Breastfeeding is a public health priority, with the potential for significant health impact and economic benefits from even modest improvements in breastfeeding rates and duration (1,2). However, despite many initiatives to promote and protect breastfeeding, reported rates have been resistant to change in many countries. The WHO European region has particularly low rates with just 25% of infants exclusively breastfed at 6 months of age in 2015 (3).

The paper by Theurich et al in this issue of JPGN (4) presents information from a survey completed by representatives of national breastfeeding committees and initiatives from 11 European countries. They report considerable variation in breastfeeding rates, methodology used to collect data and mechanisms for the support, protection and promotion of breastfeeding between countries, despite the existance of national plans in 6 of the 11 countries. The authors conclude that governments need to commit both financially and politically to evidence-based monitoring and promotion of breastfeeding. They also call for renewed efforts to promote collaboration between countries in Europe, including a sustainable platform for information exchange.

The large variation in reported breastfeeding rates between countries in this survey is particularly notable. For example, between 56% and 98% of infants were reported to receive any human milk directly after birth, whilst 13-39% were reported to be exclusively breast-fed at 6 months (4). These differences were considered at least in part to reflect differences in the methods used to collect data, which included documentation by health professionals, national reports and surveys. The latter were not always representative of the whole population; some were susceptible to bias towards groups with higher income and social status, which may result in failure to identify low breastfeeding rates in vulnerable groups who might benefit most from interventions. The definitions used for exclusive, full and partial breastfeeding were also not consistent, making comparisons difficult. This problem is not certainly not confined to the European countries included in the survey.

In a recent paper, Victora et al (1) noted that the quality of data on breastfeeding practices from high income countries (HIC) is considerably worse than that from low or middle income countries

(LMIC). Complete data were obtained from 127/139 LMIC but data were available from only 37/75 HIC, many providing a sub-set of relevant indicators. This disparity was largely because LMIC were more likely to conduct regular surveys - for example Health & Demographic Surveys or Multiple Cluster Indicator Surveys – and to use standardised WHO indicators for the study of infant feeding practices, which facilitate comparisons within and between countries, and the evaluation of trends over time. By contrast, many HIC select their own indicators and definitions. For example, the WHO indicator 'Early initiation of breastfeeding' is defined as the proportion of children born in the last 24 months who were put to the breast within an hour of birth. By contrast, in HIC 'initiation of breastfeeding' more typically refers to whether the infant is put to the breast or receives any breastmilk after birth, rather than to initiation within the first hour.

Another problematic area is measuring the duration of exclusive breastfeeding, which is important in the context of assessing adherence to the WHO recommendation that infants should be exclusively breastfed for the first 6 months of life. The WHO indicator 'Exclusive breastfeeding under 6 months' is defined as the proportion of infants aged 0-5 months who are fed exclusively with breast milk, based on the diet during the 24 hours before the survey (to avoid recall bias). This records the proportion of infants aged from birth to 5 months who have been exclusively breastfed during the last 24 hours. By contrast, many HIC record the proportion of infants who are still exclusively breastfed at around 6 months. A further complication is whether the mother is asked about infant feeding during the last 24 hours, or for the whole period since birth. Both approaches have advantages and disadvantages, which might also depend on the intended use of the data. For example, exclusive breastfeeding since birth may be important when evaluating the impact of brief exposure to allergens from infant formula or solid foods but not so if the purpose is to monitor population breastfeeding practices. However, it is difficult to directly compare data obtained using different definitions.

Reliable data on breastfeeding and indeed other aspects of infant feeding are essential to identify trends, problems and to evaluate the effectiveness of solutions, as well as making comparisons between countries. There is an argument for tailoring indicators, timing and method of data collection for individual countries reflecting the organisation of healthcare services, routine contact with health professionals and local concerns and challenges. For example, in countries where there is a steep decline in breastfeeding and exclusive breastfeeding over the first weeks of life, data collected at two or more early time-points might be most helpful. Where breastfeeding rates are already high during the first months, it may be more informative to focus on longer term practices, as measured by the WHO indicators for 'continued breastfeeding at 1 year' and 'continued breastfeeding at 2 years'. Nevertheless, having a small set of agreed standardised indicators with clear definitions and methodologies for collection that are consistently applied would be beneficial, and would help to identify real differences between countries. Indeed the need for standardised monitoring of breastfeeding rates was emphasised as an area requiring more work in an evaluation of the 'Blueprint for Action' to protect, promote and support breastfeeding in Europe published in 2010 (5).

Theurich et al rightly highlight the need for multifaceted, effective and evidence-based efforts to increase national and European breastfeeding rates and emphasise the importance of collaboration between countries in the WHO European region to achieve this. A key component of such efforts should be the systematic collection of good quality data.

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