosis.

Diabetes

Children who are not breastfed may have a higher risk of both type 1 and type 2 diabetes.[13,14] A UK calculation in 1989,[45] estimated the lifetime cost for one child or adolescent diagnosed with insulin dependent diabetes, inclusive of all diabetes related health care costs, is £45,000, without adjustment for inflation over that time. Ireland has a high incidence of type 1 diabetes in young people under the age of 15 compared to other European countries (16.6 per 100,000). In 1997, there were 140 new cases diagnosed in Irish children. [47]

Cardiovascular disease, blood pressure and obesity

Cardiovascular disease is the single biggest killer in Ireland. Forty-three percent of deaths were attributed to it in 1997. [48] Not breastfeeding, or early introduction of artificial feeding are linked with a greater prevalence of obesity and raised blood pressure in childhood – both markers of adult coronary heart disease.[15-17] These studies also show a dose-response relation, i.e. the greater the duration of breastfeeding, the lesser the risk of obesity and raised blood pressure.

In two of the above studies, the mean difference in blood pressure was 3-4 mmHg. Singhal et al,[16] point out that lowering the population-wide diastolic blood pressure by only 2 mmHg would reduce the prevalence of hypertension by 17%, the risk of coronary heart disease by 6% and the risk of

stroke and transient ischaemic attacks by 15% (US population). Therefore breastfeeding is of greater benefit in lowering blood pressure than the cumulative effect of all other forms of non-pharmacological means of lowering blood pressure i.e. weight loss, salt restriction, or exercise.

Breastfeeding rates are low in lower income groups.[23] Raised blood pressure and obesity are both more common in lower socio-economic groups.[48] Programmes to increase breastfeeding rates in low-income groups may contribute to reducing health inequalities throughout life.

Obesity

The prevalence of overweight and obesity is rising rapidly in Ireland and is the most common nutritional disease in industrialised countries. Obesity is linked to cardiovascular disease, diabetes, joint and mobility problems as well as other conditions. Childhood obesity is related to obesity in adulthood. Infant feeding practices are linked to childhood obesity.

Recent large studies in Germany[17], the USA,[49,50] Scotland[51], and the Czech Republic[52] of the relationship between early nutrition and later obesity, agree there is a reduced risk of obesity with increased duration of breastfeeding predictive of lower obesity rates in later life. Dietz[53], in a commentary summing up these findings, estimates that 15%-20% of the population attributable risk of overweight is due to formula feeding.

Interventions to reduce excess weight tend to have poor results, so prevention of obesity is of prime importance. A risk reduction of 15-20% would make a difference. On a population basis, modifying infant feeding practices to increase breastfeeding rates appears to be achievable and is an inexpensive way of preventing childhood and adolescent obesity.

Maternal obesity

Infant feeding method may also affect the body weight of the mother. Mothers who do not breastfeed are more likely to remain above their pre-pregnancy weight than mothers who breastfeed, thus contributing to long-term obesity.[21]

Blood lipids

A cross-sectional study and systematic review[54] concluded that breastfeeding is consistently associated with higher mean total cholesterol (TC) and low-density lipoproteins (LDL) levels in infancy and lower levels of TC and LDL in adulthood. These results suggest that breastfeeding with its high cholesterol level may act as a stimulus for nutritional programming at a critical period of life. Adult TC levels were 0.2 mmol/l lower in those with a history of having been breastfed compared with those who had been formula fed. Though modest, a reduction in mean TC of this magnitude in adult life would be associated with a reduction in coronary heart disease of approximately 10% based on observational data. This suggests that breastfeeding may have long-term benefits for cardiovascular health.

Breast Cancer

The largest and most comprehensive examination of the impact of breastfeeding duration on the risk of breast cancer (pre or post menopausal) including 30 countries and 50,302 breast cancer

cases and 96,973 controls found the relative risk of breast cancer decreased by 4.3% for every 12 months of (cumulative) breastfeeding in addition to a decrease of 7.0% for each birth. Based on estimates from the research studies, if women in developed countries had 2.5 children on average, by breastfeeding each child for 6 months longer than they currently do, about 5% of breast cancers would be prevented each year. If each child was breastfed for an additional 12 months about 11% breast cancers might be prevented annually.[19] There are obvious economic and social consequences to the mother and society to prolonging breastfeeding as well as the known benefits to the child.

