Report from Italy, 2023

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WBTi
World Breastfeeding Trends Initiative (WBTi)

The World Breastfeeding Trends Initiative (WBT*i*)

Italy
2023

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NOTE ON TERMINOLOGY

This document pays special attention to the gender perspective. Where possible, the correct declination of masculine and feminine has been used. When used, the masculine is to be understood as referring to female and male newborns and young children, men and women, male and female volunteers, and healthcare personnel in general. The terms “mother” and “father” mean any form of maternity, paternity and parenthood and, when the term “family” is used, it is intended to include the multiple types of existing families. The term “partner” indicates the person who is close to the mother, whether it is the father, the other parent, a trusted person or a caregiver. These terms are used interchangeably to indicate people who care for babies and children in different contexts.

World Breastfeeding Trends Initiative (WBT*i*)

The Breastfeeding Promotion Network of India (BPNI)/International Baby Food Action Network (IBFAN) South Asia and the World Breastfeeding Trends Initiative (WBT*i*) Global Secretariat launched the innovative tool in 2004 at a South Asia Partners Forum.
The WBT*i* assists countries to assess the status and benchmark the progress in implementation of the *Global Strategy for Infant and Young Child Feeding* (GS) in a standard way. It is based on the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBT*i* programme calls on countries to conduct their assessment to measure strengths and weaknesses on the ten parameters of policy and programmes that protect, promote and support optimal infant and young child feeding (IYCF) practices. It maintains a global data repository of these policies and programmes in the form of scores, colour codes, report and report card for each country The WBT*i* assessment process brings people together and encourages collaboration, networking and local action. Organisations such as government departments, United Nations (UN), health professionals, academics and other civil society partners (without conflicts of interests) participate in the assessment process by forming a core group with an objective to build consensus. With every assessment countries identify gaps and provide recommendations to their policy makers for affirmative action and change. The WBT*i* Global Secretariat encourages countries to conduct a re-assessment every 3-5 years for tracking trends in IYCF policies and programmes.
Adequate nutrition of infants and young children is the foundation of their future health and well-being. As a result, it has a significant impact on public health. The GS and the Innocenti Declaration are internationally recognized as key elements of any plan that aims to improve feeding practices, particularly breastfeeding. Countries that have implemented the GS and the Innocenti Declaration show improvements in breastfeeding rates: when interventions at different levels are combined, a multiplication effect on outcomes is observed.

Vision and mission

The WBT*i* envisages that all countries create an enabling environment for women to be successful in breastfeeding their babies optimally at home, health facilities or at work places. The WBT*i* aspires to be a trusted leader to motivate policy makers and programme managers in countries, to use the global data repository of information on breastfeeding and IYCF policies and programmes. The WBT*i* envisions serving as a knowledge platform for programme managers, researchers, policy makers and breastfeeding advocates across the globe. The WBT*i*'s mission is to reach all countries to facilitate assessment and tracking of IYCF policies and programmes through mobilising local partnerships without conflicts of interest and building a data repository for advocacy.

Ethical policy

The WBT*i* follows the 7 principles of IBFAN and does not seek or accept funds donation, grants or sponsorship from manufacturers or distributors and the front organisations of breastmilk substitutes, complementary foods, infant and young child feeding related products like breast pumps, or any such organization that has conflicts of interests.

The WBT*i* has identified 15 indicators in two parts, each indicator having specific significance.

Part I deals with policy and programmes (indicators 1-10)	Part II deals with infant feeding practices (indicators 11-15)
1. National Policy, Governance and Funding 2. Baby Friendly Hospital Initiative/Ten Steps to Successful Breastfeeding 3. Implementation of the International Code of Marketing of Breastmilk Substitutes 4. Maternity Protection 5. Health and Nutrition Care Systems (in support of breastfeeding and IYCF) 6. Counselling Services for Pregnant and Breastfeeding Mothers 7. Accurate and Unbiased Information Support 8. Infant Feeding and HIV 9. IYCF during Emergencies 10. Monitoring and Evaluation	11. Timely initiation of breastfeeding within one hour of birth 12. Exclusive breastfeeding for the first six months 13. Continued breastfeeding at 12-15 months* 14. Bottle feeding 15. Complementary feeding – introduction of solid, semi-solid and soft foods

* The recommended WBT*i* 2019 indicator 13 would be the median duration of breastfeeding (in months). This was the indicator used for the 2018 assessment in Italy, and it referred to a 2013 national survey. Considering that a) the reported value would be the same old one, and b) the median duration of breastfeeding is no longer included by WHO in its 2021 list of indicators for assessing IYCF practices, it was decided to replace it with continued breastfeeding at 12-15 months, a more easily interpretable indicator and one whose value would reflect the current national situation.

Each indicator used for assessment has the following components:

- One or more key questions that need to be investigated.
- Background on why the practice, policy or programme component is important.
- A list of key criteria to be considered in assigning scores and identifying strengths and weaknesses to document gaps and issue recommendations.
- Other useful information.
- Conclusions with a list of gaps and recommendations.

Part I. Policies and programmes

The criteria for assessment have been developed for each of the ten indicators, based on the GS and the Innocenti Declaration, and have been updated with most recent developments in this field. For each indicator, there is a subset of questions and criteria. Answers to these can lead to identification of the gaps in policies and programmes required to implement the GS. The assessment can reveal how a country is performing in a particular area of action on breastfeeding and IYCF. Additional information, which is mostly qualitative, is also sought on these indicators. Such information is used to elaborate the report; however, it is not taken into account for scoring or colour coding.

Part II. IYCF practices

These indicators ask for specific numerical data on each practice, based on data from random national household surveys. These five indicators are based on the WHO's tool, to allow for

comparison among countries. However, additional information on some other practice indicators such as 'continued breastfeeding' and 'adequacy of complementary feeding' is also sought.

Scoring and colour-coding

Policy and programmes indicators 1-10

Once the information on the WBT*i* questionnaire is gathered and analysed, it is then entered into the web-tool. The tool provides a weighted score for each individual subset of questions in indicators 1-10 (policies and programmes). Each indicator has a maximum score of 10. The total for the ten indicators has a maximum score of 100. The web tool also assigns colour codes (Red/Yellow/Blue/Green) to each indicator as per the WBT*i* Guidelines for Colour-Coding based on the scores achieved.

Indicators on IYCF practices 11-15

These indicators are expressed as percentages or absolute numbers. Once the data is entered, the tool assigns colour codes as per the Guidelines.

The WBT*i* Tool provides details of each indicator in subset of questions, and weightage of each.

Global acceptance of the WBT*i*

The WBT*i* met with success in South Asia during 2004-2008 and, based on this, the WBT*i* was introduced to other regions. By now, more than 100 countries have been trained in the use of WBT*i* tools and 97 have completed the assessment and filed a report. Many of them repeated assessments during these years.

In 2011, the BMJ published the news that 33 countries had reported on the WBT*i*.[1]. Two peer reviewed publications in international journals added value to the impact of WBT*i*, when 40 countries had completed their reports in 2012,[2] and when 84 countries had completed them in 2019.[3]

The WBT*i* has been accepted globally as a credible source of information on IYCF policies and programmes, and has been cited in global guidelines and other policy documents, e.g. WHO National Implementation of BFHI in 2017,[4] and IFE Core group's Operational Guidance on Infant Feeding in Emergencies in 2017.[5]

Completing the WBT*i* assessment is one of the seven policies asked by the Global Breastfeeding Collective (GBC), a joint initiative by UNICEF and WHO to accelerate progress towards achieving the WHA target of exclusive breastfeeding to 50% by 2030. The Global Breastfeeding Scorecard for tracking progress of breastfeeding policies and programmes, developed by the GBC, has identified a target that at least three-quarters of the countries of the world should be able to conduct a WBT*i* assessment every five years by 2030.[6] The WHO/UNICEF/IBFAN report on implementation of the International Code of Marketing for Breastmilk Substitutes and the Global database on the Implementation of Nutrition Action (GINA) of WHO also use WBT*i* as a source.[7] Global researchers have used WBT*i* findings to predict possible increase in exclusive breastfeeding with increasing scores and found it valid for measuring inputs into the GS.[8] In addition, PhD students have used WBT*i* for their research work, and New Zealand used it for developing its National Strategic Plan of Action on breastfeeding 2008-2012.

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7. https://extranet.who.int/nutrition/gina/
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Introduction

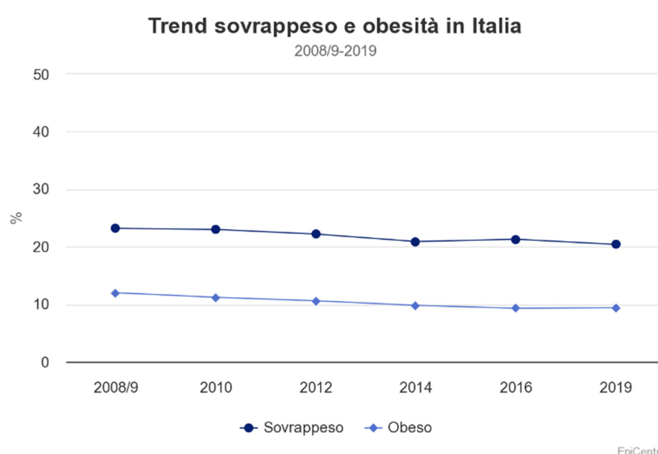
The resident population of Italy on 1 January 2023 was 58,851,000, 179,000 less than the previous year, a reduction of 3%. The trend towards population decline, therefore, continues, but with a lower intensity compared to both 2021 (-3.5%) and 2020 (-6.7%), years during which the effects of the pandemic accelerated a process that had already begun in 2014. Although the resident population in 2022 shows a decrease similar to that of 2019 (-2.9%), there is a significantly higher demographic decline in the South of Italy (-6.3%). The Centre (-2.6%) and especially the North (-0.9%), despite a negative demographic balance, have better values compared to the national average. On a regional level, the population is only increasing in Trentino-Alto Adige (+1.6%), in Lombardy (+0.8%) and in Emilia-Romagna (+0.4%). The regions where the population has been reduced the most are Basilicata, Molise, Sardinia and Calabria, all with growth rates exceeding -7%. On a national basis, the decline in the population is the result of an unfavourable demographic dynamic, which sees an excess of deaths over births, not compensated by migration from abroad. In 2022, there were 713,000 deaths and 393,000 births, a new historic low for the latter, with a natural balance of -320,000 people.

Life expectancy at birth in 2022 was estimated at 80.5 years for men and 84.8 years for women; only for the former is there a recovery quantifiable in approximately 2.5 months of extra life compared to 2021. For women, however, the value of life expectancy at birth remains unchanged compared to the previous year. Survival levels in 2022 are still below those of the pre-pandemic period, recording values 6 months less than 2019, among both men and women.[1] After the slight increase in the average number of children per woman that occurred between 2020 and 2021, the decline in the rate of fertility resumed, with a value of 1.24 children per woman in 2022, the same level recorded in 2020. The trend towards a reduction in fertility, already underway for several years, continues, with the average age at childbirth stable compared to 2021: 32.4 years.

Italy is also one of the countries in Europe with the highest prevalence of overweight and obesity in boys and girls, although a decreasing trend has been noted in recent years. In 2019, 20.4% were overweight and 9.4% obese (using the threshold values of the International Obesity Task Force); males have slightly higher obesity values than females (9.9% vs 8.8%). A clear geographical trend is clear, with Southern regions showing higher values of overweight in both genders. Higher obesity rates are also observed in families with disadvantaged socioeconomic conditions and among boys and girls who were never breastfed or breastfed for less than one month.[2,3]

Figure 1 shows the trend in overweight (dark blue line) and obesity (light blue line) rates in the 8-year age group between 2008/09 and 2019. Despite a general decrease, a north/south gradient remains, to the detriment of the south.[2]

Figure 1 Overweight and obesity in 8 years old boys and girls (NIH data)



Breastfeeding is universally recognized as the norm for infant feeding and is considered a strategic public health responsibility, not just a matter of lifestyle choice.[4,5] The implications of short-, medium- and long-term breastfeeding for the health of children, mothers and society are well documented.[6-8] Optimal breastfeeding practices are associated not only with a decrease in the risk of acute diseases (intestinal infections, otitis media, asthma, respiratory infections and sudden infant death), but also with a reduction in non-communicable diseases (obesity, cardiovascular diseases and diabetes mellitus).[9,10] Breastfeeding represents a window of opportunity for the prevention of obesity in Europe and especially in Italy.[11-13] Note that obesity contributes to 2-8% of health expenditure in Europe.[14] Given these documented health and economic consequences, and the limited results that can be achieved with therapy, breastfeeding protection, promotion and support have been identified as public health strategies and priorities for optimal nutrition and for their contribution to controlling the epidemic of overweight, obesity and related non-communicable diseases in adulthood.

As a public health measure, WHO recommends exclusive breastfeeding for the first six months of life, followed by the introduction of complementary foods while breastfeeding continues for up to two years and beyond.[15] This global recommendation has been implemented by numerous European institutions, organizations and professional associations,[16] including the Italian MOH.[17] Despite this, in Italy, breastfeeding rates, and in particular those of exclusive breastfeeding, are not monitored at national level according to WHO recommendations; there are only some data coming from the Surveillance of Children 0-2 years old carried out by the NIH, but these data are far from meeting WHO targets . Indeed, only 30% of boys and girls in the 4–5-month age group are exclusively breastfed, with a range between 13.5% and 43.2%, with a high regional variability and lower rates in Southern regions. About 13% of children are reported as never breastfed, with a range between 7% and 17.2%, higher in Southern regions.[3]

In 2002, WHO Member States adopted the GSIYCF (hereinafter the GS), which calls for the development of integrated national policies for the protection, promotion and support of appropriate infant feeding practices. The GS complements the International Code on Marketing of Breast-milk Substitutes (hereinafter International Code).[18] Furthermore, the Innocenti Declaration,[19] the Baby-Friendly Hospital Initiative (BFHI),[20] the WHO Operational Plan for the Nutrition of Mothers, Infants and Children,[21] the World Health Assembly's 2025 Global Nutrition Goals,[22] and the Global Breastfeeding Collaboration[23] play an important role in improving breastfeeding rates and monitoring progress.

Breastfeeding must be framed as a matter of human rights: the right to life, survival and development; the right to have clear, unbiased information free from commercial interests; the right to have adequate nutrition; the right to live in a safe, clean, healthy and sustainable environment; the right to maternity protection in the workplace; the right to the highest possible level of health for boys and girls and for mothers and fathers/partners; the right to an adequate standard of living. Furthermore, breastfeeding is a social equalizer and can contribute to our community's efforts to eliminate poverty and challenge inequalities. Therefore, it is necessary to frame the issue in terms of equity, as well as economic and environmental sustainability: inequalities and poverty are identified as increasing problems in many societies. Accessing infant formula has very high costs and this can easily overload a family budget.

Breastfeeding cannot be considered a private matter between mother and child: the way in which a mother feeds her baby affects our planet and the climate. Supporting mothers and parents to breastfeed helps mitigate the damage caused to our environment, contributing to reduce greenhouse gas emissions, conserve water and limit the production of waste. This applies to all countries in the world, industrialized or developing. This is an unrecognized and unappreciated contribution that women make to families and communities around the world to reduce the impact on climate

change. We need to increase environmental awareness about the impact of formula feeding. And it is necessary to increase breastfeeding rates in order to mitigate the harm caused by formula consumption. [24,25]

In February 2022, the amendments to articles 9 and 41 of the Italian Constitution were approved, which introduced the protection of the environment, biodiversity and animals among the fundamental principles of the Constitutional Charter. With the modification of Article 9, the Constitution introduced the protection of the environment, biodiversity and ecosystems among the fundamental principles, also in the interests of future generations. The reform also impacted on the second paragraph of Article 41. The new formulation postulates that private economic activity is free and cannot be carried out in conflict with social utility or "in such a way as to cause damage to health, environment, security, freedom and human dignity". The article also specifies that the law determines the appropriate programmes and controls, so that public and private economic activity can be directed and coordinated "for social and environmental purposes".

Until some time ago, the environment was understood in the Constitution as a place for the person and the priority was the well-being of living beings. Today, the environment is considered a legal matter and an asset to be protected; no longer the property of mankind, but crucial to the survival of all of us. The environment assumes constitutional status and, as such, it must be guaranteed by state and regional laws which will have to be adapted, since otherwise they will be subject to censure by the Constitutional Court. The flora, fauna and ecosystems in their entirety will enter the courtrooms, giving rise to a green revolution, in the hope that it is not just a slogan and that greater prominence and renewed strength will be given to issues and commitments supported over the years in defence of biodiversity.

