

## STUDY DAYS FOR EGNELL AMEDA BREAST PUMP AGENTS

To book: contact Chris on 01823 336362

15th March 2003	West Midlands
5th April	London
28th June	Cambridgeshire
20th September	London
21st September	Somerset/Devon/Dorset
25th October	Tyne & Wear
1st November	Manchester/London

## BRA FITTING TRAINING DAYS (NCT MATERNITY SALES)

Would you like to provide a valuable service to pregnant and early postnatal women who want to breastfeed and at the same time make money for your branch? Then come to one of our Training Days either in London or around the UK and find out more. These days also serve to revitalise our existing 150 MAVA Bra agents throughout the Country. All aspects of the (minimal) paperwork are covered along with discussion groups on promotion and advertising. We have real pregnant models for the fitting demonstration followed by fitting practise in small groups. 10.00am - 4.00pm. Cost £30 including lunch.

For further details and a booking form please phone or e-mail  
Pam Bartlett, 01932 352 989, cpdbart@waitrose.com  
OR Frankie Taylor, 0131 346 1785, Frankie\_taylor@btopenworld.com

Saturday 22nd March 2003	Camberley
Saturday 10th May	Birmingham
Saturday 20th September	South East England
A Sunday in November	London or Surrey

## TP TRAINING WORKSHOPS

To book: send booking form and fee to Direct Support Services Administrator, Alexandra House

### Introduction to the Programme:

11th/12th/13th April 2003	Uplands, Bucks
6th/7th/8th June	Sunningdale, Berks
26th/27th/28th September	Uplands, Bucks
28th/29th/30th November	Pendrell Hall, Staffs
6th/7th/8th February 2004	Hawkwood, Stroud, Glos

### Old 1st Workshop:

4th/5th/6th April 2003	Barnes Close, Birmingham
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### New Pre-teaching Workshops:

27th/28th/29th June 2003	Latimer, Bucks
10th/11th/12th October	Harrogate
13th/14th/15th February 2004	Barnes Close, Birmingham

### 2nd Workshops:

1st/2nd March 2003	Alexandra House, London
16th/17th/18th May	Barnes Close, Birmingham
12th/13th/14th September	Latimer, Bucks
28th/29th/30th November	Hinsley Hall, Leeds
5th/6th/7th March 2004	Ammerdown Centre, Bath

## BCG TRAINING WORKSHOPS

To book: send booking form and fee to Direct Support Services Administrator, Alexandra House

### 2003

8th/9th March	Counselling
5th/6th April	Antenatal
10th/11th May	Counselling
21st/22nd June (please note change of date)	Antenatal
5th/6th July	Counselling
27th/28th September	Antenatal
11th/12th October	Counselling
15th/16th November	Antenatal

## NCT EVIDENCE BASED BRIEFING Active Management of Labour

### BACKGROUND

Active management of labour (AML) was originally introduced by O'Driscoll et al. (1969) in the National Maternity Hospital in Dublin to avoid dystocia (prolonged labour), which at the time was defined as labour lasting more than 24 hours. In 1970 in England and Wales labour was longer than 24 hours in only 5.1% of labours (Francome et al., 1993). O'Driscoll defined active management as a comprehensive programme of care in labour for women having their first baby, which includes, in addition to strict diagnosis of the onset of labour, early amniotomy (the artificial rupture or breaking of the amniotic membranes surrounding the baby (ARM) during labour), regular vaginal examinations to ensure dilation of at least one centimetre an hour, early use of an intravenous infusion (drip) of synthetic oxytocin to ensure progress, advising women that their labour will not last longer than 12 hours, the continuous presence of a midwife and the active involvement of a senior obstetrician. At the time active management was introduced in Dublin, over half of women having their first baby received oxytocin, a proportion which is fairly typical of units practicing active management currently.

