

CLINICAL OBSERVATIONS

Monitoring breastfeeding rates in Italy: national surveys 1995 and 1999

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Aim: To assess and compare the rates of initiation and duration of breastfeeding in Italy in 1995 and 1999, and to examine the adherence to the ten steps to successful breastfeeding recommended by WHO. **Methods:** Two cohorts of mothers who delivered healthy infants in November 1995 ($n = 1601$) or November 1999 ($n = 2450$) were interviewed by telephone within 4 wk of delivery and when their infant were 3, 6, 9 and 12 mo of age. Type of breastfeeding was classified according to the WHO definitions. Adherence to the WHO ten steps was evaluated as experienced by the mothers. **Results:** Initiation and duration of breastfeeding increased during the 1995–1999 period ($p < 0.0001$). The rate of breastfeeding at birth, at discharge and when the infants were 3, 6, 9 and 12 mo of age was 85%, 83%, 42%, 19%, 10% and 4%, in 1995 and 91%, 89%, 66%, 47%, 25% and 12% in 1999. The rate of exclusive breastfeeding was higher in 1999 than 1995 at birth (39% vs 30%, $p < 0.0001$) and at discharge (77% vs 70%, $p < 0.0001$), but overall no longer duration was observed in 1999. At 4 and 6 mo of age the rate of exclusive breastfeeding was 25% and 8% in 1995 and 31% and 5% in 1999. The adherence to each WHO step was higher in 1999 than in 1995 ($p < 0.05$) but concomitant adherence was low (<3%).

Conclusion: Although an increase in initiation and duration of breastfeeding occurred in Italy during the 1995–1999 period, the duration of breastfeeding and exclusive breastfeeding is currently unsatisfactory, as is adherence to the ten steps specified by WHO. Promotion of breastfeeding and education and improvement in adherence to the WHO recommendations are still needed in Italy.

Key words: Breastfeeding, epidemiology, exclusive breastfeeding

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The advantages and benefits of breastfeeding for infants, mothers and health systems are well known (1–11). Exclusive breastfeeding in the first 6 mo of life and prolonged breastfeeding through the weaning period are recommended by international organizations, and recommendations for feeding infants do not vary widely (12–15).

Rates of breastfeeding initiation and duration are higher in the Scandinavian countries, where policies aimed at breastfeeding promotion have been implemented to a greater extent and objectives and targets are more established than in other industrialized countries (12, 15–21). Although the relevance of breastfeeding education for mothers and health workers has been recognized, in Italy there is no national plan to promote breastfeeding, nor have any national guidelines been proposed or local health authorities actively supporting breastfeeding. Current data on the prevalence of

breastfeeding are controversial and real prevalence rates might be lower than the reported values (22). Non-homogeneity in definitions, differences in data collection procedures, and varying admission criteria may have led to inaccurate results. Moreover, as pointed out by Cattaneo and colleagues (22), in Italy most investigations were conducted on non-representative samples. This may also be a relevant issue outside Italy; e.g. in Australia and the USA (23, 24). Therefore there is obviously a need to conduct accurate surveys to examine breastfeeding practice on the basis of representative samples, clearly identified eligibility criteria and internationally accepted standardized definitions.

The aims of this study were to assess and compare the rates of initiation and duration of breastfeeding in Italy in 1995 and 1999, and to assess the adherence to the ten steps to successful breastfeeding recommended by WHO.

Subjects and methods

Two cohorts of infants born in Italy on either November 1995 or November 1999 were enrolled before 30 d of age according to the following eligibility criteria: weight at birth equal or above 2500 g, gestational age between 37 and 42 completed weeks, single birth, absence of congenital malformations, Italian-speaking mother. Exclusion criteria were: presence of inherited metabolic disease and neonatal diseases requiring hospitalization for longer than 7 d.

Lists of births were obtained from hospitals and clinics, and then merged. Infants were then randomly selected to give a homogeneous representation of the geographical distribution of yearly live births in Italy. A randomization list for each of the 20 administrative regions in Italy was generated by computer, assuming that all the infants had the same probability of being recruited. At the first interview, the mothers were checked for eligibility criteria.

