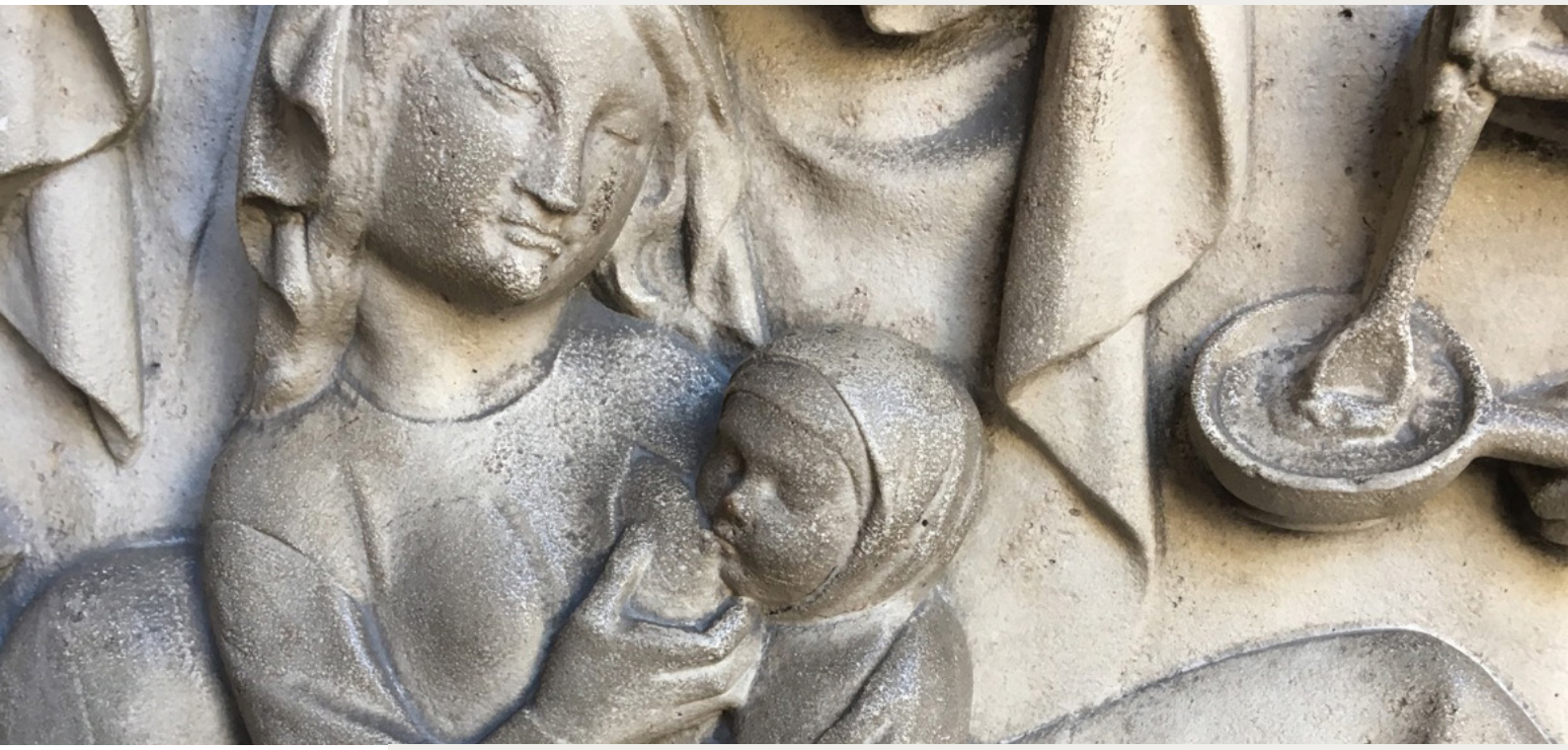
World Breastfeeding Trends Initiative (WBT*i*)

Assessment Report Australia 2018



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World Breastfeeding Trends Initiative (WBT*i*)
AUSTRALIA

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Report

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The World Breastfeeding Trends Initiative (WBT*i*)

Australia

2018

In September 2017, a group of advocates, academics, clinicians and NGO representatives came together for a Gender Responsive Budgeting and Breastfeeding workshop, organised and led by Associate Professor Julie Smith from the Australian National University (ANU) in Canberra. Funding and other support for the event was provided by the ANU College of Asia and the Pacific (Tax & Transfer Policy Institute with an APIP grant) and the ANU Gender Institute. Dr Shoba Suri, from IBFAN, presented the background information for the WBTi and how it could be used in Australia, along with Alessandro Iellamo who explained the importance of the World Breastfeeding Costing initiative (WBCi), and from there the WBTiAUS Core group was formed. The Core group then set about inviting other individuals and non-government organisations (NGOs) to join the team as part of a Reference group to ensure this would be truly collaborative process. At the same time data was being collected to complete the assessment tool. This report will provide a benchmark, enabling future assessments to measure progress on action resulting from this initial study.

Also relevant to this assessment is that in 2012, IBFAN concluded that, based on analysis of the implementation of the Global Strategy for Infant and Young Child Feeding, very few of the 51 countries that conducted the assessment could implement all the strategies indicated in the Strategy. The primary obstacle was lack of adequate resources, especially financial resources. The main problem was that no one had any idea of what protecting, promoting and supporting breastfeeding would actually cost. The few estimates existing consider only some aspects of promotion, even though there is evidence that several actions, including effectively enforcing the International Code of Marketing of Breastmilk Substitutes and Maternity Protection need to be undertaken concurrently, if breastfeeding rates are to improve.

International Baby Food Action Network Asia (IBFAN Asia) took on the challenge of trying to estimate the minimal cost of implementing the Global Strategy in its entirety through the World Breastfeeding Costing Initiative (WBCi) and launched a costing tool to accompany the WBTi. For more information please visit http://ibfan.org/world-breastfeeding-costing-initiative

This WBTi Australia report is the first to explicitly incorporate gender responsive budgeting approaches and the principles of the WBCi tool into the analysis and assessment.

World Breastfeeding Trends Initiative (WBT*i*)

Background

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative tool, developed by IBFAN Asia, to assess the status and benchmark the progress of the implementation of the Global Strategy for Infant and Young Child Feeding at national level. The tool is based on two global initiatives, the first is WABA's Global Participatory Action Research (GLOPAR) Project and the second the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBT*i* is designed to assist countries in assessing the strengths and weaknesses of their policies and programmes to protect, promote and support optimal infant and young child feeding practices. The WBT*i* has identified 15 indicators in two parts, each indicator having specific significance.

Part-I deals with policy and programmes (indicator 1-10)	**Part –II deals with infant feeding practices (indicator 11-15)**
1. National Policy, Programme and Coordination 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 & IYCF) 6. Mother Support and Community Outreach 7. Information Support 8. Infant Feeding and HIV 9. Infant Feeding during Emergencies 10. Mechanisms of Monitoring and Evaluation System	11. Early Initiation of Breastfeeding 12. Exclusive breastfeeding 13. Median duration of breastfeeding 14. Bottle feeding 15. Complementary feeding

Once assessment of gaps is carried out, the data on 15 indicators is fed into the questionnaire using the WBT*i* web based toolkit© which is specifically designed to meet this need. The toolkit objectively quantifies the data to provide a colour-coded rating in Red, Yellow, Blue or Green. The

toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international.