At the time that active management was introduced at the National Maternity Hospital in the 1960s and 1970s, efficient uterine action was considered the key to normality. Active management was based on a belief that inefficient contractions need to be corrected to decrease the number of prolonged labours. The cause of difficult or prolonged labour (dystocia) was identified as being due to one of three factors, known in short as **the forces, the passenger and the passages**. The most common cause, affecting 80% of prolonged labours, was inefficient uterine action (**the forces**). In 10% of cases the cause was the baby's persistent occipito-posterior position (**the passenger**). And in a further 10% of prolonged labours there was cephalo-pelvic disproportion (**the passages**) (Keane, 2002). These assumptions continue to underpin AML. Another factor, the amount of cervical resistance that must be overcome is discussed in A Guide to Effective Care in Pregnancy and Childbirth (Enkin et al., 2000) For those who practice AML, if there is a diagnosis of failure to progress, intervention designed to improve uterine action is taken. This may facilitate progress either by improving the effectiveness of

the contractions or by optimising the baby's position. If there is true cephalo-pelvic disproportion, intervention to increase contractions will help to identify this by eliminating other causes (Keane, 2002).

In 1969, there were no substantial differences in the caesarean section rate (CSR) between institutions in Ireland, the United Kingdom and the United States and it rarely exceeded 5%. Throughout the 1970s, a fourfold increase in CSR occurred across the US with the CSR reaching 20%. An official enquiry identified "dystocia" as the main reason for the change and seven times more caesareans were performed for this indication across the US than in Dublin, where the CSR remained at 5% (O'Driscoll et al., 1984). This observation led many to infer that introducing AML would contain or reduce their CSR. An increasing number of units adopted some aspects of AML, usually amniotomy and oxytocin (together called augmentation), or all of the components of active management in an attempt to contain spiralling caesarean rates. In a survey conducted by the Audit Commission (1997), 52% of women reported that their labour was augmented.

"Failure to progress" has become a commonplace term on labour wards, yet data are continuing to emerge which show that the concepts of failure to progress and active management are overly simplistic (Olah, Gee, 1996). For AML to be safe, it must be carried out with caution and careful assessment of the effects. As augmentation with synthetic oxytocin may produce overall oxytocin levels well in excess of those encountered during normal spontaneous labour (Enkin et al., 2002), very strong and more painful contractions may result, with additional risks of fetal distress.

### THE RESEARCH

In the late 1980s and 1990s, a series of trials of some of the components of active management of labour were carried out. There are currently Cochrane Library systematic reviews on amniotomy and on caregiver support, with a review of early augmentation of labour with amniotomy and oxytocin expected shortly. The next sections summarise the evidence on outcomes associated with these interventions.

### Amniotomy

The Cochrane Library systematic review *Amniotomy for shortening spontaneous labour* (Fraser et al., 2002) shows that amniotomy is associated with:

- Reduction of labour length of between one and two hours.
- Reduction in dystocia (defined as a mean rate of dilation less than 0.5cm/hour).
- Marked trend towards an increase of caesarean deliveries (Odds Ratio (OR) = 1.26; 95% Confidence Interval (CI) = 0.96-1.66).
- Decrease in the use of oxytocin. (OR=0.79; 95%CI=0.67-0.92).
- Reduction in abnormal five-minute Apgar scores. (OR= 0.54; 95%CI=0.30-0.96).
- There is a non-significant trend towards an increase in the frequency of cephalhaematoma and meconium aspiration in the baby.

A variety of adverse effects of amniotomy on the baby have been mentioned, but all these studies were subject to considerable selection bias, which precludes adequate assessment. (Enkin et al., 2000)

### Oxytocin

Despite the wide use of oxytocin for augmentation, there is remarkably little evidence from controlled trials on its effect (Enkin et al., 2000). There is currently not a Cochrane systematic review on use of amniotomy and oxytocin, though one is expected soon. A meta-analysis of randomised trials, comparing the effects of early augmentation of labour with amniotomy and oxytocin with more conservative care, in women having their first baby (Fraser et al., 1998) shows:

- Labour was shorter with early augmentation.
- Less risk of prolonged labour.
- No reduction in the caesarean section rate (OR=0.9; 95%CI= 0.7-1.1).
- No difference in operative vaginal delivery (OR=0.9; 95%CI =0.8-1.1).
- No difference in neonatal outcomes.
- Labour more painful.