The institutional ethics committee approved the study. Mothers of eligible infants were required to give their verbal consent to participate in the surveys. The mothers were interviewed by telephone when the infants were 1, 3, 6, 9 and 12 mo of age. Interviews were conducted precisely within 3 d of 30, 91 and 183 d of age, and within 5 d of 274 and 365 d of age. The interviews were conducted by the same well-trained staff of a private agency, who used a standardized sequence of questions and informed the mothers that the survey was being coordinated by researchers from a university department of paediatrics. The questions in the two surveys were identical, and in 1999 additional questions were included. The wording of each question was pre-tested on a representative sample of 40 mothers who were delivered at the maternity ward of our department. The questions are available from the authors.

During the first interview the mothers were requested to provide information on the pregnancy, customary routines at the maternity ward, and feeding methods during the early days of life. Demographic, educational, social and anthropometrics data for infants and parents were also recorded. Further information on feeding practices was gathered at any subsequent interview. Information on the WHO's ten steps to successful breastfeeding was collected during the interviews. At the end of the first interview the mothers were instructed to record, in a 24-h recall diary, the type of feeding experienced when the infant was 61, 91, 122, 152, 183, 213, 244, 274, 305, 335 and 365 days old. At the end of each interview the mothers were reminded to maintain this protocol. This procedure allowed accurate information about type of feeding to be recording prospectively, from 1 mo of age onwards.

Breastfeeding practices described in this article were defined according to the WHO definitions (25–27) as follows: exclusive breastfeeding required that the infant

received breast milk only, and was allowed supplementation of drops and syrups; predominant breastfeeding required that the infant received breast milk only, and was allowed supplementation of liquids (water or water-based drinks, fruit juice, oral rehydration salts), drops and syrups; breastfeeding required that the infant received breast milk, and was allowed supplementation of any food or liquid including non-human milk; non-breastfeeding required that the infant did not receive any breast milk.

Initiation of breastfeeding (breastfeeding “at birth”) was defined as the mother starting breastfeeding within 48 h of delivery. This definition may lack full objectivity. However, in the absence of standardized definitions, it appeared to be a reasonable choice. Initiation after as much as 48 h is very late indeed. The type of feeding “at discharge” was the type of feeding practised at discharge from the hospital or clinic.

The questions focused on WHO's ten steps were designed to elicit a yes or no answer, and were adapted accordingly (28, 29). Steps 3–9 were assessed in both surveys, while step 10 was assessed in the 1999 survey only. Steps 1 and 2 were not assessed. For example, the inquiry about step 3 was: Have you been personally informed at any maternity service about the benefits and management of breastfeeding? (English translation from Italian). The questions related to step 4–9 were similarly constructed. In 1999 the inquiry concerning step 10 was: Have you been referred to or have you had any opportunity to join support groups for breastfeeding after discharge from the hospital or clinic?

In the present analysis, the 20 administrative regions in Italy were grouped into 4 major geographical areas (North-west, North-east, Centre and South/Islands), to allow for major economic, historical and cultural differences. Besides geographical area and the WHO ten steps, some variables were considered as potential determinants when previous studies showed that they might be associated with initiation and/or duration of breastfeeding, and included the mother's age, the mother's body mass index, parity, the mother's education, social class, the mother's smoking habits and the mother having been breastfed herself.

Statistical analysis

Sample sizes were determined to allow an estimation of the national rate of breastfeeding initiation with a margin of error rate of 2% and 1.5% in 1995 and 1999, respectively. Assuming a participation rate of 65% and a reference breastfeeding rate of 80% (85% in 1999), samples of 2400 and 3500 infants were required in 1995 and 1999, respectively.

Descriptive data are reported as number of observations or percentage. The 95% confidence interval (CI) was also determined. Comparison between groups was made using Student's *t*-test for continuous variables and the χ^2 test for discrete variables. A multiple logistic

regression analysis was carried out to assess the significance of potential determinants on breastfeeding initiation and Cox's regression analysis to assess the significance of potential determinants on the duration of breastfeeding. All *p*-values less than 0.05 were considered to indicate statistical significance (two-tailed test). The SPSS package version 8.0 for Windows (SPSS Inc., Chicago, IL, USA) was used for the statistical analysis.

Survey samples

The selected cohorts comprised 2400 and 3500 infants, respectively. We were unable to contact 494 (20.6%) mothers in 1995 and 709 (20.3%) mothers in 1999. Of the mothers who could be contacted, 220 (11.5%) in 1995 and 271 (9.7%) in 1999 were excluded from the study, as their infants did not fulfil the eligibility criteria. Details are reported in Table 1.