This change paves the way for a new relationship between public power and the market, with a possible consequent re-expansion of the role of the State in the economy, in line with recent European policies. Large companies intending to access the European market, including those based outside the European Union, are asked to implement systems and processes suitable to prevent (and, where this is no longer possible, to alleviate) the negative impact on human rights and the environment caused by their activity and along their entire production chain.

In light of the above, this constitutional reform has been greeted by various people in the fields of science, politics, anthropology, the business world and activism as an occasion, an opportunity for environmental protection to enter concretely in the minds and plans of all of us and in particular with respect to health and the right to breastfeed and to be breastfed.[26]

Table 1 offers an overview of the policies currently existing in Italy on breastfeeding, infant feeding and the BFHI.

Table 1. Summary state of the art of policies and programmes on breastfeeding and infant feeding.

National policies and programmes on breastfeeding, infant feeding or nutrition.	Yes	Only for breastfeeding, not for IYCF. Generic national operational programme, but some regions have adopted the BFHI and implement support actions in line with it. There is no budget dedicated to breastfeeding, infant feeding and nutrition.
National breastfeeding and infant feeding committee.	No	Only a technical advisory group, not a real and operational committee.
Number of Baby Friendly hospitals.	34	There is a national commitment to the BFHI, but not an obligation for all hospitals to join.
Percent of births in Baby Friendly hospitals.[27]	5,7%	More in the northern and central regions than in the southern ones (inequalities).
Monitoring of breastfeeding rates.	Yes/No	Continuous or periodic data collection limited to some regions. There is no national monitoring system (with the exception of a data collection system for vaccinations at 3, 5, 11 and 18 months in a sample of regions). ISTAT has included some questions on breastfeeding in its national surveys on the health of women and children, carried out every 4-5 years (the last report dates back to 2013).

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Assessment process followed in Italy

Report 2018

Two Italian healthcare workers, both paediatricians, participated in a 3-day international training course (Geneva, May 2015, and Vilnius, December 2017) to learn how to plan, carry out and report a WBT*i* assessment. Indicators, methods and systems for assigning scores were subsequently discussed within IBFAN Italy working groups (medical, nursing, obstetric and legal staff, as well as mothers), and specific tasks were assigned to some people based on their interests and professional skills. The preliminary results were eventually verified by pairs of people.

At the end of November 2017, before the second course in Vilnius, a first report had already been drafted. This draft was shared with members of the 10 associations and groups of mothers belonging to CIANB (Italian Coalition on Infant and Child Nutrition) to find a consensus on the recommendations, to identify any other shortcomings and gaps, and to verify that major changes in the situation in the country since the project began had not passed unnoticed. All the people involved in IBFAN Italy working groups and the members of CIANB had no conflicts of interests, respected the International Code and collaborated in the WBT*i* assessment following the required methods. Finally, the two trained health workers compared their respective drafts and discussed how to activate an expanded group of health professionals.

A formal contract between IBFAN Italy and IBFAN Asia was signed in January 2018. Given the tight delivery deadline, the two coordinators proceeded to update the indicators based on available data and information. In April 2018, the final draft of the report was reviewed by IBFAN Italy working groups, to approve the final text. The full report was sent to IBFAN Asia at the beginning of May 2018 for an initial check of completeness and consistency with their approach. The final report was then sent to the following institutions:

- Technical Advisory Committee on breastfeeding of the Italian Ministry of Health (TAS);
- Italian National Committee for UNICEF;
- Italian network of Baby Friendly hospitals and communities;
- Italian Breastfeeding Movement (MAMI).

The report was published at the end of September 2018 and it was launched, and subsequently disseminated, during a public event held in November 2018 in Rome. During this event, the report was illustrated and discussed, with emphasis on the need to continue and to update monitoring, to verify changes and develop new recommendations. Concrete ideas were also solicited on how to put the recommendations into practice, in an attempt to involve as many institutions, associations, groups of health professionals and mothers and parents as possible. It was thought that the WBT*i* assessment could be repeated after 3-5 years. Finally, it would have been important to find an agreement at the European level between countries that have joined the WBT*i* to discuss and possibly implement activities and monitoring at a broader level.

Report 2023

Based on the experience of the 2018 report, the highlighted gaps and the recommendations made, the first step towards the 2023 assessment was an effort to increase the number of healthcare personnel in the core drafting and stakeholder groups, so that the WBT*i* report, consistently with the international indications of WHO, UNICEF and IBFAN, would increasingly represent a shared lens on the GS in multiple sectors, in particular the institutional and academic ones, such as universities, often and unfortunately with conflicts of interests. The WBT*i* report should also become a strategic tool to evaluate the impact of Italian policies and programmes on breastfeeding rates, considered synthetic indices of maternal and child health, an assessment that should be followed by specific action plans and national monitoring of breastfeeding rates. Collaboration with research bodies is therefore valuable for developing specific recommendations and comparing Italy to other countries.

To achieve these objectives, we proceeded as described below. In July 2022, four new health professionals and members of NGOs were trained, with online training promoted by the international WBT*i* network. These people have been added to the previous collaborators for a total of six people trained in the core team (one trained person is no longer active). These trained people coordinated the working groups, together with three people who edited the 2018 report. All these people were trained on the new WBT*i* tools and guidelines.

Another important aspect was the involvement of relevant health and academic institutions. The 2023 report, in addition to the organizations of the previous report, saw the participation of the National Institute of Health (NIH), the public health technical and scientific body of the Italian National Health Service, of the Sant'Anna School of Advanced Studies in Pisa (with the involvement of more sectors than in the previous report), and of two universities, UNICamillus and LUMSA.

The activity that led to the preparation of the 2023 Report began at the end of 2022 with the activation of the core drafting group and continued with the involvement of all the partners in an online plenary meeting on 27 March 2023. Subsequently, the working groups worked until the beginning of August 2023. August 2023 was then used to share scores and contents with the core editorial team. The first draft was developed in September 2023 and its dissemination to the various partner institutions was scheduled for October 2023.

During WBW, an online webinar was organized on 7 October 2023 in which the results were presented and compared to those of 2018. The update of the WBT*i* Italy and IBFAN Italy websites will follow. The 2023 report will also be presented at the Italian BFHI network conference in November 2023, as well as at various events during 2024, with the collaboration of the various partner organizations that have joined the WBT*i*.

List of partners for the assessment process

Report 2018

IBFAN Italy coordinated the process with the help of 12 organizations:
- ACP - Cultural Association of Paediatricians
- AICPAM - Italian Association of Professional Lactation Consultants
- Italian National Committee for UNICEF
- Creattivamente ostetriche
- GIFA - Geneva Infant Feeding Association (Alessia Bigi)
- Il Melograno - Information Centres for Maternity and Birth
- LLL - La Leche League Italy
- MAMI - Italian Breastfeeding Movement
- MIPPE - Italian Perinatal Psychology Movement
- STC - Save the Children Italy
- SUSSA - Sant'Anna School of Advanced Studies, Pisa (Anna Murante)
- UPPA - A Paediatrician For Friend

Report 2023

IBFAN Italy coordinated the process with the help of 14 organizations and the participation of more than 30 people (meetings, working groups):
- ACP - Cultural Association of Paediatricians
- AICPAM - Italian Association of Professional Lactation Consultants
- Italian National Committee for UNICEF
- FNO/TSRM/PSTRP – National Confederation of the Orders of Health Technicians (radiology, rehabilitation, prevention and other technical health professions)
- Il Melograno - Information Centres for Maternity and Birth
- LLL - La Leche League Italy
- LUMSA – Free University Maria Ss. Assunta
- MAMI ODV - Italian Breastfeeding Movement
- MIPPE - Italian Perinatal Psychology Movement
- NIH – National Institute of Health
- STC - Save the Children Italy
- SUSSA - Sant'Anna School of Advanced Studies, Pisa
- UniCamillus – International Medical University
- UPPA - A Paediatrician For Friend

WBT*i* 2023

Coordinators (core group) and working groups

Indicators and Coordinators	Working groups	Affiliation
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2. Baby Friendly Hospital Initiative/Ten Steps to Successful Breastfeeding Maria Enrica Bettinelli	Maria Enrica Bettinelli Elise Chapin Stefania Solare	IBFAN Italy UNICEF Italy UNICEF Italy
3. Implementation of the International Code of Marketing of Breastmilk Substitutes Luisa Mondo	Maria Enrica Bettinelli Luisa Mondo Carla Scarsi	IBFAN Italy IBFAN Italy LLL Italy
4. Maternity Protection Claudia Pilato	Maria Enrica Bettinelli Marco Evola Claudia Pilato	IBFAN Italy LUMSA IBFAN Italy
5. Health and Nutrition Care Systems (in support of breastfeeding and IYCF) Francesca Marchetti	Alessandra Corocher Francesca Marchetti Arianna Parodi Carla Scarsi	FNO/TSRM/PSTRP UniCamillus AICPAM LLL Italy
6. Counselling Services for Pregnant and Breastfeeding Mothers Rosanna Piscione	Francesca Romana Marta Arianna Parodi Rosanna Piscione Patrizia Prosperi Porta Consuelo Puxeddu Carla Scarsi Monia Scarton Maddalena Ugoli	STC Italy AICPAM IBFAN Italy Il Melograno IBFAN Italy LLL Italy MAMI MIPPE
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Abbreviations

ACP	Cultural Association of Paediatricians
AICPAM	Italian Association of Professional Lactation Consultants
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BFI	Baby Friendly Initiatives
BMS	Breastmilk Substitutes
CEDAP	Certificate of Birth Attendance
CSB	Centre for Child Health
DPCM	Decree of the Presidency of the Council of Ministers
EU	European Union
FAO	Food and Agriculture Organization
FIMP	Italian Federation of Paediatric Doctors
FNCO	National Federation of the Colleges of Midwives
FNOPO	National Federation of the Orders of Midwives
GSIYCF	Global Strategy on Infant and Young Child Feeding
GU	Official Gazette
HIV	Human Immunodeficiency Virus
IBCLC	International Board Certified Lactation Consultant
IBFAN	International Baby Food Action Network
IC	International Code on Marketing of Breastmilk Substitutes
IEC	Information, Education, Communication
IFE	Infant Feeding in Emergencies
ILO	International Labour Organization
INPS	National Institute for Social Assistance
IPASVI	Professional Nurses Health Assistants Nursery Assistants
IRCCS	Hospitalization and Care Institute with a Scientific Role
ISEE	Indicator of Equivalent Economic Situation
ISTAT	National Institute of Statistics
LEA	Essential Levels of Care
LHA	Local Health Authority
LLL	La Leche League (Italy)
MAMI	Italian Breastfeeding Movement
MD	Ministerial Decree
MOH	Ministry of Health
NBC	National Breastfeeding and Infant Feeding Committee
NHS	National Health System
NIH	National Institute of Health
NGO	Non-Government Organization
PA	Autonomous Province
PAA	Inter-Society Project for the Promotion of Maternal and Child Health
PEC	Municipal Plan of Emergency
PNE	National Outcomes Plan
PNP	National Prevention Plan
PNRR	National Recovery and Resilience Plan
PRP	Regional Prevention Plan
SIGO	Italian Society of Gynaecology and Obstetrics
SIN	Italian Society of Neonatology
SIP	Italian Society of Paediatrics
SUSSA	Sant'Anna School of Advanced Studies, Pisa
TAS	Technical Advisory Committee on breastfeeding of the Italian Ministry of Health
UNICEF	United Nations' Children's Fund
WBT*i*	World Breastfeeding Trends initiative
WBW	World Breastfeeding Week
WHA	World Health Assembly
WHO	World Health Organization

Assessment findings

Indicator 1. National Policy, Governance and Funding

Key questions. Is there a national policy on breastfeeding and feeding of infants and young children that protects, promotes and supports breastfeeding and optimal infant feeding practices? Is this policy supported by a national programme? Is there a programme for implementing this policy? Is the programme adequately funded? Is there a coordination mechanism, such as a National Breastfeeding Committee and a Committee coordinator?

Criteria for assessment and scoring
The Table shows the 8 criteria for assessment; the maximum score is 10.

Criteria for Assessment – Policy and Funding	**√ Check all that apply**	
1.1) A national breastfeeding/IYCF policy/guideline (stand alone or integrated) has been officially approved by the government.	Yes: 1 √	No: 0
1.2) The policy recommends initiation of breastfeeding within one hour of birth and exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	Yes: 1	No: 0 √
1.3) A national plan of action is approved with goals, objectives, indicators and timelines.	Yes: 2	No: 0 √
1.4) The country (government and others) is spending on breastfeeding and IYCF interventions.[1] a. no funding b. < 1 € per newborn from the Government c. 1-2 € per newborn from the Government d. 2-5 € per newborn from the Government e. ≥ 5 € per newborn from the Government or from donations	 a: 0 √ b: 0.5 c: 1 d: 1.5 e: 2	
Governance		
1.5) There is a National Breastfeeding/IYCF Committee.	Yes: 1	No: 0 √
1.6) The committee meets, monitors and reviews the plans and progress made on a regular basis.	Yes: 2	No: 0 √
1.7) The committee links effectively with all other sectors like finance, health, nutrition, information, labour, disaster management, agriculture, social services etc.	Yes: 0.5	No: 0 √
1.8) The committee is headed by a coordinator with clear terms of reference, regularly coordinating action at national and sub national level and communicating the policy and plans.	Yes: 0.5	No: 0 √
Total score	**1/10**	

Background

In application of the National Guidelines on the protection, promotion and support of breastfeeding of 2007,[1] an NBC was established in 2008 with a decree published in the Official Gazette.[2] The decree referred to the IC and the BFHI and provided for the involvement of all relevant stakeholders. In 2012 the NBC was not renewed and a Technical Advisory Committee (TAS) was

[1] Enabling Women To Breastfeed Through Better Policies And Programmes – Global Breastfeeding Scorecard, 2018
https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2018-methology.pdf?ua=1

established for the first time, with a decree of the MOH Director General for food hygiene and safety and nutrition, Office 5 Nutrition and Consumer Information (document published on the website of the MOH, but never in the Official Gazette),[3] which progressively but clearly moved away from the spirit of the IC and the BFHI, also referred to in other MOH documents, such as that of Office 8 of the General Directorate of Health Prevention,[4] to the point of proposing a self-certification initiative for hospitals that does not refer to the IC. The initiative was not approved due to the sole opposition of the NGO component within the TAS, and was then taken on as an independent project by the paediatric, gynaecological, midwifery and nursing associations. With subsequent renewals, the TAS has had its current composition since 2021 (Table).[5] The TAS is renewed for three-year terms. The objective is to promote, facilitate and monitor the application of the recommendations indicated in the "National guidelines on the protection, promotion and support of breastfeeding", as well as to develop technical and scientific proposals. From 2018 to 2023, the TAS has published 7 documents.[6-12]

Table. Members of the NBC (2008) and of TAS (2021).

NBC 2008	TAS 2021
In addition to four MOH officers and to a representative of the NIH: • 1 representative of the Italian Committee for UNICEF; • 1 representative of the WHO Collaborating Centre for maternal and child health at IRCSS Burlo Garofolo, Trieste; • 1 representative of SIP; • 1 representative of SIN; • 1 representative of FIMP; • 1 representative of ACP; • 1 representative of SIGO; • 1 representative of FNCO (today FNOPO); • 1 representative of the National Federation of IPASVI colleges; • 1 representative of AICPAM; • 1 representative of the main NGOs on infant feeding and breastfeeding; • 1 representative of IBFAN Italy.	• Four MOH officers; • 1 representative of the NIH; • 1 representative of the regions; • 1 representative of the paediatricians; • 1 representative of the ob-gyn doctors; • 1 representative of FNOPO; • 1 single representative of LLLI, MAMI and Melograno for all the NGOs; 1 officer for each of the following: • Ministry of University and Research; • Ministry of Education; • Ministry of Labour and Social Policies; • Department for Equal Opportunities.