Breast cancer is the commonest cancer among Irish women and its incidence is higher in Ireland than in other EU countries. In 1997, there were 1,721 new diagnoses of breast cancer.[55] To reduce this by 5% could mean 86 less Irish women getting breast cancer per year.

Osteoporosis

Osteoporosis is of growing concern as people live longer. It can result in disablement and the need for long term care. Lactation is associated with a temporary increase in bone turnover that is reversed after weaning. Overall, breastfeeding confers a positive effect on bone mineral density.[20]

Osteoporosis is commonly viewed as a disease of later life. However, there is some evidence that early feeding may affect the risk factors. An Australian study[56] demonstrated a beneficial association ($p=0.0008$) between breastfeeding in early life and bone mass in 8-year-old children born at term, particularly those breastfed for 3 months or longer, which appears biological. If this association is confirmed in other populations and persists until the attainment of peak bone mass then the implication would be that osteoporosis prevention programs need to start very early in the life cycle.

Care for an ill child and employment costs

If an infant becomes ill, a parent may need time off work to take the infant to a doctor. In addition, many childcare settings will not care for an ill child, thus necessitating the parent remaining off work until the child has recovered. There is less absenteeism where mothers continue breastfeeding on return to work. One US study found that formula-fed babies were six times more likely to experience illness resulting in three times as many maternal absences from work.[10] Absences from work cost the employer money, lose income for the parent and affect overall national productivity

Costs of infant formula

Maternity units provide infants who are not breastfed with free infant formula while in hospital. During an average length of stay every healthy bottle-fed infant costs the hospital approximately €9 for artificial formula and teats. Taking account of the current national birth rate and a 63% national artificial feeding rate (1999 Perinatal Statistics) this represents a cost to the health services of €317,520.00 per annum. This estimation does not include the disposal cost (both monetary and environmental) of approx. 635,040 teats and bottles per year. Increasing the breastfeeding rate reduces the cost of purchasing formula and waste charges for the hospital and thus the cost to the health services and ultimately the taxpayer.

A number of submissions to the National Committee on Breastfeeding suggested that mothers not

intending to breastfeed should be asked to bring their own infant formula into the maternity hospital, as happens in some other countries. The idea being that mothers preparing their own babies' feeds in hospital would ensure they learned how to do this correctly while also realising the costs and difficulties in artificially feeding at a time when they could easily change to breastfeeding. This suggestion would require further discussion as it could be argued that all hospital in-patients are provided with free meals.

However, costs could still be reduced in other ways. Though the practice is discouraged, some mothers receive bottle/s of ready to feed formula on discharge to make the first feed/s at home easier. One bottle per non-breastfeeding baby at discharge would cost approximately € 17,600 per annum nationally. Sometimes more than one bottle is given when going home. Breastfeeding babies/mothers receive no equivalent present from the hospital. The giving of free sample products to mothers by health workers is forbidden under the International Code (Art. 7.5) though the Irish legislation is less clear.

In the community, some low-income mothers are provided with supplies of infant formula. In one major health board in 1996 this cost was approximately £90,000 (€114,276).[22] Asylum seekers/refugees are automatically supplied with infant formula in direct provision accommodation – whether they are breastfeeding or not. Both these actions can encourage these mothers to formula feed. If the mother cannot afford to buy infant formula, it is questionable if she should be encouraged not to breastfeed.

The mothers receiving free infant formula are also receiving free health care for their infants. The higher rates of illness in these non-breastfeeding infants add further costs to the health service. A US study found that the medical costs were twice as high for a population of low income families receiving free medical services and free formula (i.e. formula feeding) than it was for a population of low income families receiving free medical services and food vouchers (i.e. breastfeeding). Overall, the Women Infant Children (WIC) Services, for low income families in the US, estimated that during the first 180 days of life, each breastfeeding baby cost $478 less than its formula fed counterpart.[57]

Even when the cost of providing breastfeeding support programs is included, the cost savings are still seen and breastfeeding duration is increased.[58]

At an individual family level a decision not to breastfeed has costs. Formula feeding for 6 months requires approx. 22 kg of powdered formula milk. Based on a random sample of infant formulae from a suburban owner-run supermarket this represents a cost of approx. €230. Add to this the cost of feeding bottles, teats, bottle brush, sterilising equipment; plus the cost of boiling the water to make up the feeds and wash the equipment, as well as for warming the feeds. Babies who are not breastfed are more likely to be ill. Therefore add to the list the cost of extra visits to the GP and prescription costs and the total cost of a decision not to breastfeed easily exceeds €500 for the first six months. The greater likelihood of a loss in wages for parents who have to stay off work to care for a sick infant can also increase the cost further.