The participation rate at the first interview (calculated on the whole selected sample) was 66.7% and 70.0% in 1995 and 1999, respectively. Mothers exhibited a higher educational level, and there were fewer smokers in 1999 than in 1995 ($p < 0.0001$) but they were comparable for anthropometrics, social status and infant's gender, weight and length at birth. The distribution of participants with respect to the major regional areas (North-west, North-east, Centre, and South/Islands) was 562, 326, 322 and 391 in 1995, and 810, 537, 458 and 645 in 1999. Mean (SD; median) length of hospitalization of participant mothers was 4.8 (1.9; 4) d in 1995 and 4.1 (1.5, 4) d in 1999.

At the age of 12 mo, 1351 infants in 1995 and 2034 infants in 1999 continued to participate. Comparison between participants and non-participants at 12 mo of age still showed the samples to be representative for geographical area, maternal anthropometrics and gender of infant. Infants withdrawn from the study

had a mean duration of breastfeeding of about 10 d less than that of the remainder, in both 1995 and 1999.

Results

Initiation of breastfeeding

Breastfeeding. The national rate of breastfeeding during the first 12 mo after birth is presented in Table 2. In the 1995–1999 period the rate of breastfeeding initiation increased from 85.3% to 91.1%, i.e. an increase of 5.8% (95% CI: 3.7–7.9%). The increase in the rate of breastfeeding at discharge was 5.6% (95% CI: 3.5–7.7%).

The initiation rate of breastfeeding increased in each major geographical area, rising from 82.6%, 90.8%, 83.5% and 84.9% to 89.0%, 93.4%, 92.2% and 91.0% in the North-west, North-east, Centre and South/Islands, respectively. The increase in the North-west, Centre and South/Islands was significant ($p < 0.001$) but not in the North-east.

In a multiple logistic analysis, determinants independently associated with the increase in the rate of breastfeeding initiation were: higher adherence to the WHO steps 4 ($p < 0.01$), 5 ($p = 0.039$) and 8 ($p < 0.0001$); higher educational level ($p = 0.013$) and fewer mothers were smokers ($p < 0.01$).

Exclusive breastfeeding. The national rate of exclusive breastfeeding during the first 6 mo after birth is reported in Table 3. In the 1995–1999 period the rate of exclusive breastfeeding at birth increased from 29.8% to 38.7%, i.e. an increase of 8.9% (95% CI: 5.9–11.9%). The increase in the rate of exclusive breastfeeding at discharge was 6.8% (95% CI: 4.0–9.6%).

The initiation rate of exclusive breastfeeding at birth increased in each major geographical area, ranging from 32.0%, 31.6%, 25.2% and 29.8% to 42.6%, 40.8%,

Table 1. Details of participating infants.

	1995	1999
Selected infants	2400	3500
Non-contacted mothers	464	709
Errors in telephone address	101	158
Mother not having a telephone	49	57
Mother moved residence	47	78
Mother not responding to 3 calls (at daily intervals)	297	403
Mother died	–	3
Contacted mothers of ineligible infants	220	271
Gestational age <37 or >42 wk	133	169
Birthweight of infant <2500 g	59	68
No single birth	9	10
Infant with congenital malformations	7	6
Inherited metabolic disease or neonatal disease requiring hospitalization >7 d	–	2
Infant not born in November	–	2
Mother not-Italian speaker	12	20
Contacted mothers of eligible infants	1698	2540
Refused to participate	85	70
Participating infants	1601	2450

Table 2. National rate (%) of breastfeeding in Italy during the first 12 mo after birth.

Completed months of age	1995		1999		p-value
	Rate	95% CI	Rate	95% CI	
At birth ^a	85.3	(83.6–87.0)	91.1	(90.0–92.2)	<10 ⁻⁶
At discharge	83.4	(81.6–85.2)	89.0	(87.8–90.2)	<10 ⁻⁶
1	66.5	(65.2–68.8)	81.1	(80.3–81.9)	<10 ⁻⁶
2	52.0	(49.5–54.5)	72.1	(70.3–73.9)	<10 ⁻⁶
3	41.8	(39.4–44.2)	65.7	(63.8–67.6)	<10 ⁻⁶
4	31.9	(29.6–34.2)	58.6	(56.6–60.6)	<10 ⁻⁶
5	24.8	(22.7–26.9)	53.9	(51.9–55.9)	<10 ⁻⁶
6	19.4	(17.5–21.3)	46.8	(44.8–48.8)	<10 ⁻⁶
7	15.3	(13.5–17.1)	35.7	(33.8–37.7)	<10 ⁻⁶
8	12.5	(10.9–14.1)	31.0	(29.1–32.9)	<10 ⁻⁶
9	9.9	(8.4–11.4)	25.2	(23.4–27.0)	<10 ⁻⁶
10	6.6	(5.4–7.8)	17.6	(15.9–19.2)	<10 ⁻⁶
11	5.0	(3.9–6.1)	12.8	(11.4–14.2)	<10 ⁻⁶
12	4.0	(3.0–5.0)	11.8	(10.4–13.2)	<10 ⁻⁶

^a Within the first 48 h after birth.