Other useful information

1. There is no funding for breastfeeding projects. There are two decrees for the free provision of formula for children of HIV-positive mothers [13] and for families with low socio-economic status and for mothers with conditions that absolutely contraindicate breastfeeding.[14] The Ministerial Decree that regulates the application of the PNP provides funds for various projects, but none in particular linked to breastfeeding.[15] The Italian law protects working women's rights with funds, not exclusively linked to breastfeeding.[16-18] The protections for working women and fathers/partners and the organization of services for families exist but do not facilitate motherhood in Italy.[19]
2. The number of births is decreasing: from 400,249 in 2021 to 393,000 in 2022.
3. The infant nutrition industry, or its intermediaries, is not represented in the NBC, nor in the TAS; the TAS operates within the MOH's Department of Nutrition, under the General Directorate for food hygiene and safety and nutrition, and not the department of Health Prevention.

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Conclusions

The national policy (national guidelines on the protection, promotion and support of breastfeeding) is consistent with the GSIYCF guidelines, but does not require the development of detailed, timed and financed operational plans for the implementation of the principles it sets out. The policy concerns only breastfeeding, it does not extend to IYCF. It recommends exclusive breastfeeding for the first six months and continued breastfeeding beyond one year of life (and is therefore incomplete or not consistent with the recommendations of the GS). Approved in 2007, it has not been reviewed since, nor has it been tracked in its application.
The NBC established in 2008 in application of the national policy, was not renewed in 2012 and has been replaced by the TAS, with technical consultancy functions and more oriented towards

promotional activities. Over the years, the TAS has progressively disengaged itself from the GSIYCF, ignoring the protection of breastfeeding and limiting its promotional activities.
The promotion of breastfeeding is a recommendation of the PNP 2020-2025, meant to acquire useful information at a regional level for planning awareness programmes and related strategies. However, there is no national analysis on whether and how much funding goes specifically for breastfeeding-related programmes and for the training of health personnel, as stated in the national policy. The only two decrees published on breastfeeding are those related to the free supply of formula for children of HIV-positive mothers, mothers with low socio-economic status and those with absolute contraindications to breastfeeding.

Limitations and gaps

1. The national policy recommends exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 1 years. It does not recommend breastfeeding up to 2 years and beyond, nor initiation of breastfeeding within one hour of birth
2. There is lack of a national plan of action, with dedicated resources for its implementation, and of an NBC to monitor the implementation of plans.
3. There is inadequate link between the TAS and the regional and local health authorities.

Recommendations

1. In the absence of a NBC, it is recommended to create an official and operational connection between TAS, the technical body of the MOH, and PNP, which has the function of coordinating and monitoring policies to support breastfeeding at regional level.
2. It is also necessary to define a budget for the implementation of the interventions proposed by this coordination (currently each region can use PNP funds in a discretionary manner for each individual project).
3. Compared to the previous WBT*i* assessment (2018), UNICEF Italy was not included in the TAS, where there is a single representative for LLL (which was already present), MAMI and Melograno. It is recommended to continue to refer to these informed actors for the Third Sector.

Indicator 2. Baby Friendly Hospital Initiative/Ten Steps to Successful Breastfeeding

Key questions. What percentage of hospitals and maternity facilities are designated, accredited or awarded as baby friendly? Or what percentage of new mothers has received maternity care as per the 'Ten Steps' within the past 5 years? What is the quality of implementation of BFHI?

Criteria for assessment and scoring

The Tables show the quantitative and the nine qualitative criteria for assessment; the maximum score is 10.

Quantitative criteria

2.1) 34 out of 399 (**8.5%**) hospitals (public and private)[1] providing maternity services have been accredited for the implementation of the 10 steps in the past 5 years.

Criteria for assessment	√ Check
0	0
0.1 – 20%	1 √
20.1 – 49%	2
49.1 – 69%	3
69.1 – 89 %	4
89.1 – 100%	5
Score	**1/5**

Qualitative criteria

Criteria for assessment	√ Check	
2.2) There is a national coordination body/mechanism for the BFHI or to implement Ten Steps with a clearly identified focal person.	Yes: 1	No: 0 √
2.3) The Ten Steps have been integrated into national/regional/hospital policy and standards for all involved health professionals.	Yes: 0.5	No: 0 √
2.4) An external assessment mechanism is used for accreditation /designation/awarding/evaluation of the health facility.	Yes: 0.5	No: 0 √
2.5) Provision for the reassessment [2] have been incorporated in national plans to implement Ten Steps.	Yes: 0.5	No" 0 √
2.6) The accreditation/designation/awarding/measuring process for BFHI/implementing the Ten Steps includes assessment of knowledge and competence of the nursing and medical staff.	Yes: 1	No: 0 √
2.7) The external assessment process relies on interviews of mothers.	Yes: 0.5	No: 0 √
2.8) The International Code of Marketing of Breastmilk Substitutes is an integral part of external assessment.	Yes: 0.5	No: 0 √
2.9) Training on the Ten Steps and standard of care are included in the pre-service curriculum for nurses, midwives and doctors and other involved health care professionals.	Yes: 0.5	No: 0 √
Score	**0/5**	
Total score (2.1 to 2.9)	**1/10**	

Background

The BFIs, called in Italy "Together for Breastfeeding",[3] are based on the WHO and UNICEF initiatives and on actions envisaged in the National Breastfeeding Policy[4] and in the National and Regional Plans for assistance in the first 1000 days[5] in local services (BFCI),[6] in birth centres (BFHI)[7] and in pre-service training (Breastfeeding Friendly and Specialization Courses).[8] They are also based on evidence-based actions (the 10 steps), confirmed by 30 years of experience and various literature reviews, with a wide-ranging scope that demonstrates the importance of synergy in the application of all 10 steps to achieve the best health outcomes for girls and boys, mothers, fathers and society.
In Italy there are currently 34 accredited hospitals, 9 communities and 4 university courses (3 for midwives, 1 for paediatric nurses).[9] There are also over 300 Baby Pit Stops (areas reserved for families for breastfeeding and nappy changing)[10] recognized by LLL, more than 1000 Baby Pit Stops recognized by UNICEF Italy and another thousand that have arisen spontaneously.
The history of the BFIs in Italy demonstrates that this project requires strong institutional support, ideally by the MOH, with a well-defined reference frame and horizon. The MOH itself, through a series of documents such as the "First 1000 days"[5], the PNP 2020-2025[11] and the LEAs,[12] recommends the implementation of the actions envisaged by the BFIs, including the IC.
In 2021, a memorandum of understanding was signed by the MOH and UNICEF Italy,[13] which provided for the promotion of recognition as a Baby-Friendly Structure (UNICEF Italy) at an institutional level and the protection of breastfeeding in the social and economic context, countering information, attitudes and practices that may discourage and/or counteract it, in compliance with international standards such as the IC. Also, in the same year, a collaboration agreement was signed between UNICEF Italy and the NIH aimed at creating a joint path in the field of promoting maternal and child health and in the first 1000 days, with a focus on the protection, promotion and support of breastfeeding according to WHO/UNICEF standards, the health of populations in conditions of increased vulnerability and infant nutrition in emergencies.[14]
In 2022, based on international documents, UNICEF Italy developed a guide to the application of steps to protect, promote and support breastfeeding in maternity facilities[15]. The guide proposes the same steps for BFHI and BFCI, with different paths based on the application context and a detailed description of the steps and expected standards. Furthermore, the guide adopts a kit for verifying the competencies of health personnel [16] in the implementation of the BFI for hospitals and local services, to ensure that the staff who work in contact with mothers, fathers and families have the knowledge, skills and attitudes to protect, promote and support breastfeeding throughout the entire birth process and the first 1000 days.
The BFIs are collaborative organizational models, based on evidence of effectiveness, which require the staff involved to have an integrated vision of the processes, with the aim of guaranteeing the best care centred on the mother-child dyad and the family. The strong community orientation towards this objective allowed BFHI hospitals to maintain good practices even during the first pandemic wave of COVID-19, compared to other non-BFHI hospitals.[17]

Other useful information

Although BFHI and BFCI are cited in official MOH documents as references for evidence-based practices, there is no national implementation plan, nor coordination as described in the Innocenti Declaration,[18] nor mandatory training on breastfeeding of all staff in contact with pregnant women, mothers, fathers and children, nor a national monitoring system, let alone a dedicated budget. BFHI/BFCI accreditation is not mandatory for hospitals and local healthcare communities. However, there are plans and programmes to promote and manage BFHI/BFCI accreditation at provincial and regional level on the basis of agreements between UNICEF Italy and local and regional administrations (for example, the Autonomous Province of Trento in 2018, the Veneto Region in 2017, Tuscany Region in 2014, Milan and Liguria Region in 2016). Currently, a project

called PAA has spread at a national level.[19] This is a private initiative conceived and promoted by professional associations (SIP, SIN, FIMP and others) which takes up only part of the first Step of the BFHI (policy) and excludes external evaluation, a fundamental component to guarantee any quality improvement certification process, and compliance with the IC, generating confusion with the BFIs.[20] Most of the PAA signatory associations had committed since 2004 to proposing information and training courses for their members, aimed at promoting the objectives of the 1990 Innocenti Declaration,[21] including BFHI and IC.
It has been demonstrated that conflicts of interests deriving from relationships with the industry contribute to reducing breastfeeding rates, considering that the marketing of formula represents the primary interest of companies. Various reports by WHO and UNICEF in 2022,[22,23] and a very recent series of articles in the Lancet,[24-26] have highlighted the strong role of aggressive and unethical marketing by an industry that devotes to it approximately 10% of its $55 billion revenues per year, an increase of nearly 40 times in 40 years.
The 2018 WHO/UNICEF Nurturing Care Framework reports the IC and the BFIs as reference models for infant nutrition.[27] The February 2022 WHO/UNICEF report concludes that we must "put children above profits".[22] In this regard, it is important to note that, following the publication of this report, some Italian paediatric associations called for legislative intervention to regulate aggressive digital marketing.[28]
In Italy, recent data from the Surveillance of Children 0-2 years have highlighted high breastfeeding rates in the Regions and Autonomous Provinces that follow the BFI, unlike in the Regions where health authorities have only adopted breastfeeding policies.[29]

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Conclusions

The Italian initiative "Together for breastfeeding" is based on WHO and UNICEF programmes and on actions envisaged in national and regional health plans. It provides for the protection, promotion and support of breastfeeding and of the parent-child relationship through collaboration with public health, social and educational services, to improve care during birth and in the academic courses that train the staff who will work with women and families during pregnancy and lactation. The initiative represents an integrated action that involves the entire birth process, so that parents and children have timely access to a continuous support network of birth centres and local services staff, support groups and the local community. This objective must be achieved through the creation of a knowledgeable environment, which allows women to breastfeed or choose a breastmilk substitute in an informed way.

Limitations and gaps

1. There is no official agreement between MOH and UNICEF Italy for the implementation of a national BFI programme.
2. There is no dedicated funding for BFIs in hospitals and communities.
3. There is no official Government recognition of Baby Friendly health facility status (for example, through the inclusion of BFI steps in accreditation and quality assessment systems, financial plans or other types of incentives).
4. Baby Friendly hospitals, communities and academic courses are still few and located mainly in the north and centre of the country. There are still no Baby Friendly facilities in the south, although many have started the accreditation process and many more have expressed an interest.

Recommendations

1. There is a need for a national agreement between MOH and UNICEF Italy to put BFI into practice at a national level.
2. Dedicated national funding is needed for the implementation of BFIs.
3. Standards based on breastfeeding rates and the application of BFI steps should be included in the PNE for all healthcare facilities.
4. It is essential to modify the curricula for pre- and post-graduate training of all health personnel who deal with mothers, fathers, newborns and infants and early childhood: professions and specializations in the medical, obstetric, nursing (including paediatric nursing), psychology, nutrition, pharmaceutics, etc. This training must be in line with the BFI and comply with the IC and subsequent resolutions.

Indicator 3. Implementation of the International Code of Marketing of Breastmilk Substitutes

Key questions. Are the IC and subsequent relevant WHA resolutions in effect and implemented in the country? Has any action been taken to monitor and enforce the above?

Criteria for assessment and scoring
The Table shows the 13 criteria for assessment; the maximum score is 10.

Criteria (*legal measures in place in the country*)	√ **Check**
3a: State of the International Code	
3.1) No action taken.	0
3.2) The best approach is being considered.	0.5
3.3) Draft measure awaiting approval (for not more than three years).	1
3.4) Few Code provisions as a voluntary measure.	1.5
3.5) All Code provisions as a voluntary measure.	2
3.6) Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions.	3
3.7) Some articles of the Code as law.	4 √
3.8) All articles of the Code as law.	5
3.9) Relevant provisions of WHA resolutions subsequent to the Code are included in the national legislation:* a) Provisions based on 1 to3 of the WHA resolutions as listed below are included. b) Provisions based on more than 3 of the WHA resolutions as listed below are included.	 5.5 6
3b: Implementation of the International Code/National legislation	
3.10) The law provides for a monitoring system independent from the industry.	1 √
3.11) The law provides for penalties and fines to be imposed to violators.	1 √
3.12) The compliance with the law is monitored and violations are reported to concerned agencies.	1
3.13) Violators of the law have been sanctioned during the last 3 years.	1
Total score (3a + 3b)	**6/10**

* Following WHA resolutions should be included in the national legislation/enforced through legal orders:

1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labelling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32)
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

Background

The most recent Italian legislation is represented by MD 82/2009,[1] which does not fully transpose the IC and only prohibits the advertising of type 1 infant formula, for infants up to 6 months of age. The advertising of all other types of formula, as well as that of herbal teas, water, baby food, baby bottles, teats, pacifiers and any other product related to the feeding of infants and children, is permitted. MD 84/2011 provides for sanctions for violations of the aforementioned MD 82/2009.[2]

In Italy, as well as in all other EU countries, the two regulations 127/2016 and 128/2016 are also in force;[3,4] this does not imply any difference in terms of the prohibition of advertising of products related to feeding of infants and children.
The national guidelines on the protection, promotion and support of breastfeeding establish that the MOH recognizes it as the physiological and normal way of feeding in early childhood, as well as bringing health benefits, recognizing that breastfeeding is a fundamental right of children, mothers and fathers and therefore committing the Government to support the activities of the regions for the training of health and social personnel, according to the WHO/UNICEF recommendations.[5] The same guidelines also commit the regions and health institutions to respect the IC, therefore in contradiction with the legislation cited above.
In Italy, individually or through associations, violations of the law can be reported using the instructions available on the MOH website,[6] or directly contacting IBFAN Italy. For over 20 years, this association has been collecting violations of the IC and the law, organizing and transmitting them to the TAS and to the international IBFAN network. IBFAN Italy publishes an analysis of the violations of the IC every three or four years. Furthermore, IBFAN Italy writes to manufacturers and distributors that violate the IC and the law. Where necessary, the report is followed by a notification to competent authorities.
The WHO/UNICEF/IBFAN document on the state of application of the IC in the world in 2022 assigns Italy, like all other EU countries, a score of 32/100, higher only than the score of countries that do not yet have an IC legislation.[7]

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Conclusions

Italy, like all EU countries, only applies EU regulations. Governments could go beyond these regulations by integrating all provisions of the IC into their national legislation. For the moment, no improvement in EU regulations is expected in the direction of greater compliance with the provisions of the IC.

Limitations and gaps

1. In the absence of legislation relating to the marketing of products other than type 1 formula, parents and consumers often get confused. Promotional health and nutrition claims are permitted for products other than type 1 formula. The marketing of complementary foods,

bottles and teats is not regulated. At the moment, the Government shows no intention of expanding the law by considering including other products covered by the IC.

2. There is no public and independent system for monitoring the implementation of the IC, nor a structured system for notifying and sanctioning violations, nor any indication on how to pay fines, if applied. At the time of writing this report there is no news of sanctions and fines applied based on DM 84/11.
3. Manufacturers and distributors of products under the scope of the IC can sponsor training or medical education events, and other activities of professional associations.
4. In general, those who hold political offices, managers and administrators, as well as health personnel are not aware, informed or trained on the IC.
5. The violations detected and reported by parents and attentive and informed staff, in points of sale and shops, or online, on the means of communication (radio, television, internet), concern both Italian law and the IC. Violations of Article 5 are prevalent: direct contacts between women/couples and companies: through mobile phone applications, various social media and commercial sites, companies create long-term relationships, guaranteeing the trust of mothers, especially those at their first experience of pregnancy and lactation.