Each indicator used for assessment has following components;

- The key question that needs to be investigated.
- Background on why the practice, policy or programme component is important.
- A list of key criteria as subset of questions to be considered in identifying achievements and areas needing improvement, with guidelines for scoring, colour-rating, and ranking how well the country is doing.

Part I: A set of criteria has been developed for each target, based on Global Strategy for Infant and Young Child Feeding (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005). For each indicator, there is a subset of questions. Answers to these can lead to identify achievements and gaps in policies and programmes to implement Global Strategy for Infant and Young Child Feeding. This shows how a country is doing in a particular area of action on Infant and Young Child Feeding.

Part II: Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random household survey that is national in scope.

Once the information about the indicators is gathered and analyzed, it is then entered into the web-based toolkit through the ' WBT*i* Questionnaire'. Further, the toolkit scores and colour-rate each individual indicator as per **IBFAN Asia's Guidelines for WBT*i***

Abbreviations

ABA	Australian Breastfeeding Association
ACM	Australian College of Midwives
APHDPC	Australian Population Health Development Principal Committee
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
AHPRA	Australian Health Professional Regulation Authority
ANBS	Australian National Breastfeeding Strategy
ART	antiretroviral therapy
BFHI	Baby Friendly Health Initiative
BFWA	Baby Friendly Workplace Accreditation
COMDISPLAN	Australian Government Disaster Response Plan
CRC	Committee on the Rights of the Child
FSANZ	Food Standards of Australia and New Zealand
GDP	Gross Domestic Product
GP	General Practitioners
GSIYCF	Global Strategy for Infant and Young Child Feeding
HIV	Human Immunodeficiency Virus
IBFAN	International Baby Food Action Network
IBCLC	International Board Certified Lactation Consultant
IEC	Information, Education and Communication
Indigenous	Aboriginal and Torres Strait Islander
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child feeding in Emergencies
MAIF	Marketing in Australia of Infant Formulas
MAIF Agreement	Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement
NGO	Non-government Organisation
NHMRC	National Health and Medical Research Council
UN	United Nations
UNICEF	United Nations Children's Fund
WABA	World Alliance for Breastfeeding Aaction
WBTi	World Breastfeeding Trends Initiative
WBCi	World Breastfeeding Costing initiative
WHA	World Health Assembly
WHO	World Health Organization
WHO Code	International Code of Marketing Breast-milk Substitutes

Background

Australia's government consists of a federation of eight states and territories. As Australia operates under a federalist system, the responsibility for meeting Infant and Young Child Feeding (IYCF) commitments lies with all three levels: federal, state and territory, local governments and agencies. With this in mind, the assessment tool could be used to assess data from each state, territory and local government. However, since the Federal Government collects most of the taxes and is the main revenue source for states and territories, it sets priorities through budget policy. This, as well as the fact that the criteria in the WBTi assessment tool ask for national data, and the states and territories committed jointly in 2010 to a national breastfeeding strategy, the group assessed only national policy and commitment to IYCF. Furthermore, the Federal Government departments work with government bodies on issues such as human rights, consumer protection, health worker training and accreditation, and workplace and employment issues, and it is essential that these are considered at a federal level in a gender-equity assessment of breastfeeding in Australia.

Policy priorities and implementation can vary widely between these levels of government and differences occur between states and territories in the health needs of their populations. For example, in 2016, Australia had a national population of 24 million people and there were 311,104 births with an overall infant mortality rate of 3.1 infant deaths per 1,000 live births.[1] However, mortality rates were doubled for Aboriginal and Torres Strait Islander (Indigenous) infants and young children under five years.[1,2] While Indigenous Australians represent 3% of the national population, they comprise a quarter of the Northern Territory (NT) population.[1] This places a unique requirement for Indigenous-focused programs in the NT, compared to the country as a whole, and emphasises the vulnerability of subpopulations in a high-income country like Australia.

The 2016 *Lancet Breastfeeding Series* confirmed that breastfeeding is an important issue for mortality and morbidity of all population groups in all countries.[3] The analysis showed that in high-income countries, premature cessation of breastfeeding and a lack of breastfeeding are important risk factors for sudden infant death and necrotising enterocolitis in infants, and around 20,000 women's deaths. The Series also documented the very poor collection of data in relation to breastfeeding and health outcomes across high-income countries.

Like other high-income countries, the protection, promotion, support and measurement of breastfeeding is not seen as a priority issue in Australia. As demonstrated throughout this report, this is evidenced by the lack of continued commitment and funding for breastfeeding education and support, despite the evidence for such measures in the government's own inquiries and commitments, such as *The Best Start Report on the inquiry into the health benefits of breastfeeding* (2007)[4], the *Australian National Breastfeeding Strategy: 2010-2015*[5] and the following international strategies and human rights statements. (See below a table identifying the progress on commitments made from the Best Start Report).

As a member state of the World Health Organization (WHO)[6] and a founding member of the United Nations (UN)[7], Australia has adopted or endorsed the following actions to protect, promote and support breastfeeding, not only as the normal food for infants and young children, but also as a human right for women and children:

- development in 1981 of The International Code of Marketing of Breast-milk Substitutes (The WHO Code)[8]
- Convention on the Elimination of All Forms of Discrimination Against Women (1981)[9]
- Conventions on the Rights of the Child (1989)[10]
- endorsement of the Innocenti Declaration in 1990 [11]
- establishment of the Baby Friendly Health Initiative (BFHI) in 1991[12]
- development of the Global Strategy on Infant and Young Child Feeding (GSIYCF) in 2003[13]
- and the subsequent World Health Assembly (WHA) resolutions to update the WHO Code as recently as 2016.[14]

Furthermore, in 2017 the *UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in Law and in Practice, and the Committee on the Rights of the Child (CRC)*[15] put out a statement to remind States of '*their obligations under relevant international human rights treaties to provide all necessary support and protection to mothers and their infants and young children to facilitate optimal feeding practices*.'

'*Children have the right to life, survival and development and to the highest attainable standard of health, of which breastfeeding must be considered an integral component, as well as safe and nutritious foods*.'

'Women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding... They also have the right to good quality health services, including comprehensive sexual, reproductive and maternal health services. And they have the right to adequate maternity protection in the workplace and to a friendly environment and appropriate conditions in public spaces for breastfeeding which are crucial to ensure successful breastfeeding practices'.[15]

In Australia, these human rights conventions are implemented through the Australian Human Rights Commission and the state and territory Human Rights Commissions. Despite the protection of breastfeeding through these international conventions, it has not been implemented as a national priority through policy and programs in Australia. This is demonstrated by the fact that the most current relevant data available for national breastfeeding rates was gathered in 2010 and is therefore unusable in this WBTi assessment. To provide context, however, it found that while initiation rates were high, exclusivity and continuity of breastmilk dropped dramatically in the first few months. According to the survey, 96% of mothers initiated breastfeeding while in hospital, but by less than six months of age only 15% of babies were being 'exclusively' breastfed and only 60% of infants were receiving 'any' breastmilk at six months.[16]

To address this stagnation in breastfeeding policy and outcomes, the Australian WBTi assessment uses an innovative approach to link the assessment to both economic and gender equity principles. If the above statistics are taken into account and breastmilk is included in the Gross Domestic Product (GDP), breastfeeding becomes a health investment, in addition to being a health issue. Revised GDP calculations, that allowed women's investment of time in breastfeeding to be formally recognised and valued as part of the economy, would show that breastfeeding by Australian women contributes around $3.6 billion per year to the food system.[17]A 2014 report by the Australian Bureau of Statistics estimated that, in 2006 dollars, childcare and household work was valued at AUD65 billion and AUD586 billion,[18] respectively, much of which is provided by women and is known to be especially associated with the care and feeding of infants and young children.[19] This represented 58.7% of GDP for 2006 and would be a much higher amount if done today.