36.6% and 33.0% in the North-west, North-east, Centre and South/Islands, respectively. At discharge, the rate of exclusive breastfeeding increased from 70.8%, 74.5%, 66.1% and 69.0% to 76.9%, 81.3%, 77.4% and 71.9% in the North-west, North-east, Centre and South/Islands, respectively. Increases were significant in the North-west, North-east and Centre ($p < 0.05$) but not in the South/Islands.

In a multiple logistic analysis, determinants independently associated with the increase in the initiation rate of exclusive breastfeeding were: higher adherence to WHO steps 4, 6, 8 ($p < 0.0001$) and 5 ($p = 0.013$); fewer mothers were smokers ($p = 0.015$). Similar results were found at discharge.

Predominant breastfeeding. The national rates of predominant breastfeeding during the first 6 mo after birth are presented in Table 4. In the 1995–1999 period the rate of predominant breastfeeding at birth changed from 25.9% to 28.9%, i.e. an increase of 3.0 (95% CI: 0.3–5.7%). The difference in the rate of predominant breastfeeding at discharge and thereafter was not significant.

The rate of predominant breastfeeding at birth

changed from 24.8%, 29.8%, 21.5% and 26.9% to 26.7%, 35.9%, 23.5% and 27.6% in the North-west, North-east, Centre and South/Islands, respectively.

Duration of breastfeeding

Breastfeeding. The duration of breastfeeding was longer in 1999 than in 1995 ($p < 0.0001$) (Table 2).

In mothers who started breastfeeding, the median duration of breastfeeding increased from 2.4 mo (95% CI: 2.2–2.6 mo) to 5.8 mo (95% CI: 5.5–6.3 mo).

The duration of breastfeeding was longer in 1999 than in 1995 in each major geographical area ($p < 0.0001$). In mothers who started breastfeeding, the median duration of breastfeeding ranged from 2.2 mo (South/Islands) to 3.2 mo (North-east) in 1995 and from 3.4 mo (South/Islands) to 6.1 mo (North-east) in 1999.

In Cox's regression analysis, determinants independently associated with the increase in the duration of breastfeeding were: higher adherence to the WHO steps 4 ($p = 0.042$) and 9 ($p < 0.01$); higher educational level ($p = 0.014$) and fewer mothers who were smokers ($p < 0.001$).

Table 3. National rate (%) of exclusive breastfeeding in Italy during the first 6 mo after birth.

Completed months of age	1995		1999		p-value
	Rate	95% CI	Rate	95% CI	
At birth ^a	29.8	(27.6–32.0)	38.7	(36.8–40.6)	<10 ⁻⁶
At discharge	70.0	(68.2–72.6)	76.8	(75.1–78.5)	<10 ⁻⁵
1	54.4	(52.0–56.8)	56.6	(54.6–58.6)	0.161
2	46.0	(43.6–48.4)	52.1	(50.1–54.1)	<0.001
3	36.2	(33.8–38.6)	47.0	(45.0–49.0)	<10 ⁻⁶
4	25.4	(23.3–27.5)	30.9	(29.0–32.8)	<0.001
5	17.1	(15.3–18.9)	19.9	(18.3–21.5)	0.031
6	7.6	(6.3–8.9)	4.7	(3.8–5.6)	<0.001

^a Within the first 48 h after birth.

Table 4. National rate (%) of predominant breastfeeding in Italy during the first 6 months after birth.