Recommendations

1. The Italian Government should integrate all provisions of the IC into national legislation, enforce its application according to the 2016 WHO guidance on ending inappropriate promotions of baby food, and create a public and independent system of monitoring of violations.
2. Political office holders, managers and administrators should be made aware of the importance of the IC and the role they have to play in its implementation, including better legislation, monitoring and funding.
3. All government sectors (health, labour and trade), health workers and their associations, as well as investing bodies, should assume their responsibilities and exercise their influence to insist on practices that prioritize children and women over commercial interests.
4. Training and technical expertise on the IC should be extended to all health personnel involved, including pre- and postgraduate education.
5. Healthcare professionals should ask their professional associations to eliminate all financial ties with manufacturers and distributors of products under the scope of the IC, to avoid any conflict of interests.
6. The participation and role of NGOs in the TAS, and in a desirable future NBC, should be strengthened.

Indicator 4. Maternity protection

Key question. Is there a legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labour Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including mothers working in the informal sector?

Criteria for assessment and scoring

The Table shows the 10 criteria for assessment; the maximum score is 10.

Criteria	Scores
4.1) Women covered by the national legislation are protected with the following weeks of paid maternity leave: a. less than 14 weeks b. 14 to 17 weeks c. 18 to 25 weeks d. 26 weeks or more	a: 0.5 b: 1 c: 1.5 √ d: 2
4.2) Does the national legislation provide at least one breastfeeding break or reduction of work hours? a. unpaid break b. paid break	a: 0.5 b: 1 √
4.3) The national legislation obliges private sector employers to: a. give at least 14 weeks paid maternity leave b. paid breaks	*Tick one or both* a: 0.5√ b: 0.5√
4.4) There is provision in national laws that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. a. space for breastfeeding/breastmilk expression b. crèche	*Tick one or both* a: 1 b: 0.5 √
4.5) Women in informal/unorganized and agriculture sector are entitled to: a. some protective measures b. the same protection as women working in the formal sector	a: 0.5 b: 1
4.6) a. Accurate and complete information about maternity protection laws, regulations or policies is made available to workers by their employers on commencement. b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	*Tick one or both* a: 0.5 b: 0.5 √
4.7) Paternity leave is granted in public sector for at least 3 days.	Yes: 0.5 √ No: 0
4.8) Paternity leave is granted in private sector for at least 3 days.	Yes: 0.5 √ No: 0
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	Yes: 0.5 √ No: 0
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	Yes: 1 √ No: 0
Total score	**7/10**

Notes and observations on assessment criteria

4.2 There are important differences in treatment among the various categories of workers, and also between parents belonging to the same category.

4.3 There are specific disciplines for various types of employment (self-employed, para-subordinate or independent). To make protection more homogeneous, those who legislate gradually extend the forms of protection in place to other types of workers; this operation, however, does not yet seem completed and does not seem sufficient to fully understand the needs of parents who belong to different categories.

4.4 Article 70 of Law 448 of 2001 provides for the creation of a fund to create day-care facilities in the workplace in order to facilitate parents in reconciling work and family needs. In reality, however, this legislation is poorly enforced due to difficulties in obtaining the limited available funds or loans related to this type of project.

4.7 Paternity leave means that the father can stay at home with the child for the entire duration of the maternity leave or for the residual part not taken by the working mother in specific cases. In order to promote a culture of greater sharing of care within the couple, the latest pension reform provides that the working father has the right to request 10 consecutive paid days of absence from work during the first 5 months of the child's life. Also, Legislative Decree no. 80/2015 (one of the four measures of the Jobs Act) provides for the father's request for leave, even if the mother is self-employed.

4.8 The law is aimed at all employees, including those in public administrations and the private sector, para-subordinate workers and those with apprenticeship contracts or members of cooperatives.

4.9 But only up to 7 months after birth; the prohibition on night work only covers the first year of life.

4.10 Female workers cannot be transferred only during the first year of the child's life. Breastfeeding breaks are doubled in the case of twin births, adoption or custody of at least two girls or boys, including non-twins, and even if they enter the family on different dates.

Background

Women have the right to adequate support to be able to breastfeed their children. Countries are obliged to apply the rights established by international conventions, among which those of the ILO are of particular importance. In 2020, following the Covid-19 pandemic, more than seventy thousand jobs were lost by women, compared to an increase in male employment of sixty thousand units.[1] Even at the end of the pandemic period, when the emergency containment measures were removed in June 2021, gender differences, although reduced, remained higher than in the pre-pandemic period.[2] Motherhood also has a significant impact on the probability of holding a management role, with a penalty in terms of mothers' career opportunities compared to women without children.[3] In Italy, mothers with a lower educational qualification are more likely to leave the job market upon the arrival of a son or daughter, while those who are more educated remain employed despite seeing their career slowed down.[4]

Observing employment by intervals that represent income groups, there is a greater concentration of female employment in some sectors (particularly services and the public sector), more limited work performance (fewer number of hours worked and greater part-time) and difficulty in accessing managerial and career roles.[5] Low-income jobs (and part-time work) are also linked to the number of children: 38.5% of women in the lowest income percentile have two or more, while for men the share stops at 15%. The link between work security and fertility is crucial; fixed-term work is more characteristic of women without children and young women with two children, for whom the dimensions of inactivity or unemployment prevail. Wage gaps and contractual precariousness, together, penalize young women and create a job market that is not very conducive to parenthood planning.

Care work, in addition to being essential for the well-being and growth of children, also has an

economic value. It has been included by the ILO among the crucial components for the economic future of the world, clarifying its equivalence in terms of importance compared to paid work. There are various definitions of care work, depending on the tasks it involves. The ILO distinguishes between two activities, direct and indirect. The former include personal and relational care activities, such as breastfeeding a child or taking care of a sick partner; the latter include practical activities such as cooking and cleaning. According to the ILO, in Italy, women dedicate 5 hours and 5 minutes of unpaid assistance and care work per day, while men only 1 hour and 48 minutes. Therefore, 74% of the total hours of unpaid care and assistance work fall on women. Even when women contribute as much to income and work as men, they shoulder most of the care work. Women working in paid jobs contribute 2.8 hours more per day than men, a gap that rises to 4.2 when there are children in the home.[6]
The clear gender imbalance that has characterized voluntary resignations after birth for ten years is confirmed, even if it has significantly reduced over time.[7] According to the INAPP survey,[5] the alternative to parental care for those with minor children are grandparents, which 57.9% of parents turn to. This is a solution considered economically advantageous, highly flexible in terms of timetables and adaptability to needs, including those linked to mobility. A group that deserves attention are single-parent families, who in a third of cases were at risk of poverty and exclusion in 2021. Single-parent families have increased over time from less than 1.8 million in 2000 to approximately 2.9 million in 2021, 17% of the total number of families, and in 80% of cases they are made up of single mothers.[8] According to a comparative study,[9] it is estimated that in Italy 44% of single mothers are in poverty, and this once again increases as the level of education varies. Single mothers are equally distributed across education levels, but poverty is widespread at 65% in case of low education level, 37% in case of medium education level, 13% among highly educated single mothers. These mothers are often doubly disadvantaged in the labour market, as their employment situation is limited not only by their low education, but also by difficulties in combining paid work with family responsibilities.[2]
The PNRR identifies gender equality as a transversal objective of all the measures into which it is divided. A central role is represented by the employment of women, with the aim of removing gender inequalities, a condition which has deteriorated for women due to the pandemic: low participation in the world of work, higher unemployment rate, wage gap, difficulties in career progression, difficult balance between care work in the family and work, low number of women entrepreneurs. And again, women suffer various forms of discrimination: bullying, sexism in the workplace, violence and feminicide. However, it should be noted that the notion of gender used by the PNRR concerns exclusively women, while it is known that discrimination can arise not only from gender, but from further identities that are associated with it, such as skin colour, disability, migration. And indeed, intersectionality represents one of the major challenges to the human rights protection system and one of the crucial steps of the EU Strategy 2020-2025.

Other useful information

Article 4, paragraph 24, letter a), of Law 28 June 2012, n. 92 established compulsory leave and optional leave, which can be used by employed fathers, including adoptive and foster fathers, no later than the fifth month of the child's life. The 2022 budget law has consolidated both types of paternal leaves, therefore, starting from 2021, they are no longer experimental and employed fathers can benefit from them in the event of birth, adoption, foster care or temporary placement of minors, but also in the case of perinatal death of a son or daughter. The idea is to create a work-life balance, implementing EU Directive 2019/1158.
The financial allocation for paternity leave does not affect maternity leave. In Italy, employed fathers, including adoptive, foster or placement fathers, can benefit from leave no later than the fifth month from birth or entry into the family, or in Italy in the case of national or international adoption, or from foster care. The compulsory leave can be used by the father within the fifth month of the child's life (or from entry into the family/Italy in the case of national/international adoptions

or from foster care or temporary placement) and therefore during the maternity leave of the employed mother or even subsequently, as long as within the time limit mentioned above. This leave is configured as an independent right and is therefore additional to that of the mother and a father is entitled to it regardless of the mother's right to her own maternity leave. Mandatory leave is also recognized to the father who takes paternity leave pursuant to article 28, Legislative Decree 26 March 2001, n. 151. Employed fathers are entitled to ten days of compulsory leave, which can also be taken on a non-continuous basis, for childbirth, adoption or foster care events that occur after 1 January 2021. Compulsory and optional leave for fathers were introduced initially for the three-year period 2013-2015, then for the following years up to 2021 the measures were confirmed and modified annually by the Budget Law and finally with the 2022 Budget Law, the leaves were introduced in a permanent manner with Legislative Decree no. 105/2022.

Parental leave, in short, is the optional abstention of parents, the total months of compensated leave between the two parents have increased, going from the 6 foreseen by the previous legislation to 9 months. In order to increase the leave used by fathers, the total months eligible for compensation have been increased to 11, in the event that the father uses it for a whole or fractional period of no less than three months (in the event a father renounces the three months of paternal leave, these are not transferable). Parental leave can be requested by the employed mother and father for a continuous or split period not exceeding 6 months. It can be requested for its entire duration, fractionally or by the hour. The maximum age of a daughter or son within which parents, including adoptive and foster parents, can take parental leave has been raised from 6 to 12 years. Being a single parent increases the leave from 10 to 11 months. The coverage of 30% of the salary for parental leave remains, but, unlike in the past, without reduction of holidays, rest, thirteenth month's salary or Christmas bonus.

From 2022, both compulsory and optional paternity leave will become operational, and the duration of 10 days and one day, respectively, 100% paid, is confirmed. Sanctions are foreseen for companies that adopt behaviour towards the employed father that is aimed at hindering or preventing the use of leave. Regarding parental leave, the 2023 Budget Law provides for an extra month of optional leave paid at 80%, which can be used by one of the two parents (alternatively) up to the age of six years of the son or daughter's life. The right to maternity allowance in favour of self-employed workers and freelance professionals has been extended to the two months before giving birth in the event of a high-risk pregnancy, and to parental leave for self-employed fathers, for a maximum of three months. Furthermore, the decree extends the allowance to 30% of the salary for the entire period of extension of the leave in the case of children with documented serious disabilities.

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Conclusions

The protection of female workers is guaranteed for mothers who are hired as employees, not in the same way for women who work as self-employed workers, freelancers, entrepreneurs. National legislation does not provide for the creation of care facilities in the workplace and/or nursery schools in the workplace. While legislation guarantees paternity leave, this is often considered by parents to be complementary or alternative to that of the mother. This indicates how care work continues to not be considered or valued, so that legislation alone is unable to produce the necessary cultural changes.

The protections provided for pregnancy also extend to foreign workers residing in Italy, since the same regulations valid for Italian citizens are followed. In some cases, the tools to support the family are made available directly by INPS. Protections are recognized for the pregnancy period and for the period immediately following it. These allow, for example:

- to receive financial compensation for the period of absence from the workplace;
- the ban on dismissal due to pregnancy, unless there are cases of incorrect behaviour or due to the termination of the employment contract;
- the ban on night work;
- the possibility of caring for children until they reach 12 years of age, or when they have a serious handicap.

It is mandatory for pregnant workers to abstain from work for a certain period of time and the State protects their condition by guaranteeing these rights. Some of the protections provided are also extended to the father. An example is the mandatory 10-day paternity leave, which can be used between the two months preceding the expected date of birth and the five months following birth.

A foreign worker in Italy is entitled to the same economic treatment provided for Italian workers, even if she has only recently worked in the national territory and therefore has not accrued contributions. There is an exception to this rule: agricultural, domestic and family workers, who must have paid contributions to be entitled to maternity leave. The measures in favour of parents are many and often coincide with those provided for individuals with Italian citizenship:

- compulsory abstention from work, for a period of 5 months;
- maternity allowance, the rules of which have recently been modified with a view to broadening the range of beneficiaries, with atypical and discontinuous jobs; this allowance is paid for each child;
- maternity/paternity leave;
- granting of time off for medical visits.

With a view to greater protection of the mother and the unborn child, the State provides for the impossibility of expulsion of a pregnant woman without a residence permit during the first six months after birth. The police headquarters issues a special residence permit to a pregnant woman to carry out the necessary medical treatment. The father of the boy or girl is also entitled to a residence permit. Finally, all visits and treatments for pregnancy are free and therefore excluded from the obligation to pay the ticket, even for women who do not have a valid residence permit.

Limitations and gaps

1. The implementing decrees of the Family Act are still being adopted, in particular the measures to support the education of children, including contributions to families for the coverage (even total) of the cost of fees for attending educational services or programs for children and kindergartens, reimbursements on the purchase of books and for sports-cultural activities.
2. The indications present in the national breastfeeding policy have not yet been adopted and regulated.
3. There are no campaigns that enhance care work, especially for women.
4. There are no nurseries (for example in universities) or areas for expressing and storing breast milk in public and private workplaces, with the rare exception of some companies, despite Law 448 of 28.12.2001 (Law budget of 2002) provides for a fund for this purpose based on estimates

provided by the Ministry of Labour and Social Policies (article 70 - provisions relating to nursery schools). This law is not applied because the public and private companies that could contribute to the disbursement of the funds are few (around 20).
5. There is a lot of undeclared illegal work, especially among women.
6. All categories of workers currently enjoy the right to compulsory maternity and paternity leave as a social security measure in the event of the birth of a child, but also of adoption or custody. Differences persist between different categories of male and female workers, and this lack of homogeneity between the various categories of male and female workers, as well as the oldness of the regime compared to the new contractual typologies, only increases inequalities and lack of fairness.
7. There is no maternity protection for high school or college students.
8. Adequate spaces for breastfeeding or caring for the baby or young child involve expenses for employers. It might be useful to think of groups of companies pooling their resources to ensure this right at the lowest cost.
9. The prohibition on being assigned to dangerous tasks applies only to the first 7 months after giving birth, sometimes forcing mothers to stop breastfeeding (for example, in case of contact with toxic substances).
10. The prohibition on being assigned to night shifts applies only to the first year after giving birth.

Recommendations

1. According to the commitment made by the MOH in the 2007 national breastfeeding policy, provisions should be made to enable employed mothers to breastfeed for as long as they wish, by adapting appropriate working hours and methods for the continuation of breastfeeding.
2. Maternity protection should also be extended to atypical and temporary workers in order to avoid discrimination and increase inequalities.
3. In the event of hospitalization of the newborn, maternity leave should be extended to encourage the presence of the mother in the ward next to the baby, rather than to encourage the mother's return to work.
4. In case of hospitalization of the mother, there should be the possibility of keeping the baby with her, at least in the first six months of life.
5. A greater number of welcoming environments and spaces should be planned and established for breastfeeding, for expressing breast milk and for caring for the baby or child, as well as nurseries in the workplace and/or in spaces for childcare.

Indicator 5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF)

Key question. Do care providers in the health and nutrition care systems undergo training in knowledge and skills, and do their pre-service education curricula support optimal infant and young child feeding; do these services support mother-friendly and breastfeeding-friendly birth practices, do the policies of health care services support mothers and children, and are health workers trained on their responsibilities under the IC?

Criteria for assessment and scoring

The Table shows the 7 criteria for assessment; the maximum score is 10.