The Australian health care system would also benefit economically from increasing breastfeeding exclusivity and duration through cost savings for the treatment costs of childhood illnesses, chronic disease and reproductive cancers. A saving of between AUD$60-120 million a year, using 2002 dollars, has been identified for treatment of infants and children for gastrointestinal illness, respiratory illness, otitis media, excema and necrotizing entercolitis if exclusive breastfeeding rates at three months were to increase to 80%.[20] Furthermore, Australian studies show that around around 6-24% of major chronic diseases are attributable to premature cessation of breastfeeding[21] and that 235 women per year are diagnosed with breast cancer and other reproductive cancers.[22]

This economic perspective is essential to addressing the fact that the care of infants and young children, including breastfeeding, is a major underlying factor in the maternity pay penalty experienced by women, according to a major International Labour Office study. The disproportionate burden on women as mothers and the under resourcing of breastfeeding education of health professionals is a major gender inequity that is poorly recognised by Australian governments.[23]

To better account for equity of investment in women and children, IBFAN launched *A Global Drive for Financial Investment in Children's Health and Development through Universalising Interventions for Optimal Breastfeeding in 2012.*[24] IBFAN's World Breastfeeding Costing Initative (WBCi) tool has been used to assist agencies to develop budgets for implementing the WHO Global Strategy components, such as the Baby Friendly Health Initiative (BFHI), the WHO Code, or Maternity Protection.

As well as program management costs, and the costs of policy development, legislation, planning and coordination, it provides guidance for policymakers to estimate the funding and training costs within the health and nutrition care system, mother support and community-level IYCF actions. Such programs may include communications strategies for behavior and social change, paid maternity leave and breastfeeding-friendly workplaces, and IYCF in exceptionally difficult circumstances such as if Human Immunodeficiency Virus (HIV) has been diagnosed or in emergencies.

By highlighting this gender inequity, the report can be used by the Australian government to determine adequate funding for implementation of the *Australian National Breastfeeding Strategy: 2018 and Beyond* [25] and other associated health and economic policies. This will achieve more equitable sharing of the costs of breastfeeding between women, men, society and governments.

	Indicator	Recommended in 2007 in *The Best Start: Report on the inquiry into the health benefits of breastfeeding*	Current Situation in Australia, 2017
1	**National Policy, Programme and Coordination**	That the Department of Health and Ageing coordinate and oversee the implementation of a national strategy to promote and support breastfeeding in Australia, including providing leadership in the area of monitoring, surveillance and evaluation of breastfeeding data.	Strategy was developed for 2010-2015, but did not provide leadership in monitoring, surveillance and evaluation of breastfeeding data and is now expired and yet to be replaced.
2	**Baby Friendly Health Initiative (Ten steps to successful breastfeeding)**	That the Department of Health and Ageing work with the Australian Council on Healthcare Standards (and/or equivalent accreditation organisation) towards including Baby Friendly Health status as part of the accreditation process.	Baby Friendly Health status continues to be opt-in and is not included as part of the ACHS accreditation process.
		That the Commonwealth Government, when negotiating future Australian Health Care Agreements, require state and territory governments to report on the number of maternity wards in public hospitals that have been accredited under the Baby Friendly Health Initiative.	This has not been established as the only publicly available data is from the providers of the BFHI training and accreditation provider.
		That the Department of Health and Ageing fund the Australian College of Midwives to run the Baby Friendly Health Initiative in Australia, to facilitate the accreditation of all maternity hospitals	The Australian College of Midwives does not receive any funding assistance from any level of government to administer the Baby Friendly Health Initiative.
		That the Department of Health and Ageing commission a study into the economic benefits of breastfeeding	There has not been a publicly funded study completed into the economic benefits of breastfeeding.
3	**Implementation of the *International Code of Marketing of Breast-milk Substitutes***	That the Department of Health and Ageing adopt the World Health Organisation's International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions	The WHO Code and all subsequent WHA resolutions have not been adopted or implemented in full.
		That Food Standards Australia New Zealand change the labelling requirements for foods for infants under Standard 2.9.2 of the Food Standards Code to align with the NHMRC Dietary Guidelines recommendation that a baby should be exclusively breastfed for the first six months	This has not happened.

	Indicator	Recommended in 2007 in *The Best Start: Report on the inquiry into the health benefits of breastfeeding*	Current Situation in Australia, 2017
4	**Maternity Protection**	That the Department of Health and Ageing fund an awards program, which provides recognition for workplaces, public areas and shopping centres that have exemplary breastfeeding facilities,	This has not been implemented.
		That the Department of Health and Ageing provide additional funding for the Australian Breastfeeding Association to expand the Breastfeeding-Friendly Workplace Accreditation (BFWA) Program nationally to enable the accreditation of more workplaces.	The Australian Breastfeeding Association does not receive any federal funding for the administration of the Baby Friendly Workplace Accreditation.
		That the Speaker of the House of Representatives and the President of the Senate take the appropriate measures to enable the formal accreditation by the Australian Breastfeeding Association of Parliament House as a Breastfeeding Friendly Workplace	This has been completed
5	**Health and Nutrition Care Systems (in support of breastfeeding & IYCF)**	That the Department of Health and Ageing fund research into best practice in programs that encourage breastfeeding, including education programs, and the coordination of these programs	Skills training across curricula is either not required or inadequate
		That the Minister for Health and Ageing provide Medicare provider/registration numbers to International Board Certified Lactation Consultants (IBCLC) as allied health professionals	IBCLCs have not as yet been provided with Medicare provider numbers.
		That the Treasurer move to exempt lactation aids such as breast-pumps, nipple shields and supply lines from the Goods and Services Tax	This has not occurred.
6	**Mother Support and Community Outreach - Community-based support for the pregnant and breastfeeding mother**	That the Department of Health and Ageing fund the Australian Breastfeeding Association to expand its current breastfeeding helpline to become a toll-free national breastfeeding helpline.	The Australian Breastfeeding Association helpline is federally funded, though not on a permanent basis, to be a toll-free national helpline.
		That the Commonwealth Government promote breastfeeding within Indigenous Australian communities as a major preventative health measure	There have been no federally-funded national campaigns to work with Indigenous Australians to promote breastfeeding as a major prefentative health measure.