A second meta-analysis (Sadler et al., 2000) produced very similar results. The trials in these meta-analyses, however, are very different from one another, with different settings and widely different caesarean rates. In the Sadler trial, the active management protocol was not strictly followed in 40% of women randomised to active management.

Paradoxically however, large numbers of women in the more conservative arms of the trials did receive oxytocin. In the Frigoletto et al., trial (1995), as many as 56% of women in the normal management arm received oxytocin, compared with 70% in the active management arm. In Cammu and Van Eckhout's trial (1996), while twice as many women in the experimental arm of the trial received oxytocin compared with those in the normal management control arm (53% vs. 27%), it is a weakness that over a quarter of women assigned to normal management received oxytocin.

Oxytocin is a double-edged sword. It can increase the powers and speed up labour, but not all babies can cope well with the effects (Impey, 2001). Oxytocin administration during labour can cause uterine hyperstimulation and fetal heart rate abnormalities, which can be associated with hypoxia (Johnson et al., 1994). Anecdotal reports of oxytocin apparently causing hypoxic brain damage, albeit usually after protocol violations, are frequent in medico legal practice (Thornton, Lilford, 1994).

### Caregiver Support

The Cochrane Library systematic review *Caregiver support for women during childbirth* (Hodnett, 2002a) shows that with the continuous presence of a support person there is:

- Reduced likelihood of medication for pain relief.
- Reduced operative vaginal delivery (OR=0.77; 95%CI= 0.67- 0.90).
- Reduced caesarean delivery (OR=0.77; 95%CI=0.64-0.91).
- Reduced four minute Apgar score<7 (OR= 0.50; 95% CI= 0.28-0.87).
- An association with a slight reduction in the length of labour.

A further trial, (Hodnett et al., 2002) conducted in North America, showed that in hospitals characterised by high rates of routine intrapartum interventions, continuous labour support by nurses does not affect the likelihood of caesarean delivery or other medical or psychosocial outcomes of labour and birth (Hodnett et al., 2002). Hodnett has recently incorporated this trial into the systematic review. The risk of caesarean birth is still significantly reduced and thereby places the results on a much stronger evidence base (Hodnett, 2002b). Continuous caregiver support is the most effective ingredient of the package of active management.

### WOMEN'S VIEWS

Partograms, which are graphs showing the progress of labour, show cervical dilation and descent of the presenting part in relation to time. They include an "alert" line and an "action" line, which are the basis for a diagnosis of prolonged labour. Partograms implicitly support active management with these alert and action lines. A trial (Lavender et al., 1998), in which women were randomised to have their progress of labour recorded on a partogram with an action line two, three or four hours to the right of the alert line, discovered that in an uncomplicated population of first-time mothers as many as 44% were considered to have prolonged labour. Those women allocated to the two hour arm were more satisfied with their labour experience than women who had no intervention for three or four hours, despite receiving more intervention. A small Finnish study however, reported that over half of the women found oxytocin treatment unpleasant. Over 80% reported increased pain after treatment, compared with 20% allocated to ambulation (Hemminki et al., 1985). Another study (Impey, Boylan, 1999) concluded that many women want a quick and painless labour, and that they do not object to interventions that help to achieve this. However Impey's questionnaire has been criticised for including leading questions focusing heavily on the length of labour (Dahlberg et al., 1999).