Criteria	√ Check one that applies in each question		
5.1) A review of schools and pre-service education programmes for health professionals, social and community workers indicates that IYCF curricula or session plans are adequate/inadequate.*	More than 20 out of 25 content/skills are included: 2	5-20 out of 25 content/skills are included: 1√	Less than 5 out of 25 content/skills are included:0
5.2) Standards and guidelines for mother friendly childbirth procedures and support have been disseminated to all facilities and personnel providing maternity care.	Disseminated to more than 50% of facilities: 2	Disseminated to 20-50% of facilities: 1	No guideline, or disseminated to less than 20% of facilities: 0√
5.3) There are in-service training programmes available providing knowledge and skills related to IYCF for relevant health/nutrition care providers.	Available for all relevant workers: 2√	Limited availability: 1	Not available: 0
5.4) Health workers are trained on their responsibilities under the IC and national regulations, throughout the country.	Throughout the country: 1	Partial coverage: 0-5√	Not trained: 0
5.5) IYCF information and skills are integrated, as appropriate, into training programmes not covered in 5.1 but where the care providers may have some contact with families with infants and young children.	Integrated in more than 2 training programmes: 1	Integrated in 1-2 training programmes: 0.5	Not integrated: 0√
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.	Throughout the country: 1	Partial coverage: 0.5	Not provided: 0√
5.7) Health policies provide for mothers and babies to stay together when one of them is hospitalised.	Provision for staying together for both: 1	Provision for only one of them: mother or baby: 0.5√	No provision: 0
Total score	**4/10**		

* The score assigned to criterion 5.1 is an estimate determined by the impossibility of analysing in detail the individual training paths and pre-service training programmes for healthcare, social and community staff in the country.[1,2]

Background

Pre-service training

Regarding institutional pre-service training in Italy, university curricula present significant differences depending on the course of study and the university to which they belong, and it is often not possible to obtain detailed data on specific training programs on infant feeding and breastfeeding. The training offer of the various study courses (medicine, nursing, paediatric nursing, midwifery, health care, dietetics, professional education, speech therapy, occupational therapy and other health professions, as well as specialization in paediatrics, obstetrics and gynaecology and specific master courses in the field of nutrition and breastfeeding), in fact, is defined independently by the individual universities, in compliance with ministerial provisions and in response to the achievement of the training objectives qualifying the various professional skills.[1,2] The student's commitment to protection , promotion and support of optimal infant feeding practices is therefore defined by the teaching regulations of the individual study courses.

In recent years, some initiatives relating to the pre-service training of healthcare personnel have been carried out in the country. Among these:

- Publication of the policy document "Recommendations of the Interdisciplinary Technical Operational Table on the Promotion of Breastfeeding (TAS), of the scientific societies and of the professional orders and associations",[3] containing some recommendations on the pre-service training of healthcare personnel, including indications on the hourly requirement for theoretical and practical training (differentiated based on the professional figure being trained) and on the minimum contents to be covered (based on the degree of involvement of the professional figure).
- Certification of a new Breastfeeding-Friendly University Degree Course, which has been added to the 3 previously recognized.[4]
- Implementation of the training model "Primal Health and breastfeeding: the first 1000 days" (NIH - Order of the Obstetric Profession of Rome and Province, based on WHO/UNICEF models and updated according to the most recent scientific evidence and recommendations) in the Degree Courses in Obstetrics of all the Universities of Rome.[5,6]

Despite the implementation of these initiatives, many aspects are still lacking or poorly defined.

A further problem relating to pre-service training is represented by the fact that the practical training of students often takes place in structures for which it is not possible to certify the adequacy of the assistance provided in relation to the protection, promotion and support of breastfeeding and optimal infant feeding practices. Baby Friendly hospitals and communities, in fact, still have a very poor distribution across the national territory,[7] and there are currently no other equally reliable certification strategies for structures. The absence of practical training in appropriate contexts can unfortunately have a negative impact on basic training.

In-service training

Currently, in Italy, in-service training on infant feeding and breastfeeding takes place using various continuous and permanent education methods. The national recommendations provide some references on in-service training,[3] listing the training proposals available on the national territory and differentiating them according to the profession. In recent years, in fact, various initiatives in this regard have been carried out by professional orders and associations.[8-13] At the moment, however, there is no national strategy for monitoring the training courses activated and carried out in Italy, neither in relation to the WHO/UNICEF training package (main training reference, also from what is reported in the TAS document) nor in relation to other types of courses. Therefore, the only effective guarantee of in-service training and updating on infant feeding and breastfeeding can currently be found in the structures that join the BFI, for which universally recognized training programmes and constant monitoring of training activities are provided.[7] Specifically, following

the recent revision of the 10 Steps, accredited structures have moved from a focus on "training" to a focus on "competency verification", designed to identify gaps in staff knowledge or skills and to facilitate planning additional training that will help develop effective skills, provide consistent messages, and implement standards.[14] In general, training and refresher courses often do not take place in a structured manner by the structure/company to which they belong, nor do they have a mandatory nature for the purposes of the professional activity, except within accredited healthcare facilities or those undergoing Baby Friendly accreditation. Furthermore, the interprofessional educational modality, which would be vital to guarantee homogeneous and continuous assistance in the different levels of assistance, is often not used.
With regards to in-service training and the professional updating of dedicated staff, at the moment in Italy the training path for IBCLC is not considered as a standard component of specialist training, despite representing a high-quality reference recognized at international level.[15]

Health services and related policies

Mother-friendly care is cited in the recent MOH policy document "Investing early in health: actions and strategies in the first 1000 days of life" which underlines the need to promote respectful care and non-invasive interventions during birth, also with a view to improving the start of life for newborns and to facilitate breastfeeding.[16] But the implementation of the international recommendations, defined by WHO and confirmed in recent years by the document "WHO recommendations: intrapartum care for a positive childbirth experience",[17] appears to be very slow and lacking in Italy, both in terms of the services offered to women and couples during labour/birth, and regarding policies and procedures available in health facilities. However, in accredited Baby Friendly facilities, these good practices are promoted, supported and monitored periodically. The health emergency caused by the SARS-Cov-2 pandemic has had a negative impact on the promotion of mother-friendly care, contributing to slowing down implementation processes and, in some cases, causing care practices not in line with international recommendations, such as frequent exclusion of the woman's partner during labour, birth and postpartum.[18-20]
As far as the continuity of the mother-child and parent-child relationship is concerned, an important document was drawn up by the multi-professional working group of the MOH,[21] with the aim of allowing the breastfeeding mother to stay with her baby in the event of hospitalisation, thus reducing the risk of interrupting breastfeeding. The current national recommendations, therefore, include:

- In the event of hospital admission of the child, guarantee the presence of a parent and the continuity of the relationship with the parents for the entire duration of the hospitalization as an integral part of care, providing unlimited access to the ward 24/7 of at least one and, as far as possible, both parents.
- In the event of the mother's hospitalization, facilitate the presence of the child and a family member/caregiver, implementing rooming-in.

Nonetheless, at present these recommendations still represent an objective to be achieved rather than a consolidated reality. In fact, although some virtuous local realities exist, no national policies have been defined that guarantee zero separation between mothers/parents and children. Also in this sense, the recent SARS-Cov-2 pandemic has had a negative influence, in many cases worsening the separation of the family unit.[22]

Other useful information

The presence of a national policy document on training undoubtedly represents the starting point for a future positive evolution.[3] Despite this, at the moment there is a lack of clear definition of the implementation strategies of the recommendations set out therein, as well as of the monitoring and evaluation activities. Although there has been a positive transposition of the indications of the TAS by some categories of professionals, with the creation of specific training contents for professional

categories,[23] at the moment the recommendations have a predominantly theoretical content or, in any case, implementation is neither uniform nor guaranteed throughout the country.
In relation to the training offer of the various courses of study for healthcare personnel, the TAS guideline document recommends that the University Training Credits of these regulations be modulated differently in the courses whose students are attributable to the sphere of informed personnel (minimum core of knowledge), or rather involved (active role expected in the sector), or completely dedicated to the care of mother, family and babies.[3] The document also suggests a series of minimum contents for breastfeeding training for healthcare professionals based on the degree of involvement in the care of the breastfeeding woman and her family, which however are stated in very general terms and do not explicitly mention some important topics, such as knowledge/skills on: IC, care and support during the prenatal period, intra-partum and immediate post-partum care that promotes and supports effective breastfeeding, dietary and nutritional needs of pregnant and breastfeeding women , breastfeeding in children with special needs, including premature infants and newborns, and medications and treatments compatible with breastfeeding.
With regards to in-service training, the creation, in recent years, of numerous distance training initiatives is undoubtedly a positive sign of increased sensitivity to the topic, as well as the use of current and agile training tools.[8-13] It also allows a diffusion of courses at national level, helping to standardize knowledge and reduce the differences between the different realities. On the other hand, what appears lacking in the context of distance learning courses are the methods of acquiring practical skills and abilities, an aspect which adequate training in the field of breastfeeding and infant feeding cannot ignore. Furthermore, unfortunately, in most cases the choice to participate in these training proposals is left to the individual interest of health workers.

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Conclusions

Although initiatives relating to pre-service and in-service training of healthcare personnel have been carried out across the country in recent years, the educational paths and training programmes still present significant critical issues and gaps. From what emerged from the analysis of the sources, for most pre-service training courses it is impossible to certify the adequacy of the curricula and educational programmes on infant nutrition. Furthermore, Breastfeeding-Friendly University Degree Programmes are sporadic and have an irregular distribution, concentrating only in northern Italy. Finally, national recommendations on training present poor and uneven implementation across the country.
In relation to health policies and services, international recommendations on mother-friendly care and continuity of the mother/parents-child relationship are often disregarded, except for accredited Baby Friendly facilities, and have not been translated into clear national policies.

Limitations and gaps

1. Lack of implementation, planning, monitoring and evaluation of the MOH recommendations on pre-service and in-service training.
2. Difficulty in finding detailed data on pre-service training programs on infant feeding and breastfeeding due to the teaching autonomy of the Universities in defining the specific contents of their study plans.
3. Lack of structures participating in BFIs (Breastfeeding-Friendly University Degree Programmes, Baby-Friendly hospitals and communities) and uneven distribution across the country, with consequences on the quality of pre-service practical training which is difficult to trace, inequalities among and within regions, also with regard to in-service training proposals and their monitoring/evaluation.
4. Lack of clarity on the training methods used in distance learning courses for the acquisition of practical skills and abilities.
5. Failure to implement international recommendations on mother-friendly care.
6. Absence of operational guidelines and policies at national, regional and local level that would allow the joint hospitalization of mother and child during maternal and child hospitalization.

Recommendations

1. Carry out a revision of the university curricula of healthcare personnel, identifying the minimum contents for training on infant feeding and breastfeeding of professional figures based on the degree of involvement in the care of mothers, fathers, families and children (informed/involved/dedicated personnel) and ensuring the acquisition of knowledge, skills and abilities to protect, promote and support breastfeeding.
2. Standardize the pre-service training of dedicated staff at national level, defining in writing a unique breastfeeding training curriculum.
3. Define implementation strategies of the recommendations contained in the guidance document "Recommendations of the Interdisciplinary Technical Operational Table on the Promotion of Breastfeeding (TAS), of the scientific societies and professional orders and associations", as well as plan strategies for monitoring and evaluating the in-service and pre-service training activities. Consider the implementation of training courses among the performance objectives of healthcare facilities.
4. Ensure interprofessional in-service training.
5. Add IBCLC training as a specialist training component which should be recognized as added value for healthcare personnel dealing with breastfeeding.
6. Provide hospital policies and procedures on the application of the recommendations contained in the document "WHO recommendations: intrapartum care for a positive childbirth experience" (2018) and reiterated by the Italian MOH.
7. Provide hospital policies and procedures on the application of good practices during the hospitalization of mother and/or child according to current scientific evidence and as reported in the MOH document on "The continuity of the mother-child relationship and the maintenance of breastfeeding in the event of hospitalisation". Insert the application of good practices among the performance objectives of healthcare facilities.

Indicator 6. Counselling Services for Pregnant and Breastfeeding Mothers

Key question. Are there counselling and support services in place to protect, promote and support breastfeeding and optimal IYCF practices both at facility and community level?

Criteria for assessment and scoring
The Table shows the 5 criteria for assessment; the maximum score is 10.

Criteria	√ Check that apply		
6.1) Pregnant women receive counselling services for breastfeeding during antenatal care.	>90%: 2	50-89%: 1√	<50%: 0
6.2) Women receive counselling and support for initiation of breastfeeding and skin to contact within an hour from birth.	>90%: 2	50-89%: 1√	<50%: 0
6.3) Women receive post-natal counselling for exclusive breastfeeding at hospital or home.	>90%: 2	50-89%: 1√	<50%: 0
6.4) Women/families receive breastfeeding and IYCF counselling and support at community level.	>90%: 2	50-89%: 1√	50%: 0
6.5) Community-based health workers are trained in counselling skills for IYCF.	>50%: 2√	<50%: 1	No training: 0
Total score	**6/10**		

Background

In Italy, breastfeeding remains a practice whose protection, promotion and support are ensured in a non-homogeneous way by geographical area and socio-cultural condition. The impact of this discrepancy has become particularly evident in conjunction with extraordinary events such as the recent Covid-19 pandemic. This situation does not guarantee the full enjoyment of every mother's right to up-to-date and evidence-based information, free from conflicts of interests that are increasingly pervasive and difficult to sanction, especially in light of the circulation of information on new media. Furthermore, the extreme difficulty in finding data at national level regarding mother-to-mother breastfeeding counselling and support, individual or group counselling, home visits or other relevant support measures and activities at local level has a negative impact on guaranteeing women access to adequate and respectful information, care, counselling and support services to improve breastfeeding and infant feeding practices.
Throughout the country, there are only 9 communities recognized by UNICEF Italy as BFCI, where an integrated birth path has been activated between birth centres and local services, mainly in family clinics, creating an integrated breastfeeding support network that involves actively medical staff (including family paediatricians) and health workers, pharmacies and the entire community, including peer support. These are all located in the north: Milan, Sondrio, Ancona, Trieste, Roma B, Massa, Bergamo, Trento and Verona.
Further worsening compared to the poor situation highlighted in the 2018 WBT*i* report, family clinics continue to decrease, with numbers well below the legal threshold, they operate without the involvement of general medicine/family paediatricians, and with financial resources that are more and more limited. As highlighted by the 2018-2019 national survey on family counselling published by the NIH, and in the face of new cuts in recent years, support for mothers and consequently for children has dramatically worsened, especially in the most disadvantaged or isolated areas.[1] Pregnant women must increasingly turn to private services and this makes it impossible, also in

light of the pervasive conflicts of interests highlighted in international reports,[2] to evaluate whether and how correctly they are informed about breastfeeding.
If in the 2018 report less than half of pregnant women participated in birth support meetings, and access to services was not easy for women of foreign origin and for those in disadvantaged economic conditions, with the Covid 19 pandemic the situation has changed in some ways positively, but in others negatively. If, for example, many health or social facilities, private clinics, associations and even specialized magazines [3] have made online birth support meetings available in this period, these do not provide, however, univocal and objective indications on the real usefulness and effectiveness of these new forms of support for mothers in conditions of fragility and economic and/or social disadvantage, or for those of foreign origin. Furthermore, despite the indications of the NIH,[4] very reassuring and in favour of breastfeeding even in case of Sars-Cov-2 positivity, the factual situation of extreme loneliness inside and outside the hospital wards certainly did not contribute to the increase in breastfeeding rates. Italian mothers who breastfeed up to six months are only 30%, in the south 23.9%. Only 65% of newborns are exclusively breastfed at the first paediatric visit (generally in the first month of life). Exclusive breastfeeding in the sixth month prevails in mothers working in paid jobs (32.9% vs 21.6% of stay-at-home or unemployed women) and with a university education (31.9%).[5] Confirming the great geographic disparity, during the pandemic only a few regions in Italy started supporting mothers with home healthcare personnel for care during the puerperium and breastfeeding, which was considered a positive experience: among these, Liguria,[6] Friuli Venezia Giulia, Lombardy. The pandemic certainly marked a watershed and a unique event in terms of breastfeeding, too, but it has not contributed to an improvement in good practices or policies for the promotion, protection and support of breastfeeding.[7]
Similar to the previous WBT*i* report, practical skills for breastfeeding protection and support are insufficient in settings where staff lack serious basic training (a 20-hour WHO/UNICEF course, for example) or have not undertaken a path towards BFHI/BFCI accreditation. The start of specific training appears patchy across the country and is not characterized by regularity. However, staff who want to train have a variety of resources available on a regular basis, including on institutional sites, such as the basic course and the NIH in-depth course.[8] For healthcare personnel, the advanced distance learning course on breastfeeding is also worth mentioning, designed and aimed at neonatal nursing staff, born from the collaboration of four professional associations (SIN, SIP, SIN nurses and SIP nurses), designed to offer all nursing and paediatric nursing staff advanced and up-to-date training on breastfeeding.
Similar to the previous WBT*i* report, the distribution of peer support groups across the country is not uniform, and their collaboration with healthcare, hospital and community facilities is not a consolidated practice. It is worth mentioning the constant commitment and growing effectiveness of these support groups in the training of mothers (and fathers) and in the creation of networks between health services, families and the professionals that gravitate around birth, parenting and early childhood. Even today, there is not always integration between hospital services and family counselling. An institutional and exhaustive mapping of peer support groups has never been carried out, nor is it possible to unambiguously establish the scientific reliability or the real adherence to the WHO/UNICEF guidelines of the associations. The process of imposing effective sanctions on those who spread information that is false, scientifically unfounded, harmful or otherwise tainted by more or less hidden conflicts of interests is still complex. This means that mothers do not have a uniform possibility of support in the area. On the other hand, one cannot exclude that mothers in vulnerable conditions rely on networks or counsellors, if not on influencers, who are not exactly suitable or trained for this delicate role, especially in light of the increasingly widespread tendency to find information, including health information, on new media and in particular on social networks (trend which exploded in the Covid 19 pandemic wave). The trend of celebrities who become parents to share their parenting experience with their followers is now widespread, generating a flow of promotion of brands of products for early childhood, from clothing to strollers, from bottles to teats, to breast pumps, up to formula brands and baby food: real promotions that