	Indicator	Recommended in 2007 in *The Best Start: Report on the inquiry into the health benefits of breastfeeding*	Current Situation in Australia, 2017
7	**Information Support**	That the Department of Health and Ageing fund a national education campaign to highlight: the health benefits of breastfeeding to mothers and babies; that breastfeeding is the normal way to feed a baby; that the use of breast milk is preferable to the use of infant formula; and the supportive role that the community can play with breastfeeding	There has been no federally-funded national education campaign about breastfeeding.
		That the Department of Health and Ageing fund research into: - the long-term health benefits of breastfeeding for the mother and infant; and- the evaluation of strategies to increase the rates of exclusive breastfeeding to six months.	There is currently no federally funded research into breastfeeding.
8&9	**Infant Feeding and HIV; Infant and Young Child Feeding during Emergencies**	That the Attorney General investigate whether breastfeeding is given suitable consideration in the implementation of shared custody arrangements and also provide advice to the Family Law Court and Family Relationships Centres on the importance of breastfeeding	Not aware of the status at time of report.
10	**Mechanisms of Monitoring and Evaluation Systems**	The Department of Health and Ageing implement the recommendations in the *Towards a national system for monitoring breastfeeding* in Australia document commissioned by the Commonwealth Government in 2001	No identifiable progress has been made towards a national system as there is no current national data on brestfeeding rates and outcomes.
		That the Department of Health and Ageing provide leadership in the area of monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas	As there is no national monitoring system, there has been no leadership provided by the Department of Health and Ageing.

References

1. Australian Bureau of Statistics (ABS). *Snapshot of Australia: 2016 Census Data Summary*. 2017 Accessed 20 March 2018. https://goo.gl/fz2zcH.
2. Commonwealth of Australia. *Aboriginal and Torres Strait Islander Health Performance Framework Report*. 2017 Accessed 28 March 2018. https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier1/120.html.
3. Victora, C.G., et al., *Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect.* The Lancet, 2016. **387**(10017): 475-490.
4. Standing Committee on Health and Ageing, *The Best Start: Report on the inquiry into the health benefits of breastfeeding*. 2007, Commonwealth of Australia: Canberra, Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/breastfeeding/report/fullreport.pdf.
5. Australian Health Minister's Conference 2009, *Australian National Breastfeeding Strategy 2010-2015*. 2009, Australian Government Department of Health: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/content/aust-breastfeeding-strategy-2010-2015.
6. World Health Organization Western Pacific Region. *Australia*. 2018 Accessed 25 April 2018. http://www.wpro.who.int/country_support/countries/aus/en/.

7. United Nations Association of Australia. *United Nations Association of Australia*. 2018 Accessed 25 April 2018. https://www.unaa.org.au/learn/australia-and-the-un/.
8. World Health Organization, *International Code of Marketing of Breast-milk Substitutes*. 1981, WHO: Geneva. www.who.int/nutrition/publications/code_english.pdf.
9. Australian Human Rights Commission. *The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Sex Discrimination - International Activities*. Accessed 28 April 2018. https://www.humanrights.gov.au/convention-elimination-all-forms-discrimination-against-women-cedaw-sex-discrimination-international.
10. Australian Human Rights Commission. *Convention on the Rights of the Child (1989)*. 2007 Accessed 28 April 2018. https://www.humanrights.gov.au/publications/australias-commitment-childrens-rights-and-reporting-un.
11. *Innocenti Declaration (2005)*. Accessed 28 April 2018. https://www.unicef.org/nutrition/files/innocenti2005m_FINAL_ARTWORK_3_MAR.pdf.
12. World Health Organization/UNICEF, *Baby-friendly Hospital Initative* 2009, WHO: Geneva. http://www.who.int/nutrition/topics/bfhi/en/.
13. World Health Organization, *Global Strategy on Infant and Young Child Feeding*. 2003. http://whqlibdoc.who.int/publications/2003/9241562218.pdf.
14. World Health Assembly, *Ending inappropriate promotion of foods for infants and young children. Sixty-ninth World Health Assembly. Agenda Item 12.1 (28 May 2016)* WHA: Geneva. http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf?ua=1&ua=1.
15. Office of the United Nations High Commissioner for Human Rights (OHCHR). *Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breast-feeding*. 2017 Accessed 19 March 2018. http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871.
16. Australian Institute of Health and Welfare, *2010 Australian National Infant Feeding Survey: indicator results*. 2011, AIHW: Canberra. http://www.aihw.gov.au/publication-detail/?id=10737420927.
17. Smith, J., *"Lost milk?": Counting the economic value of breast milk in gross domestic product.* Journal of Human Lactation, 2013. **29**(4): 537-546.
18. Australian Bureau of Statistics (ABS). *Spotlight on the national accounts: unpaid work and the Australian economy*. 2014 Accessed 28 April 2018. http://www.abs.gov.au/ausstats/abs@.nsf/mf/5202.0?OpenDocument.
19. Veerle, M., *Cooking, caring and volunteering: Unpaid work around the world*. 2011: OECD Publishing.
20. Smith, J., J. Thompson, and D. Ellwood, *Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory.* Australian and New Zealand Journal of Public Health, 2002. **26**(6): 543-551.
21. Smith, J. and P. Harvey, *Chronic disease and infant nutrition: is it significant to public health?* Public Health Nutrition, 2011. **14**(2): 279-289.
22. Jordan, S.J., et al., *Cancers in Australia in 2010 attributable to total breastfeeding durations of 12 months or less by parous women.* Australian and New Zealand Journal of Public Health, 2015. **39**(5): 418-421.
23. Grimshaw, D. and J. Rubery, *The motherhood pay gap: A review of the issues, theory and international evidence, Conditions of Work and Employment Series No. 57*. 2015, International Labour Office: Geneva. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_348041.pdf
24. Holla, R., et al. *The need to invest in babies - A global drive for financial investment in children's health and development through universalizing interventions for optimal*

breastfeeding. 2013 Accessed 28 April 2018. https://www.researchgate.net/publication/266383145_The_need_to_invest_in_babies_-_A_global_drive_for_financial_investment_in_children's_health_and_development_through_universalizing_interventions_for_optimal_breastfeeding.

25. Department of Health. *Australian National Breastfeeding Strategy: 2017 and Beyond* 2017 Accessed 28 April 2018. http://www.health.gov.au/breastfeeding.

Assessment process followed by the country

September 2017	Gender responsive budgeting and breastfeeding Australian National University, Canberra Dr Shoba Suri, IBFAN, WBTi presentation Core group formed and the 15 indicators allocated to team members.
September toNovember 2017	Reference group and Community Interest group formed
September 2017 to February 2018	Data collection
February 2018	Indicator report cards completed and collated
February to March 2018	Reference group consultation process
April 2018	Final report card due to IBFAN for validation
May 2018	Communication and collaboration with Federal Department of Health and Ageing
May 2018 onwards	Continued advocacy and communication with the Department, other relevent agencies and the public.

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List of the partners for the assessment process

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Australian Breastfeeding Association
Lactation Consultants of Australia and New Zealand

Reference Group

UNICEF Australia
Breastfeeding Coalition Tasmania
Childbirth and Parenting Educators of Australia
South East Qld Breastfeeding Coalition

Individuals

Financial Support for travel costs associated with ABA representative in Core group from ABA (Darwin Palmerston and Rural group).