Completed months of age	1995		1999		p-value
	Rate	95% CI	Rate	95% CI	
At birth ^a	25.9	(23.8–28.0)	28.9	(27.1–30.7)	0.004
At discharge	1.8	(1.1–2.5)	1.2	(0.8–1.6)	0.131
1	4.8	(3.7–5.8)	5.0	(4.0–6.0)	0.865
2	2.6	(1.8–3.4)	2.5	(1.9–3.1)	0.899
3	1.1	(0.6–1.6)	1.4	(0.9–1.9)	0.538
4	0.9	(0.4–1.4)	1.2	(0.8–1.6)	0.400
5	0.6	(0.2–1.0)	0.5	(0.4–0.6)	0.825
6	0.5	(0.1–0.9)	0.3	(0.2–0.4)	0.471

^a Within the first 48 h after birth.

Exclusive breastfeeding. Prevalence of exclusive breastfeeding was higher in 1999 than in 1995, up to the fifth month of age, except in month 1, but no significant difference was found in the overall duration (Table 3). In mothers who breastfed exclusively at discharge the median duration of exclusive breastfeeding was 3.1 mo (95% CI: 2.9–3.3 mo) in 1995 and 3.2 mo (95% CI: 3.0–3.4 mo) in 1999.

In the 1995–1999 period, the overall duration of exclusive breastfeeding did not significantly differ in any of the major geographical areas. In mothers exclusively breastfeeding at discharge, the median duration of exclusively breastfeeding ranged from 2.6 mo (North-west) to 3.2 mo (Centre) in 1995, and from 3.0 mo (South/Islands) to 3.3 mo (North-east) in 1999.

In Cox's regression analysis, determinants independently associated with the increase in the rates of exclusive breastfeeding up to the fifth month of age were: higher adherence to the WHO steps 6 ($p < 0.01$) and 9 ($p < 0.001$); higher educational level ($p = 0.003$) and fewer mothers who were smokers ($p < 0.0001$).

Adherence to the WHO ten steps

Table 5 shows the national rate of adherence to the ten

steps recommended by WHO, as reported by the mothers. Adherence to each step significantly increased during the 1995–1999 period. The highest increase (14.4%, 95% CI: 12.6–16.2%) occurred for step 6, the lowest (4.0%, 95% CI: 1.0–7.0%) for steps 3 and 5. Concomitant adherence to the WHO ten steps was lower than 3%.

Adherence to the WHO steps significantly increased in the North-west, North-east and Centre (p ranging from 10^{-6} to 0.047), with the exception of step 5 in the North-west. In the South/Islands a significant increase in the adherence to the WHO steps occurred for steps 6, 7, 8 and 9.

Discussion

To ensure good reliability, prevalence data on breastfeeding should be obtained from representative population-based samples using clear and standardized definitions.

Infants included in this study were recruited among the live births that occurred in Italy in 1995 or 1999. Randomization was designed to give a homogeneous representation of the national geographical distribution of births. The reference population of the study was

Table 5. National rates (%) of adherence to the WHO ten steps to successful breastfeeding in Italy, as experienced by the mothers.^a

WHO step	1995		1999		p-value
	Rate	95% CI	Rate	95% CI	
1	na	–	na	–	–
2	na	–	na	–	–
3	63.9	(61.5–66.2)	67.9	(66.0–69.8)	0.007
4	12.4	(10.8–14.0)	21.3	(19.7–22.9)	$<10^{-6}$
5	51.4	(48.9–53.8)	55.4	(53.4–57.4)	0.014
6	33.0	(30.7–35.3)	47.4	(45.4–49.4)	$<10^{-6}$
7	23.7	(21.3–25.8)	33.6	(31.7–35.5)	$<10^{-6}$
8	44.3	(41.9–46.7)	52.4	(50.4–54.4)	$<10^{-6}$
9	47.7	(45.2–50.2)	60.5	(58.6–62.4)	$<10^{-6}$
10	na	–	12.2	(10.9–13.5)	nv
All steps	3.0	(2.1–3.9)	1.1 ^b	(0.7–1.5)	nv

na: Not assessed; nv: not valuable.

^a According to the WHO definitions (28, 29).

^b Rate (95% CI) was 2.7% (2.1–3.0%) when calculated excluding step 10 (1999 vs 1995, $p = 0.634$).

clearly identified. The participation rates were similar in 1995 (67%) and 1999 (70%), and comparable to other surveys using telephone interviews (e.g. 30). However, we cannot exclude the possibility of a biased selection of participants, given that the participation rate was relatively low. From an epidemiological perspective, such a bias would be a limitation of the present study. Caution should therefore be exercised in drawing definitive conclusions from the present results. Interviews were performed at precisely specified ages of the infant. "At birth" and "at discharge" were used to indicate, respectively, when breastfeeding started within the first 48 h of birth and the type of feeding at discharge from the hospital. The type of breastfeeding was classified in accordance with standardized definitions (25–27). The WHO ten steps to successful breastfeeding (28, 29) were assessed as experienced by the mothers. Although this is not an optimal procedure, it allowed helpful information to be obtained, given the current lack of national data in Italy. In any case, interpretation of the present results should be made with caution. Studies devoted to evaluating the WHO ten steps should include data from health workers, gathered from maternity wards and health services.