escape any sanction and bypass the IC in the general praise of clicks. The same goes for advice on how, if and even for how long to breastfeed.[9]
A positive note is the contribution that the internet provides in tracing the main organizations supporting mothers: among the institutional sites, that of the NIH (which makes a list of the main associations operating in the sector available online, citing, in addition to the MOH, MAMI,[10] LLL, IBFAN Italy, UNICEF Italy, Il Melograno, CSB and AICPAM).[11] MAMI provides a valuable region-by-region mapping of support groups:[12] not claiming to be 100% exhaustive, it provides a list of self-help groups with more than 130 entries, including associations, consultants, healthcare personnel, pharmacies. MAMI periodically updates the information entered and checks in advance that they are organizations/people who have specific and up-to-date training in breastfeeding; during the Covid-19 emergency, it also made available a map of the support organizations that provided the counselling service online and for free, with over 9,000 views.[13]
Among other critical issues, the provision of the formula bonus should be noted:[14] subordinated to specific pathologies and with a limited duration, geographic disparities must also be noted regarding its application, so each region provides it in a different and more or less stringent way.
As in the past, breastfeeding support remains seriously lacking in the workplace and it is becoming increasingly difficult to obtain a leave for breastfeeding in risky environments in both the public and private sectors. Furthermore, broader and more integrated family and social support continues to be lacking. At most, there has been the opening of a few Baby Pit Stops (or similar spaces, not necessarily created in collaboration with LLL or UNICEF Italy) in airports, shopping centres, large institutional headquarters,[15] often useful for building front operations without any real and practical change in company policies. In Italy, 74% of the total hours of unpaid care and assistance work fall on women,[16] and returning to paid work constitutes a serious obstacle to breastfeeding.

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Conclusions

Real social and institutional mobilization is needed to create a “breastfeeding culture”, as set out in the Innocenti Declaration, and to energetically defend it from the “formula feeding culture”. The Covid 19 pandemic has highlighted even more dramatically the difficulty in accessing services, especially for women in conditions of fragility and economic and/or social disadvantage or for those of foreign origin. Despite the new forms of support made available thanks to the new media, many mothers are forced to turn to private personnel or, worse, do not have access to assistance and care services.

Limitations and gaps

1. Protection, promotion and support of breastfeeding are ensured in a non-homogeneous manner by geographical area and socio-cultural condition.
2. It is difficult to find data at national level on mother-to-mother breastfeeding advice and support, individual or group counselling, home visits or other locally relevant support measures and activities that ensure women access to adequate and respectful information, care, advice and support services to improve breastfeeding and infant feeding practices.
3. The communities recognized by UNICEF Italy as BFCI are few and located in the north of the country, excluding the entire south, characterized by serious economic and social marginality.
4. Family clinics continue to be curtailed and those that continue to operate are not integrated with hospital services nor adequately financed.
5. Support for breastfeeding in the workplace is seriously lacking, especially in atypical or irregular contractual forms, both in the public and private sectors, and broader and more integrated family and social support continues to be lacking.

Recommendations

1. Implement breastfeeding protection, promotion and support activities with a homogeneous distribution throughout the country, strengthening them in particular in the most disadvantaged areas of the south and on the islands.
2. Promote an institutional mapping of breastfeeding counselling and support activities at national and at regional and/or local level, truly guaranteeing the right of access to adequate and respectful information, care, counselling and support services to improve breastfeeding and infant feeding practices.
3. Increase the number of communities accredited as BFCI by UNICEF Italy, with particular attention to the southern regions.
4. Intervene on national legislation and reverse the trend by strengthening and increasing family clinics, creating an integrated breastfeeding support network that actively involves family medicine and paediatrics, pharmacies and the entire community.
5. Improve legislation and support for mothers working in paid jobs and families with longer leaves and flexible hours at least up to the sixth month of life and hopefully beyond.
6. Implement the IC and impose effective sanctions for violations, with particular attention to conflicts of interests.

Indicator 7. Accurate and Unbiased Information Support

Key question. Are comprehensive IEC strategies for improving IYCF (breastfeeding and complementary feeding) being implemented?

Criteria for assessment and scoring
The Table shows the 6 criteria for assessment; the maximum score is 10.

Criteria	√ Check that apply	
7.1) There is a national IEC strategy for improving IYCF.	Yes: 2	No: 0√
7.2) Messages are communicated to people through different channels and in local context.	Yes: 1	No: 0√
7.3) IEC strategy, programmes and campaigns like WBW and others are free from commercial influence.	Yes: 1 √	No: 0
7.4) Breastfeeding/IYCF IEC materials and messages are objective, consistent and in line with national and/or international recommendations.	Yes: 2 √	No: 0
7.5) IEC programmes (e.g. WBW) that include IYCF are being implemented at national and local level.	Yes: 2 √	No: 0
7.6) IEC materials/messages include information on the risks of formula feeding in line with WHO/FAO guidelines on preparation and handling of powdered infant formula.	Yes: 2 √	No: 0
Total score	**7/10**	

Background

Adequate, evidence-based information, free from commercial interests and well communicated, is an important part of improving child feeding practices. In Italy, there is a national policy on the protection, promotion and support of breastfeeding,[1] but not a strategy for developing and disseminating information to staff and families, with adequate funding. There are also official documents for families and healthcare professionals, as well as national MOH campaigns to promote breastfeeding. Documents from professional associations agree on the duration of exclusive breastfeeding, but do not fully adhere to the international recommendations of WHO and UNICEF, in particular on complementary feeding and duration of breastfeeding.[2-9]
Pregnant women are offered birth support meetings both in hospital and in the local area, where, in most cases, the topic of breastfeeding is also discussed.[10] There are no national data on the population coverage: in the most virtuous regions, for example Emilia-Romagna, CEDAP data allow us to estimate a coverage of around 30%. Family clinics also organize information sessions for groups of mothers and parents on the topic, but the offer is not homogeneous at national level. Only around 10% of the population (in places where there are Baby Friendly Hospitals and Communities with UNICEF certification) is reached by correct information free of commercial interests.
There are various active support organizations from peer mothers spread across the country that provide support and disseminate information, but even in this case there are no national coverage data.[11] Usually, it is the groups of peer mothers who organize the events for the WBW and disseminate, in respect of the IC, specific documentation on the annual theme.
The NHS identifies the family paediatrician as the professional who provides advice to parents on the nutrition of boys and girls. Paediatric care is guaranteed to all boys and girls, but the paediatrician may not be trained according to the GS recommendations; mothers may receive conflicting advice on infant feeding. Currently, in many areas, it is also impossible to enrol

newborns with family paediatricians because many have already reached their coverage cap or because of shortage.
The risks of formula feeding are only mentioned in the SIP position statement on breastfeeding. There are no official guidelines on the preparation of powdered formula recommending to reconstitute it with water at no less than 70ºC, despite the large number of documents clearly mentioning this indication. There is no regulation that imposes standard instructions on the labels of powder formula for reconstitution, although an article of DM 82/2009 requires that the instructions be consistent with WHO/FAO guidelines.
The information circulating in the media (especially digital) is uncontrolled and often in conflict with that of the official MOH documents. They are heavily controlled by marketing of manufacturers and distributors of baby food.

Sources of information and data

1. [National guidelines on the protection, promotion and support of breastfeeding] http://www.trovanorme.salute.gov.it/norme/dettaglioAtto?id=25229
2. http://www.salute.gov.it/imgs/C_17_opuscoliPoster_303_allegato.pdf
3. [Breastfeeding and use of human milk. Position statement 13/09/2015] http://www.salute.gov.it/imgs/C_17_pubblicazioni_2415_allegato.pdf
4. https://www.genitoripiu.it/sites/default/files/uploads/latte_artificiale_2016_0.pdf
5. [Powder formula, instructions for use: the cat is luckier than the child. In: Breaking the Code 2014] http://www.ibfanitalia.org/wp-content/uploads/2012/11/ICV2014-.pdf
6. http://www.salute.gov.it/imgs/C_17_opuscoliPoster_29_allegato.pdf
7. http://www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/792
8. Ministry of Health [Booklet for mothers] http://www.salute.gov.it/imgs/C_17_opuscoliPoster_250_allegato.pdf
9. Ministry of Health [Breastfeeding, an investment for life] http://www.salute.gov.it/imgs/C_17_opuscoliPoster_303_allegato.pdf
10. Saperidoc {Antenatal courses: who attends them?] https://www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/567
11. MAMI [Countrywide distribution of support groups] https://mami.org/gruppi-di-sostegno/

Conclusions

At national level, there is a great lack of homogeneity in the offer of both prenatal and postnatal information for parents regarding breastfeeding and infant feeding based on evidence of effectiveness and free of commercial interests. There is no communication strategy, much less monitoring that information is conveyed at the level of health and social care structures.
The BFHI and BFCI facilities offer information in line with the GS, but the coverage of the population is very low. At local level, groups of peer mothers make up for this deficiency by supporting mothers with information that is mostly consistent with international indications, but even in this case there is no monitoring of what information is provided and how many mothers are reached.
Furthermore, there is no regulation of information on websites, to reduce exposure to commercial marketing.

Limitations and gaps

1. There is no national policy on IYCF, only on breastfeeding, nor a national strategy to implement this policy, with adequate funding.
2. Information on how to safely reconstitute powdered formula is not widely available.
3. There is a lack of homogeneous information and communication, even on institutional sites.
4. There is no regulation on information conveyed through digital media.

Recommendations

1. Develop a comprehensive national policy and an adequately funded strategy for implementation.
2. Disseminate the MOH’s existing promotional material on breastfeeding more widely.
3. Update powder formula reconstitution instructions and make them mandatory for product labels.
4. Update all institutional websites with information provided by the MOH and other institutions with validated information free from commercial interests.
5. Regulate the information conveyed through the media and provide sanctions for those who spread messages that conflict with those recommended and violate the law regulating the marketing of BMS.

Indicator 8. Infant Feeding and HIV

Key question. Are policies and programmes in place to ensure that mothers living with HIV are supported to carry out the global/national recommended infant feeding practice?

Criteria for assessment and scoring
The Table shows the 9 criteria for assessment; the maximum score is 10.

Criteria for assessment	√ Check that apply	
8.1) The country has an updated policy on infant feeding and HIV, in line with the international guidelines on IYCF and HIV.	Yes: 2 √	No: 0
8.2) The policy on infant feeding and HIV gives effect to the International Code/National Legislation.	Yes: 1	No: 0 √
8.3) Health staff and community workers of the HIV programme have received training on HIV and infant feeding counselling in the past 5 years.	Yes: 1	No: 0 √
8.4) HIV Testing and Counselling (HTC)/ Provider-Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	Yes: 1 √	No: 0
8.5) Breastfeeding mothers living with HIV are provided antiretroviral drugs in line with the national recommendations.	Yes: 1	No: 0 √
8.6) Infant feeding counselling, appropriate to national circumstances, is provided to all mothers living with HIV.	Yes: 1 √	No: 0
8.7) HIV-positive mothers are supported and followed up in carrying out the recommended national infant feeding policies.	Yes: 1 √	No: 0
8.8) The country is making efforts to counter misinformation on HIV and infant feeding and to protect, promote and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	Yes: 1	No: 0 √
8.9) Research on infant feeding and HIV is carried out to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	Yes: 1	No: 0 √
Total score	**5/10**	

Background

In Italy, screening tests for HIV infection in pregnant women are recommended for all women/couples at the first prenatal visit and, for pregnant women at risk, also in the third trimester of pregnancy.[1]
HIV-positive mothers/couples who wish to breastfeed should receive personalized counselling to arrive at a shared decision-making process. If pregnant women have not undergone antiretroviral therapy or still have a viral load, formula or pasteurized human milk from a bank should be used, while in case of viral suppression during pregnancy, birth and postpartum, the risk of transmission is less than 1%, but not zero.

Sources of information and data

1. [National guidelines on the use of antiretroviral drugs and on clinical and diagnostic management of individuals with HIV-1] December 2015 http://www.salute.gov.it/imgs/C_17_pubblicazioni_2442_allegato.pdf

2. [An update on new diagnoses of HIV infection and AIDS cases in Italy at 31 December 2021] Notiziario ISS 2022;35(11) https://www.salute.gov.it/imgs/C_17_pubblicazioni_3279_allegato.pdf

Conclusions

In 2021, Italy was below the average estimated incidence of new HIV cases in EU countries (4.3 cases per 100,000 residents).[2] The reduction in the number of new HIV diagnoses affects all modes of transmission. The highest number of diagnoses is attributable to sexual transmission.
The highest incidence of new HIV diagnoses is found in the 30-39 age group (7.3 new cases per 100,000 residents), followed by the 25–29-year group (6.6 new cases per 100,000 residents). In these age groups the incidence in males is 3-4 times higher than in females.
Since 2016, there has been a decrease in the number of new HIV diagnoses in foreigners, both males and females.

Limitations and gaps

1. National guidelines do not recommend breastfeeding for HIV-positive mothers, due to the risk of transmission via breastmilk.
2. The national guidelines do not take into consideration the possibility that a newborn to an HIV-positive mother, both treated with antiretroviral drugs, can be breastfed for at least 6 months with a minimal risk of transmission.
3. Breastfeeding mothers living with HIV are not provided antiretroviral drugs in line with national and international recommendations.
4. Not enough efforts are made to counter misinformation on HIV and infant feeding and to protect, promote and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.
5. Research on infant feeding and HIV to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status, is not carried out.

Recommendations

1. Shared decision-making for infant feeding in high-resource settings is necessary to recognize patient autonomy, meet patient requests, and address the changing reality of perinatal HIV care.
2. Current guidelines continue to recommend formula feeding, an often painful renunciation for mothers who should be fully informed about the risks involved and about practices to make breastfeeding safer.
3. Correct and personalized information, observant of the clinical and psychological conditions of women and their cultural context, is an indispensable premise to allow autonomous, informed and choices shared between families and health workers.
4. Consider the possibility that an HIV-positive mother on controlled antiretroviral therapy, and with adequate support and follow-up, including antiretroviral therapy for the newborn, be allowed to breastfeed exclusively for 6 months, with possible continuation of breastfeeding for 1 or 2 years.
5. Carry out research on infant feeding and HIV to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status

Indicator 9. Infant and Young Child Feeding during Emergencies

Key question. Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies?

Criteria for assessment and scoring
The Table shows the 6 criteria for assessment; the maximum score is 10.