Assessment Findings

Indicator 1: National Policy, Programme and Coordination

Key question: *Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National infant and young child feeding committee and a coordinator for the committee ?*

Guidelines for scoring		
Criteria	**Scoring**	**Results** ✓ ***Check any one***
1.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	1	
1.2) The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	1	
1.3) A national plan of action developed based on the policy	2	
1.4) The plan is adequately funded	2	
1.5) There is a National Breastfeeding Committee/ IYCF Committee	1	
1.6) The national breastfeeding (infant and young child feeding) committee meets, monitors and reviews on a regular basis	2	
1.7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.	0.5	
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level.	0.5	
Total Score	**0/10**	

Information Sources Used:

1. Smith, J., *"Lost milk?": Counting the economic value of breast milk in gross domestic product.* Journal of Human Lactation, 2013. **29**(4): 537-546.
2. Australian Health Minister's Conference 2009, *Australian National Breastfeeding Strategy 2010-2015*. 2009, Australian Government Department of Health: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/content/aust-breastfeeding-strategy-2010-2015.
3. Department of Health, *Implementation Plan for the Australian National Breastfeeding Strategy 2010-2015*. 2010, Commonwealth of Australia. http://www.health.gov.au/internet/main/publishing.nsf/Content/D94D40B034E00B29CA257

BF0001CAB31/$File/2010%20Implementation%20Plan%20for%20the%20Australian%20National%20Breastfeeding%20Strategy%202010-2015.pdf.
4. National Health and Medical Research Council, *Australian Dietary Guidelines*. 2013, NHMRC: Canberra. https://www.eatforhealth.gov.au/sites/default/files/content/n55_australian_dietary_guidelines.pdf.
5. National Health and Medical Research Council, *Infant Feeding Guidelines: information for health workers (2012)*. 2013, NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/n56.
6. National Health and Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*. 2003, NHMRC: Canberra. http://childaustralia.mrooms.net/pluginfile.php/4134/mod_page/content/38/diet-guidelines.pdf.
7. Food Standards Australia and New Zealand (FSANZ). *Standard 2.9.2 –Food for Infants*. 2018 Accessed 13 Apr 2018. http://www.foodstandards.gov.au/code/Pages/default.aspx.
8. Office of the United Nations High Commissioner for Human Rights (OHCHR). *Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breast-feeding*. Accessed 19 March 2018. http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871.
9. United Nations, *UN Convention on the Rights of The Child* 2012, Committee on the Rights of the Child 60th Session 2012, page 15 point 63. http://www2.ohchr.org/english/bodies/crc/docs/co/CRC_C_AUS_CO_4.pdf.
10. Department of Health, *Final Progress Report: Australian National Breastfeeding Strategy 2010-2015*. 2016, Commonwealth of Australia. http://www.health.gov.au/internet/main/publishing.nsf/Content/D94D40B034E00B29CA257BF0001CAB31/$File/ANBS-2010-2015-Final-Progress-Report%20.pdf.

Conclusions

As a federation of eight states and territories, the Australian national government is responsible for ensuring that breastfeeding policy is linked across national, state/territory and local levels and accountable for policy implementation and adequate funding across jurisdictions.

As in other countries, unpaid household production is not counted in national economic statistics which mainly measure production of goods and services for sale. In a gendered context, this means the productivity of breastfeeding women in supplying food, nutrition, health and childcare is underperceived by policymakers, whereas the role of industry in providing infants and young children with food and care is overemphasised. The critical role of breastfeeding and breastmilk as central to the nutrition and care system for infants and young children is especially not recognised by Australian policymakers, with the production and sale of infant formula (and other commercial baby food products and feeding equipment) counted in economic statistics such as GDP, but not the unremunerated production of human milk (and home prepared foods).[1] Tax transfers and health insurance policies also favour infant formula over breastfeeding, with a failure of government and some private health insurers to cover the cost of breast pumps, human milk handling and storage equipment, and private lactation consultant services.

At the national level, Australia has a breastfeeding strategy that is under review. However, for the purposes of this evaluation, the most recent governance document, the Australian National Breastfeeding Strategy 2010-2015 (ANBS), does not meet the full definition of a policy because it failed to include, from the outset, an action plan and allocation of adequate resources that were available for public scrutiny.[2] The ANBS 2010-2015 was endorsed by all Health Ministers and required the Population Health Development Principal Committee to develop a detailed implementation plan in consultation with key stakeholders. However an implementation plan for the strategy was not available publically until late 2015.[3] Details of funding were not attached to the plan.

Under the Strategy, Australian states and territories are responsible for implementing breastfeeding interventions and consulting with local stakeholders to achieve the Strategy's breastfeeding goals and objectives.[2] WBTi analysis at the subnational level, by Australia's eight states and territories, could be considered in the future to evaluate the implementation and resourcing of the ANBS.

Australia has an adequate national breastfeeding guideline produced by the National Health and Medical Research Council (NHMRC); *The Australian Dietary Guidelines* (2013)[4] and *Infant Feeding Guidelines: information for health workers* 2012.[5] However these guidelines do not comply with recommendations for the period of breastfeeding exclusivity and continued breastfeeding in the WHO Global Strategy for Infant and Young Child Feeding (2003). Australian guidelines use ambiguous wording that creates uncertainty about the value of exclusive breastfeeding for six months and continued breastfeeding beyond 12 months.

The Australian guidelines state that:

'*Infants should be exclusively breastfed* ***until around*** *6 months of age when solid foods are introduced. Breastfeeding should be continued while solid foods are introduced until 12 months of age and beyond, for as long as the mother and child desire*.'[5]

This text does not recommend exclusive breastfeeding ***to*** six months, as had the previous Australian guideline[6].

(a) '*The introduction of complementary feeding (adding solid foods and liquids other than breast milk or infant formula)* ***at around*** *6 months*.'

This text can be interpreted to encourage the introduction of complementary foods before 6 months, a practice which undermines breastfeeding exclusivity to six months and increases the likelihood of premature cessation of breastfeeding. This ambiguity is perpetuated in Australian standards for labelling baby foods, which allow complementary foods to be labelled as appropriate for babies from four months rather than six months of age.[7]

The Australian guidelines recommend to continue breastfeeding '*until 12 months of age and beyond*' which fails to support breastfeeding to two years and beyond as normal, recommended practice. The guideline's failure to include breastfeeding to two years and beyond hinders recognition by employers and the community of the breastfeeding of older children and fails to protect this practice. Importantly, it also provides opportunities for the marketing of toddler milks for children aged over 12 months in Australia and countries to which Australian-made toddler milks are exported.

Differences in breastfeeding recommendations for exclusivity and duration occur between health agency policy documents at state and national levels. Also, the policy statements and other relevant

documents by state and territory governments contain inconsistencies in their language and guidelines to caregivers about breastfeeding (see Appendix). In particular, packaging and labelling requirements administered by Food Standards of Australia and New Zealand (FSANZ) are not consistent with recommendations for six months of exclusive breastfeeding, because they continue to permit statements on commercial baby foods such as '*not before 4 months*' (Food Standard 2.9.2-Infant Foods).[7] Such statements confuse caregivers about the recommended age to introduce complementary foods.

Australia does not have a National Breastfeeding/IYCF Committee.

The ANBS requires states and territories to be responsible for consultation with stakeholders '*at a local level*', and fails to have a mechanism for national coordination of policy and consultation between non-government stakeholders and government.