As breastfeeding has been shown to affect a wider society than just the individual family, there is a need for a whole society approach to protecting and enabling breastfeeding to ensure both families and society benefit.

Appendix C:

BFHI further details

Summary of self-appraisals of the 18 hospitals participating in the BFHI plus telephone survey of the units not participating in BFHI.

Step One : Have a written breastfeeding policy that is routinely communicated to all health care staff.

Does the maternity unit have a written breastfeeding policy?	18
Is the breastfeeding policy posted or displayed in all areas of the health facility which serve mothers and babies?	10
Is compliance with the policy compulsory for all health care staff?	15
Is there a procedure in place to audit the policy and to ensure continuing compliance?	4

Step Two : Train all health care staff in skills necessary to implement the policy.

Are all staff oriented to the breastfeeding policy of the hospital when they take up their posts?	12
Are new staff responsible for assisting mothers and babies with breastfeeding fully trained in breastfeeding and lactation management within 6 months of beginning work?	4
Has the hospital arranged for specialized training in lactation management for specific staff members? (above 18 hour course)	16

Step Three : Inform all pregnant women about the benefits and management of breastfeeding.

Is breastfeeding information provided to all women, including those who do not attend antenatal classes?	16
Do antenatal records indicate whether breastfeeding has been discussed with the pregnant woman?	13
Have written materials given to pregnant women been reviewed to ensure they are accurate, effective and consistent?	15
Are pregnant women protected from oral or written promotion of and group instruction for artificial feeding?	13

Step Four: Help mothers initiate breastfeeding within a half-hour of birth.

Are mothers with vaginal deliveries given their babies to hold, immediately or within a maximum of half an hour, following completion of the second stage of labour, with full skin-to-skin contact?	20
Are babies born by Caesarean section given to their mothers with skin-to-skin contact within a half hour of being able to respond to their babies?	16
Are mothers allowed to hold their babies like this for at least the first hour or for as long as they like in an unhurried environment?	16
Are all mothers offered help to initiate breastfeeding during this first hour or as soon as the baby is ready?	22
Is skin contact encouraged and provided for all mothers, regardless of feeding intention?	15

Step Five: Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

Are all mothers offered further assistance with breastfeeding within six hours of delivery?	22
Are mothers of babies in special care helped to establish and maintain lactation by frequent expression of milk (at least 6-8 times in 24 hours)?	20

Step Six : Give newborn infants no food or drink other than breast milk, unless medically indicated.

Do breastfeeding babies receive only breast milk unless clinically indicated or as a result of fully informed parental choice?	16
Is all promotion for infant formula, other breast milk substitutes, bottles, teats and dummies absent from the facility?	12
Are regular checks made to ensure that sample packs and/or publications produced by external companies are free from promotion for breast milk substitutes, bottles, teats or dummies?	12

Step Seven : Practice rooming-in -- allow mothers and infants to remain together 24 hours a day.

Do mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, regardless of feeding method, unless separation is medically indicated?	11

Step Eight : Encourage breastfeeding on demand

Are mothers advised that there should be no restrictions on the frequency or length of breastfeeds?	19
Are mothers advised to breastfeed their babies whenever their babies are hungry and as often as their babies want to breastfeed?	19
Is breastfeeding permitted in all public areas of the hospital's premises?	20

Step Nine : Give no artificial teats or dummies to breastfeeding infants

Are breastfeeding babies cared for without using artificial teats?	16
Are breastfeeding babies cared for without using dummies?	16
Are breastfeeding mothers advised not to give bottles or dummies to their babies?	20
Are any necessary supplements or expressed breast milk fed to breastfed babies without using bottles and teats?	15

Step Ten : Foster the establishment of breastfeeding support groups and refer mother to them on discharge from the hospital or clinic.

Are breastfeeding mothers given contact details of local breastfeeding counsellors or support groups?	22
Is the mother's public health nurse informed within 48 hours of her discharge from the hospital?	19
Are mothers given written breastfeeding information on discharge?	21

Note that this data is self-reported. Some data is from 1999 and may no longer be accurate. Hospitals who completed forms in 1999 and 2000 have been asked to re-do them in 2003.