### OTHER WAYS OF MANAGING LABOUR

The National Maternity Hospital still has remarkably low caesarean rates. The rate is around 5% for first-time mothers at term, in spontaneous labour with a single, head-down baby, sometimes referred to as "Robson category 1" women who are predominantly low-risk (Keane, 2002). However, equally low and lower rates of caesarean section can be achieved in other ways. For the years 1966-1985, caesarean section rates as low as 1.3% were reported for low-risk women in the Netherlands and in Vienna giving birth using services which specialised in supporting physiological birth (van Alten et al., 1989 and Rockenschaub, 1990).

In a very different population served by the North Central Bronx Hospital in New York City, in which 70% of women were considered at-risk or high-risk, the CSR in 1988 was 11.8% with only 6.4% of women receiving oxytocin augmentation (Haire, Elsberry, 1991). Currently, in England, the NHS trust with the lowest CSR, The Royal Shrewsbury NHS Trust, does not practice AML. Around 25% of women using the Trust give birth in a midwife-led unit or at home with minimal interventions. Oxytocin augmentation is used selectively at the district general hospital (Oates, 2002). Data collected in 2001 for the National Sentinel Caesarean Section Audit showed that the Trust's CSR for women in Robson category 1 was 6% (personal communication).

### CONCLUSION

Randomised controlled trials of amniotomy, with or without early oxytocin, show little effect on the caesarean rate. However, these trials have not tested the complete package of AML and poor protocol compliance reduces their power to be able to show the effects of active management (Impey, Boylan, 1999).

The National Maternity Hospital still has remarkably low caesarean rates, including a 5% rate for women in Robson category 1 (Keane, 2002), compared with 11.8% in similar mothers in England and Wales as a whole (Thomas, Paranjothy, 2001). However, very low CSRs have been reported by services that specialise in supporting physiological birth. Currently, in a United Kingdom setting, the CSR at The Royal Shrewsbury NHS Trust for women in Robson category 1 is 6%, around half the national average.

From the currently available data it is not clear that liberal use of oxytocin augmentation in labour is either necessary, or of net benefit to women and babies. However, this does not imply that there is no place for oxytocin augmentation in slow progress of labour. For example, increasing the power of contractions can be helpful when the baby is in a persistent posterior presentation and does not respond to ambulation and changes of position. Oxytocin augmentation can make all the difference between a spontaneous birth and the need for operative delivery. Every effort should be made to correct ineffective contractions before resorting to caesarean section for dystocia. (Enkin et al., 2000). Approximately half the women judged to have slow labour or poor progress in cervical dilation will progress equally well whether or not they receive oxytocic drugs. Other simple measures such as moving about and eating and drinking as the woman pleases may be at least as effective and considerably more pleasant (Enkin et al., 2000).

The implications are clear: units not practising active management liberally should provide continuous support in labour, but should not introduce the rest of the package. Units practising active management for all primiparous women in established labour who do not make progress at the rate of one centimetre per hour should review the evidence base underpinning their protocols. Amniotomy and oxytocin simply to speed up a labour which is slow but in other respects normal, should be used selectively, if at all (Thornton, 1996).

### KEY POINTS

Active management is a package of interventions. The most effective component is continuous support from a midwife. Augmentation of labour is associated with both benefits and risks. Labour is shorter but more painful. No reduction in the

caesarean rate has been found in trials randomising women to augmentation; trials suggest there may in fact be an increase. There is no overall positive effect on maternal or fetal outcomes. Units not practising active management should provide continuous support in labour, but should not introduce the rest of the active management package. Units practising active management should review the evidence base underpinning their protocols. Amniotomy and oxytocin acceleration should not be used for routinely for slow progress, but may be useful in specific cases as a means of avoiding a caesarean section if other, less invasive actions have not had the desired effect.

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## REPS' & RESEARCH NETWORKERS' MAILING

Compiled by Clare Kanarick

January 2003

Dear NCT Maternity Services Representative,

I would like to take this opportunity to thank all of you who sit on the many different committees, panels, councils, forums and groups that are constantly striving to improve Maternity Services across the UK. You give freely of your time and energy to speak out on behalf of the NCT and speak up for all those new mothers, soon to be mothers and yes, even to those who aren't yet mothers but may be one day.