Criteria	√ Check that apply	
9.1) The country has a comprehensive policy, strategy or guidance on IFE as per global recommendations with measurable indicators.	Yes: 2	No: 0√
9.2) Persons tasked to coordinate and implement the above policy, strategy or guidance have been appointed at national and subnational levels.	Yes: 2	No: 0√
9.3) The health and nutrition emergency preparedness and response plan based on the global recommendation includes:		
a. Basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately skill trained counsellors, and support for relactation and wet-nursing.	Yes: 0.5	No: 0√
b. Measures to protect, promote and support appropriate and complementary feeding practices.	Yes: 0.5	No: 0√
c. Measures to protect and support non-breastfed infants.	Yes: 0.5	No: 0√
d. Space for IYCF counselling support services.	Yes: 0.5	No: 0√
e. Measures to minimize the risks of formula feeding, including an endorsed joint statement on avoidance of donations of BMS, bottles and teats, and standard procedures for handling unsolicited donations, and minimize the risk of formula feeding, procurement management and use of any infant formula and BMS, in accordance with the global recommendations on emergencies.	Yes: 0.5	No: 0√
f. Indicators and recording and reporting tools exist to closely monitor and evaluate the emergency response in the context of IYCF.	Yes: 0.5	No: 0√
9.4) Adequate financial and human resources have been allocated for implementation of the emergency preparedness and response plan on IYCF.	Yes: 2	No: 0√
9.5) Appropriate orientation and training material on IFE has been integrated into pre-service and in-service training for emergency management and for relevant health care personnel.	Yes: 0.5	No: 0√
9.6) Orientation and training is taking place as per national plan on emergency preparedness and response is aligned with the global recommendations (at national and sub-national levels).	Yes: 0.5	No: 0√
Total score	**0/10**	

Background

Newborns and children are among the most vulnerable groups in emergencies. The absence or inadequacy of breastfeeding, and inadequate complementary feeding, increase the risk of malnutrition, disease and mortality. In emergency and humanitarian relief situations, the affected country and the agencies responsible for responding to the emergency share the responsibility to protect, promote and support optimal infant feeding practices, and to minimize harmful practices for all affected women, families and children. A concise operational guide on how to ensure appropriate feeding in emergency situations and comply with international standards has been

developed by an inter-agency working group (IFE Core Group).[1] In 2018, a WHA resolution called on all governments to ensure that IFE is part of their policies and plans and that their staff have the necessary capacities to protect, promote and support child feeding practices during emergencies.[2] Since no actions have been implemented to comply with the resolution, the score in the Table, which refers to the national situation, is equal to zero.

Other useful information

The PEC is an operational tool for the protection and safeguard of citizens and territories in the event of an emergency due to disasters of public impact. It contains the procedures necessary to respond to any expected or sudden disaster, allowing the authorities to activate and coordinate relief efforts to support the affected population. Given the importance of this tool, the government has made it mandatory since 2012 with Law 100/2012. The PEC therefore has a public function: it must be a tool that can be used by citizens, understandable by anyone and constantly promoted, so that each person can use it to deal consciously with emergency situations and become an active promoter, reducing the risks for themselves and for other people as much as possible.

In 2016, the newly installed municipal administration of Marino, near Rome, recognized the urgency of complying with Law 100/2012 and recognized the fundamental role of local voluntary and civic organizations and associations in the management of emergencies. For this reason, the drafting of the PEC took place in a participatory manner through the involvement of around 50 associations, neighbourhood committees, citizens, employees of the municipality and the LHA, the Red Cross, as well as local institutions responsible for managing emergencies and mainly fire brigades and police forces. Coordination was undertaken by two local associations particularly prepared and sensitive to emergencies, “Marino Aperta Onlus” and “Gruppo di Presenza Mons. Grassi”. The PEC was drawn up as part of meetings and information exchanges on web platforms and training seminars with sector experts who addressed various topics useful for the development of the document. In particular, the voluntary organization “La Goccia Magica” proposed that in the PEC attention should be paid to infants (0-12 months), children under two years of age and pregnant and breastfeeding women, since they present specific needs which must be responded to immediately and adequately during emergencies. The PEC, approved on 29 November 2016, consists of 8 annexes which list: the associations available to provide support in managing the emergency in the local area; the materials and means immediately available, in addition to the agreements stipulated by the Municipality for supply within tight deadlines; the operational procedures adopted for possible disasters that may occur in the area; the procedure to be tested and applied for IFE.[3]

Consistent with the general aim of the PEC to promote the efficiency of relief and respond adequately to the objectives of the population, in particular of groups with increased vulnerability, the objective of the IFE procedure is to regulate the supply and management of BMS, with attached rules of hygienic safety for preparation and distribution, so that they are guaranteed to those who need them and do not interfere with the protection and promotion of breastfeeding for others. The IFE procedure is divided into 8 sections, which reflect the key points of the IFE operational guide, relevant to the local context, and include:

- collection of key information on pregnant or breastfeeding women and on infants and children in the population, disaggregating the information by age (0-6, 7-12, 13-24 months, 2-5 years) and type of nutrition (exclusive, predominant, complementary, non-breastfeeding);
- provision of reception areas dedicated to mothers, fathers and children, which respond to their specific needs;
- initial assessment of the context, including the environments, the availability of foods suitable for complementary feeding, the training of dedicated staff involved in caring for mothers and children;
- response to the children’s needs, appropriate for age and type of breastfeeding/nutrition;

- reduction of risks linked to the inappropriate use of BMS, with reference to current legislation and the provisions of the IC.

In 2021 the Civil Protection of the Calabria Region implemented what is foreseen in the IFE Operational Guide, preparing a plan of assistance for the most fragile groups of the population through synergistic action between those who in different capacities are dedicated or involved in the emergency preparation, management and recovery. This plan promotes and supports the feeding of infants and young children who, in emergency situations, present an increased vulnerability, favouring breastfeeding and providing them with dedicated or alternative spaces, adequate complementary or replacement nutrition.[4] Regarding donations, the procedure insists on the need to inform those responsible for humanitarian aid that donations of formula and other BMS are not necessary and may interfere with emergency management and breastfeeding. Any unsolicited donations of formula and BMS should be collected from access points and handled by the emergency coordination agency. The distribution of BMS is subject to clinical evaluation carried out by personnel trained in IFE, who define for which infants the supply is necessary (temporary or long-term) and guarantee the supply.

Since the beginning of the COVID-19 pandemic, to respond to the emerging needs for reorganization of the healthcare network in the maternal and child health area, it has become necessary to review the pathways for taking care of pregnant women, mothers, fathers and newborns. The initial pressure, especially in the most affected areas, led the regional health services to define care paths based on organizational and logistical availability. Moreover, in the initial phase of the pandemic, between January and March 2020, the scientific evidence to support these decisions was still scarce and not always unambiguous. Currently, the available literature more consistently indicates the possibility of breastfeeding, of practicing skin-to-skin contact and rooming-in, and of having a person of the woman's choice close by during labour, delivery and hospital stay according to the international recommendations, in addition to breastfeeding during emergencies in general, also for women with suspected or confirmed SARS-CoV-2 infection. For this reason, the NIH has made available to healthcare personnel a selection of resources, literature and scientific evidence on pregnancy, childbirth and breastfeeding, including the Interim indications for pregnancy, childbirth, breastfeeding and care of children aged 0- 2 years in response to the COVID-19 emergency.[5]

In addition, the NIH and UNICEF Italy developed information materials on breastfeeding and IFE to support the protection and promotion of health by healthcare and emergency personnel involved in welcoming migrant and refugee people. The multilingual infographics in Italian, English and Ukrainian highlight the importance of supporting mothers to initiate and continue breastfeeding, which is essential to protect their health and well-being and that of their children. The materials also show how to support and protect the nutritional needs of non-breastfed children, to minimize the risks to which they are exposed.[6,7]

Sources of information and data

1. IFE (Infant Feeding in Emergencies) Core Group. [Infant and young child feeding during emergencies. Operational guide for first-aid personnel and for people in charge of emergency programmes] 2017 Italian edition
2. Infant and young child feeding. WHA Resolution 71.9, Geneva, 26 May 2018 https://apps.who.int/iris/bitstream/handle/10665/279517/A71_R9-en.pdf
3. Colaceci S, Raparelli I, Cericco M, Oliva C, Dibello A, Tiberi P et al. [Development of strategies for infant feeding in emergencies: the experience of Marino municipality for a municipal and participated emergency plan] BEN, 2018 https://www.epicentro.iss.it/ben/2018/settembre/alimentazione-infantile-emergenze-marino
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6. [Breastfeeding and feeding during emergencies: the multilingual ISS and UNICEF card] https://www.iss.it/news/-/asset_publisher/gJ3hFqMQsykM/content/id/6937856

7. Iellamo A, Giusti A, Zambri F, Colaceci S, Possenti V, Brillo E et al. [The six steps on infant feeding during emergencies] BEN, 2018

Other useful documents

8. [Protection of infants during emergencies: information for the Media] https://www.ennonline.net/attachments/985/ife-media-guide-italiano.pdf
9. Bomben J, Chapin EM, Colaceci S, Giusti A [Simulation of seismic emergencies: case studies on breastfeeding and infant feeding] BEN, 2018
10. Giusti A, Brillo E, Zambri F, Pro E, Colaceci S. [The experiences of pregnant and breastfeeding women during the earthquake pregnancy in Abruzzo region: results of a qualitative descriptive study] BEN, 2018
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13. ISS [Conference on health emergencies, natural disasters and feeding in the first 1000 days] https://www.epicentro.iss.it/allattamento/ConvegnoIss2018
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15. UNICEF Education Section. Risk-informed Education Programming for Resilience: Guidance Note. New York; 2019 https://www.unicef.org/media/65436/file/Risk-informed%20education%20programming%20for%20resilience:%20Guidance%20note.pdf
16. Emergency Nutrition Network, Infant and Young Child Feeding in Emergencies (IFE) Core Group. Operational Guidance on Breastfeeding Counselling in Emergencies. 2021 https://www.ennonline.net/breastfeedingcounsellinginemergencies
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19. UNICEF. Procurement and use of breastmilk substitutes in humanitarian settings. 2021. https://www.unicef.org/documents/procurement-and-use-breastmilk-substitutes-humanitarian-settings
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Conclusions

Women, newborns and children are particularly vulnerable in emergency conditions. Their vulnerability is determined by specific nutritional needs and the immaturity of the immune system. Breastfeeding guarantees hydration, nutritional intake and immune support. In emergency conditions, non-breastfed children are exposed to greater health problems (infections, diarrhoea, dehydration). In such contexts, access to clean, boiled water for formula reconstitution and hygiene of feeding aids is difficult. Italy has been hit, even recently, by serious emergencies (earthquakes, floods, COVID-19 pandemic). In addition, there are areas with strong migratory pressure in which mothers, newborns and children have specific nutritional and health needs, also linked to the migratory context. The international guidelines on IFE, including breastfeeding protection, have been translated into Italian. Despite this, the recommendations are often not implemented. Among the main national actors for emergencies, the Civil Protection Department plays a fundamental role

in the management of the main critical issues related to the health of mothers and children. Although the IFE operational guidelines have been applied and integrated at local and/or regional level, implementation at national level is lacking.

Limitations and gaps

1. Lack of integration and implementation of IFE operational guidelines at national and local level in emergency situations (natural or man-made).
2. Inappropriate breastfeeding protection practices and poor implementation of IC recommendations.
3. Not culturally sensitive assistance with the feeding of women, newborns and children.
4. Deficiencies in IFE training for healthcare and lay personnel involved in emergency response.

Recommendations

1. A national policy on the use of formula during emergencies should be developed and approved.
2. The Civil Protection Department and other bodies that intervene in emergency situations (Red Cross, Caritas, NGOs, voluntary associations, etc.) should adopt and share operational guidelines on IFE based on scientific evidence and international standards, which include preparation and management strategies for any BMS donations. They should then ensure that these guidelines are applied as needed, ensuring the involvement of adequately trained personnel.
3. Formula donations should be prohibited or at least discouraged during all emergencies. For the benefit of mothers and infant nutrition, the following can be donated:
    a. other nutritious foods, for example, foods of animal origin such as fish or canned meat;
    b. other products, for example clothes, toiletries for children, blankets, water, diapers;
    c. funds to support child feeding programmes.
4. The provision of formula to infants and children who need it should be accompanied by advice on correct preparation, administration and storage and by a supply of clean water.
5. Training should cover local and support staff, members of associations, and anyone involved in IFE, including volunteers. The media and people dealing with donations should be informed of the existence of the operational guidelines. The goal is to protect, promote and support breastfeeding during emergencies, and to ensure, through compliance with the IC, that humanitarian assistance does not interfere with breastfeeding.
6. In emergencies, as in normal situations, public health recommendations on exclusive breastfeeding for the first six months and breastfeeding with complementary foods for two years and beyond remain valid.

Indicator 10. Monitoring and Evaluation

Key question. Are monitoring and evaluation systems in place that routinely or periodically collect, analyse and use data to improve IYCF practices?

Criteria for assessment and scoring
The Table shows the 5 criteria for assessment; the maximum score is 10.

Criteria	√ Check	
10.1) Monitoring and evaluation of IYCF programmes or activities (national and sub national levels) include the following indicators: early breastfeeding within an hour from birth, exclusive breastfeeding under 6 months, continued breastfeeding, complementary feeding and adequacy of complementary feeding)	Yes: 2	No: 0 √
10.2) Data and information on progress made in implementing IYCF programmes are used by programme managers to guide planning and investment decisions.	Yes: 1 √	No: 0
10.3) Data and information on progress made in implementing IYCF programmes are routinely or periodically collected at sub national and national levels.	Yes: 3 √	No: 0
10.4) Data and information related to IYCF programme progress are reported to key decision-makers.	Yes: 1 √	No: 0
10.5) IYCF data is generated at least annually by the national health and nutrition surveillance system, and/or health information system.	Yes: 3	No: 0 √
Total score	**5/10**	

Background

The Italian NHS is experiencing an increasingly accentuated process of regionalization which also involves health monitoring and evaluation systems, and not only for the nutrition and nutritional status of infants and children. In some regions (Friuli Venezia Giulia, Emilia Romagna, Tuscany, Autonomous Province of Trento) regional data collection systems on breastfeeding have been operational for years, with the relative estimate of some indicators used to plan, evaluate and re-plan activities. However, these systems vary from region to region and, although they use standardized definitions and methods based on WHO indications, they are incompatible both from a methodological point of view (routine data vs sample surveys, transversal vs longitudinal) and in terms of the indicators used (hospital, local, at different ages).

The available national estimates for some of the indicators recommended by WHO derive from a 2013 ISTAT survey on maternal and child health.[1] These data were used to prepare the 2018 WBT*i* report, but are now obsolete and can no longer be used for evaluation and programming purposes. More recently, the Surveillance of Children 0-2 years was launched (Surveillance System for 0-2 years on the main determinants of child health) promoted by the MOH and coordinated by the NIH in collaboration with the Regions and PAs. Surveillance of Children aged 0-2 years allows to estimate at regional and/or local level the prevalence of certain protective or risky behaviours for the health of children, and to produce indicators required by WHO and/or by PNP and PRP, including breastfeeding. This surveillance, included in the MD of 2017 on Surveillance Systems

and National Registers,[2] after a first test in 2013 in 13 health districts,[3-4] in 2018 involved 11 regions,[5] and in the data collection of 2022 all the regions, with the exception of Molise and the Autonomous Province of Bolzano.[6] Tuscany participated by making available the results of the survey on childbirth already active in its territory and coordinated by SUSSA. Thanks to this surveillance, for the first time accurate and precise estimates are promptly available, even at a regional level, for some of the indicators recommended by WHO. The availability of these data, the monitoring of indicators over time and the analysis of regional differences, also in relation with socioeconomic factors, allow national and regional health authorities to plan targeted actions in all territories.

The results of the 2022 Surveillance of Children aged 0-2 years

About 46.7% of children aged 2-3 months in the pool of participating regions are exclusively breastfed, with a regional variability between 29.6% in Sicily and 62.5% in the Autonomous Province (PA) of Trento. Exclusive breastfeeding is significantly reduced in the 4–5-month age group, involving 30.0% of children, with variability between 13.5% in Sicily and 43.2% in the AP of Trento and in Friuli Venezia Giulia. As far as breastfeeding beyond one year of life is concerned, 36.2% of children continue to receive breastmilk in the 12–15-month age group (24.8% in Campania; 46.2% in Marche and 49.7% in Tuscany). Out of all surveyed children, 13.0% were never breastfed, with rates ranging between 7.0% in Marche and 17.2% in Sicily. In the southern regions, compared to the central-northern regions, lower values are observed for all the indicators taken into consideration.