Processes for policy formulation also fail to provide commitments to ensuring transparency and avoiding conflicts of interest, in accordance with the *Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breast-feeding*[8] and the *UN Convention on the Rights of The Child Committee on the Rights of the Child* 60th session 2012.[9]

The ANBS's implementation was led by the Australian Government through a Jurisdictional Senior Officials Group within the Australian Government Department of Health. The department reported to state and territory Health Ministers through the Australian Health Ministers Conference (AHMC) via the Australian Health Ministers Advisory Council (AHMAC) and its Australian Population Health Development Principal Committee (APHDPC).[2] In addition, the departmental group was tasked to '*facilitate collaboration and sharing of information and expertise and promote national consistency across key issues. The department will also engage with AHMAC subcommittees, particularly the Child Health and Wellbeing Subcommittee and Maternity Services Inter-Jurisdictional Committee as necessary on particular issues*.'[2]. However the frequency and minutes of these meetings within government and engagement with non-government stakeholders are not available publically.

Some states and territories report the activities of local breastfeeding stakeholder groups. For example, Western Australia '*has an active Breastfeeding Stakeholders group of community, non-government, government and private sector members that advocate for increased breastfeeding rates in WA*' and '*NSW Health chairs a stakeholder reference group which includes external stakeholders such as the Australian Breastfeeding Association.*'[10]

Overall, reporting by states and territories on the ANBS was not made clearly against criteria in the implementation plan, nor does the ANBS analyse how differences between jurisdictions in policy development and implementation could be addressed.[10]

Gaps

1. Although Australia is a signatory to the Convention on the Status of Women and Convention on the Rights of the Child, public policy approaches breastfeeding protection, promotion and support as a nutrition or health policy issue, not as enabling the realisation of the human rights of mother and child to breastfeed.

2. Human milk and breastfeeding is not visible in economic statistics such as food consumption or GDP, even though it is well recognised that not counting the production of human milk in economic statistics will make it less visible to policymakers and distort public policy. The invisibilty reduces policy attention, prioritising and resourcing of breastfeeding compared to production which is measured, such as of infant formula and baby foods.

3. National infant feeding guidelines do not recommend exclusive breastfeeding *to* six months of age, nor do they recommend to continue breastfeeding *to 2 years and beyond*.

4. Food regulations continue to permit statements referring to four months as the minimum age for introducing commercial baby foods, thus confusing and undermining recommendations to introduce complementary foods from six months.

5. A national plan of action for the Australian National Breastfeeding Strategy 2010-2015 was not available to the public until the end of 2015.

6. Adequate funding for the Australian National Breastfeeding Strategy was not included in budgets that were available publically.

7. Australia does not have a National Breastfeeding Committee/ IYCF Committee that includes non-government stakeholders across multiple sectors, including health, nutrition, breastmilk banks, food standards and labelling, workplaces, maternity protection, human rights, education and community engagement. Nor is there a stated commitment in policy formulation to ensuring transparency about involvement of industry and processes to avoid conflicts of interest in policymaking.

Recommendations

1. Australian Human Rights Commissioners be mandated to report annually on progress to ensure all mothers and children are enabled to breastfeed, including where the mother is employed, or incarcerated or faces other barriers, to fully realise their rights under the *Convention on the Elimination of all forms of Discrimination against Women*, articles 10(h) and 12; ILO Convention 183; the *Convention on the Rights of the Child*, article 24.2(a) and (c) and article 6, and other relevant human rights instruments to which Australia is a signatory.

2. Human milk should be included in GDP and national food production and consumption statistics, whether or not it is bought and sold. Food policy and food security should include impacts on the food system and food security of infants and young children, in daily life and emergency situations, including ensuring their mothers have adequate resources for this provisioning. Private health insurers should cover the cost of lactation services and breast pumps.

3. National breastfeeding policy to adopt WHO recommendations for exclusive breastfeeding to six months and thereafter continued breastfeeding to two years or beyond, and for this to be widely communicated to health workers.

4. Food standards for packaging and labelling to be brought into line with the recommendations for six months of exclusive breastfeeding, by requiring statements to refer to six months as the minimum recommended age for introduction of other foods.

5. Develop and ensure timely publication of a national plan of action for the ANBS which is easily accessible to the public and ensures implementation of national breastfeeding policy by states and territories.

6. Provide adequate funds for the ANBS in the national budget.

7. Establish and fund a National IYCF Advisory Committee that appoints a National IYCF Coordinator. Ensure that stakeholder representation on the Committee excludes industry and includes non-government groups and stakeholders across multiple sectors, and operates with full transparency to the public.

8. Conduct a WBTi analysis of policies for infant and young child feeding/breastfeeding at the subnational level for Australia's states and territories.

Indicator 2: Baby Friendly Care and Baby-Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding[1])

Key questions:

- *What percentage of hospitals and maternity facilities that provide maternity services have been designated as "Baby Friendly" based on the global or national criteria?*
- *What is the quality of BFHI program implementation?*

Guidelines – Quantitative Criteria

*2.1) **68** out of **307** total hospitals (both public & private)and maternity facilities offering maternity services have been designated or reassessed as "Baby Friendly"in the last 5 years **22%***

Guidelines for scoring		
Criteria	**Scoring**	**Results** ✓ **Check only one which is applicable**
0	**0**	
0.1 - 20%	1	
20.1 - 49%	2	✓
49.1 - 69%	3	
69.1-89 %	4	
89.1 - 100%	5	
Total rating	**2 / 5**	

Guidelines – Qualitative Criteria

Quality of BFHI programme implementation:

[1] **The Ten Steps To Successful Breastfeeding:**The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breastmilk, unless medically indicated.
7. Practice "rooming in"-- allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

Guidelines for scoring		
Criteria	**Scoring**	**Results** ✓**Check that apply**
2.2) BFHI programme relies on training of health workers using at least 20 hours training programme[2]	1.0	✓
2.3) A standard monitoring[3] system is in place	0.5	✓
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities	0.5	✓
2.5) An assessment system relies on interviews of mothers.	0.5	✓
2.6) Reassessment[4] systems have been incorporated in national plans with a time bound implementation	1.0	✓
2.7) There is/was a time-bound program to increase the number of BFHI institutions in the country	0.5	
2.8) HIV is integrated to BFHI programme	0.5	
2.9) National criteria are fully implementing Global BFHI criteria (See Annex 2.1)	0.5	
Total Score	**3.5/5**	
Total Score	**5.5/10**	

Information Sources Used (1-11)

No list of hospitals with Obstetric (Maternity) Services exists officially. Commonwealth declared public hospitals, private hospitals and day hospital facilities[1] were used as a starting point to create a list and all inpatient facilities were checked individually for obstetric services using the MyHospitals website[2] or the hopsital's own website.

1. Department of Health. *Commonwealth Hospital Declaration*. Accessed 28 April 2018. http://www.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm
2. Australian Institute of Health and Welfare. *MyHospitals*. Accessed 28 April 2018. https://www.myhospitals.gov.au/.

[2] IYCF training programmes such as IBFAN Asia's '4 in1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc. may be used.