Appendix D:

Colleges from whom curriculum information was requested

Faculty of Nursing	Dublin City University
Beaumont School of Nursing	Beaumont Hospital, Dublin
School of Nursing	James Connolly Memorial Hospital
Faculty of Nursing & Midwifery	University College Cork
School of Nursing	University College Hospital, Cork
Higher Diploma in Public Health Nursing	University College Cork
School of Nursing	Bons Secours Hospital, Cork
School of Midwifery	Unified Maternity Services, Cork
Director of Nursing & Midwifery Studies	The University of Dublin
The Adelaide & Meath School of Nursing	The Meath & Adelaide Hospitals, Dublin
School of Paediatric Nursing	National Children's Hospital, Dublin
St. James's School of Nursing	St. James's Hospital, Dublin
School of Midwifery	The Rotunda Hospital, Dublin
Director of School of Nursing & Midwifery	University College Dublin
School of Nursing	Mater Misericordiae Hospital, Dublin
School of Midwifery	Coombe Women's Hospital, Dublin
School of Midwifery	National Maternity Hospital, Dublin
School of Nursing	St. Vincent's University Hospital, Dublin
School of Nursing	St. Michael's Hospital, Dublin
School of Nursing	Our Lady's Hospital for Sick Children, Dublin
School of Nursing	The Children's Hospital, Dublin
Course Coordinator	Higher Diploma in Public Health Nursing, Dublin
Higher Diploma in Paediatric Nursing	UCD, Dublin
Director of School of Nursing & Midwifery	Institute of Technology, Athlone, Co. Westmeath
School of Nursing & Midwifery	Dundalk Institute of Technology
School of Nursing & Midwifery	Our Lady of Lourdes Hospital, Drogheda
Faculty of Nursing	RCSI, Dublin
School of Nursing	Longford/Westmeath General Hospital
School of Nursing	Tullamore General Hospital
School of Nursing	Portlaoise Hospital
School of Nursing	Galway-Mayo Institute of Technology
School of Nursing & Midwifery	Mayo General Hospital
School of Nursing & Midwifery	University College Hospital, Galway
School of Nursing & Midwifery	Portiuncula Hospital, Co. Galway
School of Nursing & Midwifery	Letterkenny Institute of Technology
School of Nursing & Midwifery	Letterkenny General Hospital, Co Donegal
School of Nursing & Midwifery	Limerick Regional Hospital
Faculty of Nursing & Midwifery	St. Angela's College, Sligo
School of Nursing & Midwifery	Sligo General Hospital
Faculty of Nursing & Midwifery	Tralee Institute of Technology, Co. Kerry
School of Nursing & Midwifery	Tralee General Hospital, Co Kerry

Faculty of Nursing & Midwifery	Waterford Institute of Technology
School of Nursing & Midwifery	Waterford Regional Hospital
School of Nursing & Midwifery	Wexford General Hospital
School of Nursing & Midwifery	St. Luke's Hospital, Kilkenny
School of Nursing & Midwifery	Cavan General Hospital
School of Nursing & Midwifery	St. Joseph's Hospital, Clonmel, Co. Tipperary
Faculty of Medicine & Health Services	University College Galway
Professor of Obstetrics & Gynaecology	University College Galway
Professor of Paediatrics	University College Galway
Faculty of Medicine	University College Cork
Course Co-ordinator	Higher Diploma in Public Health Nursing, Cork
Professor of Paediatrics	University College Cork
Professor of Obstetrics & Gynaecology	University College Cork
Faculty of Health Science	The University of Dublin
Professor of Obstetrics & Gynaecology	Coombe Women's Hospital, Dublin
Professor of Paediatrics	The Children's Hospital, Dublin
Paediatric Surgeon	University College Dublin
Professor of Nutrition	University College Dublin
Faculty of Medicine	St. Vincent's University Hospital, Dublin
Professor of Obstetrics & Gynaecology	National Maternity Hospital, Dublin
Professor of Obstetrics & Gynaecology	Coombe Women's Hospital, Dublin
Professor of Paediatrics	Rotunda Hospital, Dublin
Professor of Paediatrics	Our Lady's Hospital for Sick Children, Dublin
Director of Midwifery Services	Bons Secours Hospital, Cork
Matron	Mount Carmel Hospital, Dublin
Course Director	Nutrition & Dietetics, DIT, Kevin Street, Dublin
Co-ordinator	Higher Diploma in Practice Nursing, RCSI
Breastfeeding Co-ordinator	Unified Maternity Services, Cork
Department of General Practice	NUI, Galway
Department of General Practice	RCSI, Dublin
Department of Community Health	Trinity College, Dublin
	Irish College of General Practitioners
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