As a rep myself for some years now, I can fully appreciate what it is you have done and continue to do and the time commitment involved. It takes courage to stand up and speak out on behalf of maternity services users and to query decisions being taken. It also uses up a great deal of your spare time to read through all the information that you receive.

I hope you have found that the NCT, through the work of Rep Panel and the Policy Research Department, has given you the evidence based information and support you need to do the very best you can in the form of training, books, leaflets, briefing papers and a well stocked library. Please continue to take advantage of all that is offered and provided for you and also don't forget we can help each other by "talking" on the reps egroup: [www.groups.yahoo.com/group/nct\\_reps](http://www.groups.yahoo.com/group/nct_reps) I look forward to seeing you there!

Once again, thank you!

Yours sincerely



Dorotka Griffin  
Chair, Board of Trustees

### HOT TOPICS

Herewith a few suggestions for inclusion on your MSLC agenda:

- **SureStart** - invite a midwife or health-visitor from your local SureStart area if you have one, or from your nearest neighbouring SureStart area to update you on the new initiatives and their progress
- **Reconfiguration** - how will this impact on your maternity unit and local neonatal care?
- **Postnatal depression** - how are these women treated and could services for them be improved locally?

If anyone has any suggestions for next month's hot-topics please email me at: [michelle@greenallefans.net](mailto:michelle@greenallefans.net)

Contact details for Rep Panel are Cynthia Clarkson (email [cynthia.clarkson@virgin.net](mailto:cynthia.clarkson@virgin.net)) and Michelle Evans (email [michelle@greenallefans.net](mailto:michelle@greenallefans.net)). For Ren Panel, contact either Cynthia Clarkson or Jane Taylor (email [janetaylor@talk21.com](mailto:janetaylor@talk21.com)).

If you would like to attend the PRCC Committee or the Rep and Ren Panels for a meeting, please contact Clare Kanarick on 020 8752 2328.

### IT'S SONGTIME!!

Some of you may think that research is all dry old stuff like confidence intervals, sample sizes and selection bias. However, there are fun and games too! Try singing this song (reprinted below) in the bath or in your bleaker moments to the theme of ABBA's **Waterloo!** The words were written and the song performed by "Doubled Blonded" aka Gill Cyte and colleagues of the Cochrane Review Groups of Liverpool at the Cochrane Colloquium in Stavanger, Norway, August 2002.

#### Your Review

Well done, your review's now published in The Cochrane Library,  
Well done, you did the work and now you think your job is almost done,  
But the process is not at an end - it's always repeating itself.

Your review - you thought it was finished but we want more,  
Your review - you have to update it for evermore,  
Your review - couldn't escape if you wanted to,  
Your review - here are the trials, the rest's up to you,  
Your review - finally accept your update is due.

My, my, you try to hold it up but we are stronger,  
Oh yeah, and now it seems your only hope is giving up the fight,  
But how could you ever refuse - we need you to update reviews.

Your review - you thought it was finished but we want more,  
Your review - you have to update it for evermore,  
Your review - couldn't escape if you wanted to,  
Your review - here are the trials, the rest's up to you,  
Your review - finally accept your update is due.

So how could you ever refuse - we need you to update reviews.

Your review - couldn't escape if you wanted to,  
Your review - here are the trials, the rest's up to you,  
Your review - finally accept your update is due,  
Your review - finally accept your update is due.

### SCOTTISH STUDY ON MATERNITY SERVICE PROVIDERS & SERVICE USERS

Hundley V, Penney G, Fitzmaurice A, van Teijlingen E, Graham W. A comparison of data obtained from service providers and service users to assess the quality of maternity care. *Midwifery* 2002; 18(2): 126-35.