[3] ***Monitoring*** is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps* to assist with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an ongoing basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

[4] ***Reassessment*** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *Ten Steps* and other babyfriendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the *Global Criteria* and includes a reassessment visit by an outside team.Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

3. Australian College of Midwives. *BFHI Accredited Facilities List As At 27/09/17*. 2017 Accessed 28 April 2018. https://www.midwives.org.au/sites/default/files/uploaded-content/website-content/BFHI/bfhi_accredited_facilities_list_for_website_20170927.pdf.
4. Australian College of Midwives, *BFHI Handbook for Maternity Facilities*. 2016, Baby Friendly Health Initiative Australia. https://17-midwives.cdn.aspedia.net/sites/default/files/uploaded-content/field_f_content_file/bfhi_handbook_for_maternity_facilities_v3_20161028.pdf.
5. Australian College of Midwives, *BFHI Strategic Plan 2012 – 2017*. 2012, Baby Friendly Health Initiative Australia. https://0-midwives.cdn.aspedia.net/sites/default/files/uploaded-content/field_f_content_file/bfhi_strategic_plan_2012-2017_-_final.pdf.
6. Department of Health. *National Maternity Services Plan - Provision of maternity care*. 2018 Accessed 28 April 2018. http://www.health.gov.au/internet/publications/publishing.nsf/Content/pacd-maternityservicesplan-toc~pacd-maternityservicesplan-chapter3.
7. Australian Health Ministers' Conference (AHMC), *Standing Council on Health Communiqué 9 November 2012*. 2012, Australian Government Department of Health: Canberra. https://www.coaghealthcouncil.gov.au/Portals/0/SCoH_9%20November%202012.pdf.
8. World Health Organization, *National Implementation of the Baby-friendly Hospital Initiative 2017*. 2017, WHO: Geneva. http://apps.who.int/iris/bitstream/handle/10665/255197/9789241512381-eng.pdf;jsessionid=1683AB485730F4EABB11C31F341DB475?sequence=1.
9. Labbok, M.H., *Global baby-friendly hospital initiative monitoring data: update and discussion.* Breastfeeding Medicine, 2012. **7**(4): 210-222.
10. World Health Organization, *Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services*. 2017, WHO: Geneva. http://www.who.int/nutrition/publications/guidelines/breastfeeding-facilities-maternity-newborn/en/.
11. World Health Organization, *WHO Statement on Caesarean Section Rates*. 2015, WHO: Geneva. http://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=974636486CDEE4456AC7C96F4FE10495?sequence=1.
12. Department of Health. *National Women's Health Policy - Birth*. 7 February 2011 Accessed 6 May 2018. http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc~womens-health-policy-experiences~womens-health-policy-experiences-reproductive~womens-health-policy-experiences-reproductive-maternal~womens-health-policy-experiences-reproductive-maternal-birth.

Conclusion

Birthing women and babies are the focus of the maternity care system and nearly all mothers would prefer to breastfeed. Many prefer to avoid medical interventions during the birth process. There is longstanding, unmet demand by birthing women for greater choice of carer and continuity of care in childbirth, which is not being addressed in part because of fragmented funding systems. Caesarean birth rates in Australia are around 32%.[12] This is despite WHO recommendations that rates should be around 10-15% and should only be performed when medically necessary.[11]

There has been only very slow progress thus far in implementing the Baby Friendly Health Initiative (BFHI) in Australia. In 1997, two of 475 facilities had ever been accredited and by 2009 this had risen to 110 (20%) with minimal change since that time.[3-5] Only one woman in five who gives birth

each year is able to birth in a BFHI-accredited maternity and newborn care service. This proportion may have been declining over time. Women may have lesser access to BFHI hospitals in some locations, such as remote or regional areas or socio-economically disadvantaged areas. Such health and maternity care system factors create barriers to successful establishment of breastfeeding for Australian women.

In 2012, Australian Health Ministers noted that the goals and objectives of the Australian National Breastfeeding Strategy 2010-2015 and its implementation plan were strongly aligned with the effective, practical guidance provided by the WHO/UNICEF BFHI and its Ten Steps to successful breastfeeding for health services. Health Ministers affirmed that all jurisdictions support the BFHI and encourage all public and private hospitals to implement the Ten Steps to successful breastfeeding and to work towards or to maintain their BFHI accreditation. However, there was no requirement or resourcing for state-based maternity services to do so.[6]

Women are a majority of health workers, accounting for half of medical professionals and around 90% of nurses. Women are also well represented in medical specialities such as obstetrics and gynecology, though not in other specialities. However, they are less well paid, have lesser working conditions, and are underrepresented in decisionmaking in the health care system. For example, bodies such as the Australian Medical Association (AMA) board have only 3/14 women. By contrast, males are overrepresented on the Nursing and Midwifery board in relation to their numbers in the profession. International Board Certified Lactation Consultants (IBCLC) are nearly all female. These factors are likely to reduce women's influence in decisionmaking about the maternal and newborn care system.

Gendered norms and values within the health care system are also likely to contribute to the lack of importance given to breastfeeding support and the lack of priority given to BFHI. The lack of recognition of IBCLCs, such as by Medicare provider status, and the low levels of employment of IBCLCs in maternity care services, not only reduces the support available for women in the health care system but also reduces job opportunities for women in an area where they have unique experience, skills and qualifications to offer.

There have been concerns about BFHI governance in Australia since 1995 when UNICEF controversially handed governance of BFHI to the Australian College of Midwives (ACM). Critical to BFHI is respect and compliance with the WHO Code of Marketing of Breast-milk Substitutes. ACM knowingly continues to accept sponsorship and advertising revenue from WHO Code-violating companies which represents a fundamental conflict of interest. Along with resourcing of BFHI accreditation including training requirements (see indicator 5), concerns about governance remain an important barrier to quality BFHI implementation in Australia.

BFHI has been facilitated at ACM by a part-time administrator. Although an Advisory Committee exists, its role is superficial. Decisions about the programme, including the conferring of BFHI status, are made by administrative staff. Current BFHI Assessors have all completed two new online courses, one about BFHI in general and a generic course on peer review. Neither of these courses is adequate to conduct an assessment and assessing standards and interpretation of criteria vary significantly (new assessor training is currently frozen).

Currently in Australia, approximately 22% of hospitals that offer maternity services and two community services have been designated as 'Baby-Friendly'.[7] This designation uses Australian standards which do not meet the global criteria for full BFHI accreditation.[8]

There is an urgent need to empower women to breastfeed by integrating BFHI directly into a nationwide quality assurance system for maternity and newborn care facilities in Australia. This would also ensure greater equity in access to mother-friendly and baby-friendly care in Australia, according to accepted and evidence-based international standards rather than women's access to facilities with BFHI status, and evidence-based standards of care, resting on the role of key champions of the Ten Steps and BFHI within individual facilities.

Gaps

1. There is currently inconsistent training requirements for health workers in BFHI and so the committee cannot confirm the programme is at least 20hrs for all applicable clinical workers.

2. The BFHI program is not adequately monitored and the assessment system does not adequately demonstrate interviews have taken place with health care personnel in maternity and postnatal facilities or with mothers.

3. HIV management is not integrated into the Australian BFHI assessment criteria.

4. Global BFHI criteria are not fully implemented in the national criteria, therefore reassessment systems are not incorporated into national plans with time-bound implementation or programs to increase the number of BFHI institutions.