Other useful information

Italy achieved a good performance in sub-indicators 10.2, 10.3 and 10.4 thanks to the Surveillance of Children aged 0-2 years which, every three years, provides information that is shared with the people responsible for strategic decisions, policies and healthcare management. The information collected provides a solid basis to support national health decisions and policies, enabling a more informed approach to planning and managing resources for the health of children. The 2020-2025 PRPs, in fact, use surveillance data for planning purposes.

On the contrary, an insufficient national performance emerges in sub-indicators 10.1 and 10.5. However, it should be noted that the current evaluation criteria do not include intermediate situations, in which the indicator objectives are only partially achieved. The possibility of assigning an intermediate score would allow us to recognize laudable initiatives such as the annual longitudinal surveys on childbirth in Tuscany and the PA of Trento, the cross-sectional data collection carried out annually in Emilia-Romagna and that on breastfeeding at discharge and at the second vaccination continuously recorded in Friuli-Venezia Giulia. The next challenge will be to standardize the different regional information systems and invest resources to collect data on all the indicators recommended by WHO. It will be important to start by including questions on early breastfeeding within one hour from birth and exclusive breastfeeding within 48 hours from birth in the review of the national CEDAP roadmap currently being defined. This will help improve national performance assessment and ensure more accurate monitoring of the health and well-being of newborns, infants and children.

Sources of information and data

1. ISTAT [Pregnancy, birth and breastfeeding] Rome, 2013 https://www.istat.it/it/files/2014/12/gravidanza.pdf?title=Gravidanza%2C+parto+e+allattamento+al+seno+-+09%2Fdic%2F2014+-+Testo+integrale.pdf
2. Prime Minister Decree 3 March 2017 [Identifications of surveillance systems and mortality records for cancers and other diseases] Gazzetta Ufficiale Serie Generale n. 109, 12 May 2017

3. Pizzi E, Spinelli A, Battilomo S et al. [Determinants of infant health: pilot testing a new surveillance system in Italy] Epidemiol Prev 2019;43(1):66-70
4. Pizzi E, Lauria L, Buoncristiano M et al. [The new surveillance system on determinants of infant health. In: National Observatory on Health of the Italian Regions] Rapporto Osservasalute 2018. p. 352-3
5. Pizzi E, Salvatore AM, Donati S, Andreozzi S, Battilomo S, Privitera MG [The Surveillance 0-2 system: objectives, methods and results from the 2018-2019 survey] ISS, Rome, 2022
6. https://www.epicentro.iss.it/sorveglianza02anni/indagine-2022

Conclusions

Compared to the 2018 WBT*i* report, important progress has emerged thanks to the development of the Surveillance of Children aged 0-2 years which in 2018 had provided partial data due to the participation of half of the regions. In 2022, with the participation of almost all the regions, the results can be considered representative for the entire country, with the exclusion of the PA of Bolzano and Molise. Surveillance, by collecting data during vaccination sessions, allows monitoring 3 of the 5 WHO indicators: exclusive breastfeeding at 2-3 and 4-5 months and continued breastfeeding at 12-15 months. The initiation of breastfeeding within an hour of birth and exclusive breastfeeding in the first two days of life could be detected through the national CEDAP data. Bottle feeding and complementary feeding at 6-8 months are currently difficult to estimate and could benefit from a discussion on their priority at national and international level.

Limitations and gaps

The current Surveillance of Children aged 0-2 years system allows to estimate every 3 years only some of the indicators recommended by WHO. In particular, there is a lack of a standardized national system to collect data on breastfeeding immediately after birth and during the days of hospitalization in the maternity wards. It is important to note that these critical issues are common to many EU countries. It would therefore be desirable to consider the opportunity to address these challenges through a joint EU initiative.

Recommendations

1. Enter the data for estimating relevant WHO indicators into the national CEDAP.
2. Promote a uniform approach to collecting and recording breastfeeding data, as recommended by WHO, across the EU to facilitate more effective monitoring and evidence-based planning.
3. Promote the exchange of knowledge and good practices among EU countries to improve policy evaluation and monitoring.

Indicator 11. Timely initiation of breastfeeding within one hour of birth

Key question. What is the percentage of newborn babies breastfed within one hour of birth? **NA**

Definition
Percentage of infants and children aged 0 to 23 months put to the breast within one hour of birth.

Rating based on WHO criteria	Colour coding
0.1-29%	**Red**
29.1-49%	**Yellow**
49.1-89%	**Blue**
89.1-100%	**Green**

Source of data
There are no data for this indicator.

Comments
Current surveillance systems do not provide data for this indicator. The only estimate available refers to overall initiation of breastfeeding and has already been included in the 2018 WBT*i* report.

Indicator 12. Exclusive breastfeeding for the first six months

Key question. What is the percentage of infants less than 6 months of age who were exclusively breastfed in the last 24 hours? **46.7% (2022)**

Definition

Proportion of infants 0-5 months of age who received only breastmilk during the previous 24 hours. (0-5 months means 5 months and 29 days)

Rating based on WHO criteria	Colour coding
0.1-11%	**Red**
11.1-49%	**Yellow**
49.1-89%	**Blue**
89.1-100%	**Green**

Source of data

1. https://www.epicentro.iss.it/sorveglianza02anni/indagine-2022

Comments

About 46.7% of infants aged 2-3 months in the pool of regions where the Surveillance in Children0-2 months of age was carried out are exclusively breastfed, with a regional variability between 29.6% in Sicily and 62.5% in the PA of Trento. Exclusive breastfeeding in the 4–5-month period is 30.0%, with variability between 13.5% in Sicily and 43.2% in the PA of Trento and Friuli-Venezia Giulia. Given that the prevalence of exclusive breastfeeding at 0-1 months of age is certainly greater than 46.7%, the value at 2-3 months could be a good approximation of the indicator recommended by the WHO. However, what does not change is the score, still in the yellow band (6 points).

The national average of 46.7% hides regional differences (higher values in the northern and central regions, lower in the south) and certainly differences by level of maternal education (higher values in mothers with higher education than in the others). The rate of exclusive breastfeeding obviously decreases as the age of infants increases.

Indicator 13. A) Median duration of breastfeeding; B) Continued breastfeeding at 12-15 months

Key questions. A) Babies are breastfed for a median duration of how many months? **8.3 months**. B) What is the percentage of children breastfed at 12-15 months? **36.2% (2022)**

Indicator 13 A	Key to rating adapted from WHO tool	Value	Colour rating
Median duration of breastfeeding	0.1-18 months	8.3	Red
	18.1-20 months		Yellow
	20.1-22 months		Blue
	22.1- 24 months or beyond		Green

Indicator 13 B	Rating based on WHO criteria*	Value	Colour coding
Continued breastfeeding at 12-15 months	0.1-39.9%	36.2%	Red
	40-59.9%		Yellow
	60-79.9%		Blue
	80-100%		Green

* There are no WHO criteria for assigning a score. The ones used in this table are those of the Global Breastfeeding Collective scorecard at 12 months, and not at 12-15 months; however, there should not be much difference.

Sources of data

A. ISTAT. Gravidanza, parto e allattamento al seno. ISTAT, Rome, 2013 https://www.istat.it/it/files/2014/12/gravidanza.pdf

B. https://www.epicentro.iss.it/sorveglianza02anni/indagine-2022

Comments

A) There is no latest data available for this indicator. Therefore, data from 2013 is being used, as in the 2018 report. Also, median duration of breastfeeding is no longer included by WHO in its 2021 list of indicators for assessing IYCF practices, replaced by the more easily interpretable continued breastfeeding at 12-23 months of age. Italy does not have data for the whole second year of life, but the Surveillance System 0-2 years provides estimates for the age group 12-15 months, when children receive some vaccines and boosters.

B) The Surveillance System 0-2 years, carried out by the National Institute of Health between June and October 2022 on the main determinants of child health, gathered data on 35,550 mothers and children. The percentage of children aged 12 to 15 months who were breastfed in the last 24 hours was 36.2% As with most health indicators, this too shows a north-south gradient. The highest values, between 40% and 50%, are found in the central-northern regions (Tuscany 49.7%, Marche 46.2%), except for Veneto (37.4%) and Lombardy (36.5%). The lowest ones are in the south: Sicily (27.0%), Calabria (26.2%) and Campania (24.8%).

Indicator 14. Bottle feeding

Key question. What percentage of infants 0-12 months of age are fed with any foods or drinks (even breastmilk) from bottles? **NA**

Definition
Percentage of children 0–12 months of age who are fed with a bottle.

Rating based on WHO criteria	Colour coding
29.1-100%	**Red**
4.1-29%	**Yellow**
2.1-4%	**Blue**
0.1-2%	**Green**

Source of data
There are no data for this indicator.

Comments
It is difficult to collect reliable data on this indicator that even WHO considers of negligible or null relevance.

Indicator 15. Complementary feeding – Introduction of solid, semi-solid and soft foods

Key question. Percentage of breastfed infants receiving complementary foods at 6-8 months of age? **83% (2021)**

Definition
Percentage of infants 6-8 months of age who received solid, semi-solid or soft foods in the last 24 hours.

Rating based on WHO criteria	Colour coding
0.1-59%	**Red**
59.1-79%	**Yellow**
79.1-94%	**Blue**
94.1-100%	**Green**

Source of data

1. Nacamuli M et al. [Nutrition in the first six months of life: analysis of data from the NASCITA cohort]. Ricerca e Pratica 2021;37:53-61

Comments
The data come from a cohort study carried out by a research group of the Mario Negri Institute in Milan in collaboration with the ACP. The cohort includes 5153 children born between 1 April 2019 and 1 April 2020, cared for by 139 paediatricians spread across the whole country. The data on complementary feeding concerns 809 children who have already reached the indicated age. At the end of the seventh month, 83% of these had already introduced complementary foods. The mean for this introduction was 5.3±0.8 months. Almost 10% had started complementary foods at 4 months and 51.4% at 5 months.

Note
The 2021 WHO definition for this indicator appears not to include liquids (water, other beverages, animal milk, formula), but that of a subsequent indicator (minimum meal frequency) includes various types of animal milk and formula. The WBT*i* guide says that this indicator only measures if complementary foods are introduced "in a timely manner", i.e. after 6 months and continuing with breastfeeding. But a child who consumes complementary foods between 6 and 8 months may have started earlier, i.e. not "in a timely manner", as shown by the data of the Italian cohort.

Summary and conclusions

Part I. IYCF policies and programmes.

Indicators	Score 2018	Score 2023
1. National Policy, Governance and Funding	2	1
2. Baby Friendly Hospital Initiative / Ten Steps to Successful Breastfeeding	6	1
3. Implementation of the International Code of Marketing of Breastmilk Substitutes	6	6
4. Maternity Protection	8	7
5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF)	5	4
6. Counselling Services for the Pregnant and Breastfeeding Mothers	5	6
7. Accurate and Unbiased Information Support	8	7
8. Infant Feeding and HIV	6	5
9. Infant and Young Child Feeding during Emergencies	1	0
10. Monitoring and Evaluation	5	5
Total Score	**52/100**	**42/100**

IBFAN Asia classification for the WBT*i*
The maximum total score for indicators 1-10 is 100.

Scores	Colour coding
0 – 30.9	Red
31 – 60.9	Yellow
61 – 90.9	Blue
91 – 100	Green

Conclusions
Compared to 2018, there was a worsening of the total score in 2023. In particular, the scores for indicators 1, 2, 4, 5, 7 and 9 decreased. Part of this worsening could be due to the modification of the criteria to assign scores. In 2018 there was often the possibility of awarding half points when a criterion was partially respected, in substantial or geographical terms; in 2023 half points are not expected, especially in terms of geographical coverage. That said, the only indicator with a slight improvement is number 6. Note the score of 0 for indicator 9, despite Italy being a country frequently affected by events that cause emergencies for affected populations. The Part I total score places Italy at a slightly higher level than the minimum, far from the optimal level. Except for maternity protection and information support, which however does not take into account information on social media, often provided directly or indirectly by the baby food industry, it is necessary to fill deficiencies and gaps in all the other areas, and in particular for policies and programmes, BFIs and IFE. Some of the recommended actions require only political will (for

example, compliance with the IC). Others require human, material and financial resources (for example, BFIs). It is hoped that this report will stimulate policy makers, as well as administrators and health professionals at national, regional and local levels, to make commitments to changes towards better protection, promotion and support of IYCF, and especially breastfeeding.

Part II. IYCF practices

As far as IYCF practices are concerned, the results of the 2018 and 2023 assessments cannot be compared. First, because the revised 2019 WBT*i* tool assigns only a colour code, not a score, to indicators 11-15. Second, because there was a change of indicators. Finally because, as stated in the note to the Table of page 6, the national team in charge of the 2023 report decided to replace one of the recommended indicators, the median duration of breastfeeding (no longer listed among the WHO 2021 recommended indicators and for which only the 2013 data were available), with one for which recent 2023 data were available (continued breastfeeding at 12-15 months). The team considered that the latter would not only portray current as opposed to past situation, but would also be more meaningful.

The Table summarizes the results of the 2018 and 2023 assessments as far as IYCF practices are concerned.

IYCF practices	**Results 2018**	**2018 scores and colour coding**	**Results 2023 and colour coding**
11. Initiation of breastfeeding/Timely initiation of breastfeeding within one hour of birth	36%	6	NA
12. Exclusive breastfeeding for the first six months	42.7%	6	46.7%
13. A) Median duration of breastfeeding B) Continued breastfeeding at 12-15 months	8.3 months	3	A) 8.3 months B) 36.2%
14. Bottle feeding	NA	0	NA
15. Complementary feeding – introduction of solid, semi-solid and soft foods	73%	6	83%

Conclusions
Compared to 2018, there is a slight improvement in indicators 12 and 15. Overall, however, Italy does not fare well. Yellow and red levels require commitments to improve. Interventions are urgently needed to monitor the timely initiation of breastfeeding at birth and the exclusivity of breastfeeding during the first six months, but also continued breastfeeding at 12-15 months. It is more difficult to interpret data on bottle feeding, should they be available, and on the timely and safe introduction of adequate complementary foods. Overall, the national monitoring and evaluation system must be improved. This will allow to improve current regional and local systems and bridge the gap between north and south.

Overall conclusions

Main limitations and gaps

Given the results previously displayed, it is clear that limitations, gaps and recommendations coincide almost completely with those of 2018:

1. The national policy is old and should be updated to cover other aspects of infant feeding in addition to breastfeeding.
2. There is a lack of a national plan for the protection, promotion and support of breastfeeding and infant feeding.
3. The financial resources allocated to infant nutrition are scarce and poorly distributed.
4. The current TAS does not have the functions of a NBC.
5. BFIs do not cover the whole country and there is still a north/south gap.
6. National legislation does not include all the provisions of the IC and its application is not systematically monitored.
7. There is no regulation on information conveyed through digital media.
8. There is a lack of homogeneous information, even on institutional websites.
9. The instructions for reconstitution, handling and use of powdered formula vary from brand to brand and do not guarantee safer use.
10. Current maternity protection measures do not apply to all workers and are not applied in all workplaces.
11. Current paternity leaves should be increased, from a gender equality perspective.
12. Almost all degree and specialization courses for healthcare personnel provide insufficient and inadequate training on infant nutrition, and in particular on breastfeeding.
13. There is a lack of national and local guidelines for IFE (in natural and man-made emergencies), based on international standards.
14. Current country-wide systems for monitoring and evaluating IYCF do not meet all needs.

Main recommendations

1. Establish an NBC, as foreseen by the Innocenti Declaration, to update current policies and to stimulate the development of a national plan on IYCF, which will then be adapted and put into practice at regional and local levels, with adequate resources.
2. Include BFIs in the national plan and extend their coverage, first and foremost, to the southern regions, with adequate funding.
3. Fully integrate the IC into national legislation and enforce its application as set out in the 2016 WHO guidance on ending the inappropriate promotion of foods for infants and young children.
4. Standardize instructions for reconstitution, handling and use of powder formulas in product labels, based on the 2006 WHO/FAO standards.
5. Implement a strict regulation of information on child nutrition in digital media.
6. Extend maternity protection measures to all workers and all workplaces.
7. Update the curricula of degree and specialization courses for healthcare personnel, and motivate them to become Baby Friendly.
8. Adopt and implement international IFE recommendations.
9. Develop and implement a national monitoring and evaluation system on IYCF.