An interesting study carried out by Hundley and colleagues in Scotland highlights the different perspectives of maternity service providers and service users. The findings on postnatal reunions make depressing reading, as less than 50% of women knew about postnatal reunion meetings in those units that organised this kind of support. If your unit is planning a survey of user views, you might find it useful to replicate some of the questions used by the Aberdeen team.

### REPS' & RESEARCH NETWORKERS' MAILING

If you would like to submit articles for either of the next two issues of **New Digest**, please call Clare Kanarick on 020 8752 2328 or email: [c\\_kanarick@national-childbirth-trust.co.uk](mailto:c_kanarick@national-childbirth-trust.co.uk)

### GLOBAL STRATEGY CALLS FOR NATIONAL ACTION ON INFANT FEEDING

The World Health Organisation has drawn together research based evidence and policy proposals into a Global Strategy on Infant and Young Child Feeding, which was adopted at the last World Health Assembly. The UK government supported the Strategy and should now be developing its own policy and action plan on infant and young child feeding. The Global Strategy incorporates the International Code of Marketing of Breastmilk Substitutes, the 1990 Innocenti Declaration and the Baby Friendly Hospital Initiative, but it goes further in drawing together action at many different levels.

Governments are now expected to adopt comprehensive policies and strategies covering the whole area of infant and young child feeding, including action to:

- Promote and support exclusive breastfeeding for six months and continued breastfeeding (with good complementary feeding) for up to two years or beyond.
- Ensure that all maternity services fully implement all Ten Steps to Successful Breastfeeding and to support the extension of the Baby Friendly Initiative into community and paediatric settings
- Legislate to end all promotion of artificial feeding and to protect the breastfeeding rights of working women.
- Ensure that policies and practices take into account vulnerable groups such as refugees, mothers with HIV and those with disabilities or who are drug users.

For these to succeed there must be suitable goals and objectives, a realistic timeline for their achievement, and measurable process and output indicators that will permit accurate monitoring and evaluation and a rapid response to identified needs.

The Global Strategy also identifies the obligations and responsibilities of other organisations including local authorities, the health service, health professional and voluntary organisations, employers, education authorities, trade unions, the media, and child care facilities. The full document can be seen at:

[www.who.int/gb/EB/EB\\_WHA/PDF/WHA55/ea5515.pdf](http://www.who.int/gb/EB/EB_WHA/PDF/WHA55/ea5515.pdf)

Northern Ireland and Wales do have breastfeeding strategies in place and almost all of the 15 Health Boards in Scotland have adopted local strategies. No national policy or strategy exists in England although there are rumours that a policy is under consideration. The Global Strategy should add impetus to current activities, both in developing new policies and in supporting their implementation. Do have a look at the full document and refer to it in any lobbying on baby feeding.

### A BREASTFEEDING TARGET FOR ENGLAND

An NHS target to increase the breastfeeding initiation rate by 2% per year in England was recently announced. The current rate is 71%. Scotland set a target in 1994, to increase breastfeeding at six weeks from 36% to 50% by 2005 and Wales is aiming for an increase of 10% at eight weeks by 2005.

According to the Inequalities section of the Priorities and Planning Framework 2003 to 2006 of the NHS Plan, Trusts and SHAs in England have responsibility for developing local plans for increasing the breastfeeding initiation rate, "particularly among disadvantaged mothers, for each of the next three years". There are also targets for reducing the proportion of pregnant women who smoke and the number of teenage pregnancies.

The NHS Plan can be seen at: [www.doh.gov.uk/planning2003-2006/](http://www.doh.gov.uk/planning2003-2006/) and the section on reducing health inequalities at: [www.doh.gov.uk/planning2003-2006/appb.htm#8](http://www.doh.gov.uk/planning2003-2006/appb.htm#8) The document also lists "national capacity assumptions" related to these areas. In addition to early antenatal booking, they are looking for "strengthened primary