The results of the present study show that in Italy the current national rate of breastfeeding at birth and at the age of 1 mo is about 91% and 81%, respectively, which may be considered high enough. Although lower than in Northern European countries (16–21), this rate is higher than in many other Western countries. For instance, in the USA a breastfeeding initiation rate of 59% has been reported (12). Recently, the Euro-Growth Study investigated the feeding habits in 12 European countries and found an overall breastfeeding rate of 74% at 1 mo of age (21). The results of the Euro-Growth Study could be biased in selecting infants, as only 2 of the 22 centres involved in the study collected population-based random samples.

During the 1995–1999 period, the initiation rate of breastfeeding increased in Italy in both national size and major geographical areas. Increases were particularly marked in the South/Islands, where the breastfeeding initiation rate is now comparable with the national average. The national rate of exclusive breastfeeding also increased from 1995 to 1999, at both birth and discharge. Increases were significant in each of the major geographical areas, but in the South/Islands it remains below the national rate, which was 33% at birth and 77% at discharge in 1999. Reasons for differences among geographical areas have to be investigated.

In Italian maternity wards there is a persistent attitude towards supplementing infants with liquids during the first 48 h of life. The high conversion rate (approximately 87%) from predominant breastfeeding at birth to exclusive breastfeeding at discharge suggests that predominant breastfeeding at birth is unnecessary in most cases and may reflect an inadequate breastfeeding

practice. Indeed, the low rate of exclusive breastfeeding at birth (33% in 1999), the scanty adherence to WHO step 4 (only 12% of mothers in 1995 and 21% of mothers in 1999 reported having been helped in initiating breastfeeding within half an hour of delivery) may reflect a breastfeeding practice in Italian maternity wards that does not comply with the WHO recommendations (12–15, 27–29). Since exclusive breastfeeding should be recommended (13–15, 27), reasons for the current practice of predominantly breastfeeding during the first days after birth should be further investigated and abolished.

The duration of breastfeeding was longer in 1999 than in 1995, and prevalence of exclusive breastfeeding was higher in 1999 up to the fifth month of age (except at month 1). However, the duration of both breastfeeding and exclusive breastfeeding still appears to be unsatisfactory in Italy, as compared to international recommendations and targets (5, 12, 13, 15). Currently in Italy, fewer than 50% of mothers still breastfeed 6 mo after delivery, and only 31% exclusively breastfeed 4 mo after delivery.

The increase in the rates of initiation and duration of breastfeeding was associated with a better adherence to the WHO ten steps, a higher educational level and fewer smokers among the mothers. These results, while confirming that the WHO ten steps are important for increasing incidence and duration of breastfeeding, also suggest that maternal socio-demographic environments and attitudes play a major role in improving breastfeeding practices.

It should be noticed that adherence to the WHO ten steps remains unsatisfactory in Italy. In particular, despite recognition of its importance in the Scandinavian countries, adherence to step 4 is really low. Concomitant adherence to the WHO ten steps is even discouraging (<3%), and no improvement was observed in the 1995–1999 period.

On the whole, within the limitations of the present study, it can be concluded that an increase in initiation and duration rates of breastfeeding occurred in Italy during the 1995–1999 period. However, while the rate of breastfeeding initiation can now be considered fairly high, prevalence rates of breastfeeding and exclusive breastfeeding rapidly decrease throughout the first 6 mo after birth and remain unsatisfactory. Furthermore, too many mothers predominantly breastfeed in the maternity wards, there is inadequate adherence to the WHO ten steps, and breastfeeding practices are still strongly influenced by some sociodemographic factors. Further efforts are needed in Italy to increase breastfeeding rates, to improving adherence to the WHO ten steps to successful breastfeeding and to encourage mothers to adopt favourable attitudes towards breastfeeding. Monitoring programmes of breastfeeding practices and a national plan based on clearly defined objectives and targets in accordance with the WHO recommendations would be desirable in Italy.

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