5. The current system of BFHI accreditation and training of health workers post-accreditation is costly, inequitable and removes responsibility of care from clinician to management, rather than training health workers at university and systemising the principles of BFHI as a normal course of business.

Recommendations

1. That the Commonwealth Government enact federal legislation with policy guidance and, when negotiating future Australian Health Care Agreements, require state and territory governments to report on the number of maternity wards in public hospitals that have been accredited under the Baby Friendly Health Initiative to enable the recommendations.

2. That the Commonwealth Government task and fund the National IYCF Advisory Committee to establish an independent, WHO Code-compliant body to administer, maintain, monitor and expand BFHI with support from UNICEF Australia as required by Australia's obligations under the WHO Code *Article 6 Health Care Systems* and *Article 7 Health workers*.

3. That the Commonwealth Government task and adequately fund the National IYCF Advisory Committee to establish a working group to develop and implement a strategy to incorporate all global BFHI criteria into existing national quality improvement standards.

4. That the Commonwealth Government task and adequately fund the National IYCF Advisory Committee to develop and implement a time-bound program to increase the number of BFHI institutions in the country.

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

Key question: *Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolution are in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*

Guidelines for scoring		
Criteria (*Legal Measures that are in Place in the Country*)	**Scoring**	**Results**
3a: Status of the International Code of Marketing		✓ (*Check that apply. If more than one is applicable, record the highest score.)*
3.1 No action taken	0	
3.2 The best approach is being considered	0.5	
3.3 National Measures awaiting approval (for not more than three years)	1	
3.4 Few Code provisions as 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[5] a) Provisions based on at least 2 of the WHA resolutions as listed below are included b) Provisions based on all 4 of the WHA resolutions as listed below are included	 5.5 6	
3b: Implementation of the Code/National legislation		✓ ***Check that apply***

[5] Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.

1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling 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) are prohibited
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)

3.10 The measure/law provides for a monitoring system	1	
3.11 The measure provides for penalties and fines to be imposed to violators	1	
3.12The compliance with the measure is monitored and violations reported to concerned agencies	1	
3.13 Violators of the law have been sanctioned during the last three years	1	
Total Score (3a + 3b)	**1.5/10**	

Information Sources Used (1-7)

1. Department of Health. *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992 (MAIF Agreement)*. Accessed 6 May 2018. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm.
2. Standing Committee on Health and Ageing, *The Best Start: Report on the inquiry into the health benefits of breastfeeding*. 2007, Commonwealth of Australia: Canberra, Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/breastfeeding/report/fullreport.pdf.
3. Australian Breastfeeding Association, *Australian Breastfeeding Association submission on the Infant Nutrition Council Limited applications for authorisation A91506 and A91507*. 2015. https://www.breastfeeding.asn.au/system/files/Submission%20by%20the%20Australian%20Breastfeeding%20Association%20on%20Infant%20Nutrition%20Council%20Limited%20applications%20for%20authorisation%20A91506%20and%20A91507.pdf.
4. Department of Health. *Information for lodging complaints of alleged breaches of the MAIF Agreement*. Accessed 28 April 2018. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-brfeed-complaints.htm.
5. Food Standards Australia and New Zealand (FSANZ). *Standard 2.9.1- Infant Formula Products*. Accessed 25 April 2018. http://www.foodstandards.gov.au/code/infant/Pages/default.aspx.
6. Food Standards Australia and New Zealand (FSANZ). *Standard 1.2.7- Nutrition, health and related claims*. Accessed 25 April 2018. https://www.legislation.gov.au/Series/F2015L00394.
7. Food Standards Australia and New Zealand (FSANZ). *Standard 2.9.2- Food for Infants*. Accessed 25 April 2018. http://www.foodstandards.gov.au/code/Documents/2.9.2%20Food%20for%20infants%20v157.pdf.

Conclusions

There are substantial gaps in the effective monitoring and management of the promotion, selling, labelling and packaging of foods for infants and young children (0-36 months) in Australia.

Australia has not implemented the WHO Code and subsequent WHA Resolutions in full as Federal legislation. The voluntary industry self-regulated Code of Practice, the *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement* (1992) is outdated and limited in scope and effectiveness. The MAIF Agreement applies to infant and follow-on formula for children aged 0-12 months, but excludes toddler milks and commercial baby foods. Retailers are not included and not all manufacturers and importers are signatories. Governance, interpretation and monitoring of the MAIF Agreement are not transparent and there are no effective penalties for breaches.[1]

Australia has partly implemented the WHO Code recommendations for labelling infant and follow-up formula for children aged 0-12 months, in Food Standards Australia and New Zealand (FSANZ) *Standard 2.9.1- Infant Formula Products*[4]. However standards for labelling and packaging infant formula need to be strengthened to include toddler milks, and prohibitions on nutrition content or health claims about infant formula[6] need to be enforced. Contrary to the recommendation of the WHO/UNICEF Global Strategy for Infant and Young Child Feeding to introduce complementary foods from 6 months, Australian food standards permit the labelling of commercial complementary baby foods as suitable for children from four months of age[7].

Gaps

1. There has been minimal progress toward full implementation of the WHO Code and subsequent WHA resolutions since Australia's endorsement in 1981.
2. The Australian Government is not meeting it's responsibilities under the WHO Code for monitoring and enforcement of compliance regarding health and nutrition claims for foods for infants and young children (0-36months) as is required under the WHO Code and subsequent WHA resolutions.
3. There are no administrative directives and/or circulars implementing the WHO Code in full or in part in health facilities including administrative sanctions.
4. There are no current penalties for breaches of the MAIF agreement which renders the agreement ineffective.
5. At present in Australia, the current body responsible for administering reports of inadequate compliance, is not a transparent process nor is it free from conflict of interest.
6. There is no auditing or enforcement of requirements that hospitals shouldn't have access to reduced cost or free infant formula.

Recommendations

1. The Australian Government should meet its obligations to enact legislation or other effective measures to implement the WHO Code and subsequent WHA resolutions in full with appropriate enforcement regarding the gaps above, including (but not limited to):
    - FSANZ regulation of marketing of food for infants and young children 0-36 months,
    - MAIF scope of products, retailing, compulsory membership of MAIF etc,
    - NHMRC Infant Feeding Guidelines,

- health facility policy and practice compliance with WHO Code in respect to the marketing, purchase and use of breastmilk substitutes.

2. All health worker organisations and government programmes should include WHO Code compliance as part of their professional ethical standards. Government funding should be linked to Code compliance.
3. Monitoring and effective sanctions for breaches written into legislation and a process described.

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 Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?*

Guidelines for scoring		
Criteria	**Scoring**	**Results** **Check ✓ that apply**
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave a. Any leave less than 14 weeks b. 14 to 17weeks c. 18 to 25 weeks d. 26 weeks or more	 0.5 1 1.5 2	 ✓
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. a. Unpaid break b. Paid break	 0.5 1	 ✓
4.3) Legislation obliges private sector employers of women in the country to *(more than one may be applicable)* a. Give at least 14 weeks paid maternity leave b. Paid nursing breaks.	 0.5 0.5	
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. *(more than one may be applicable)* a. Space for Breastfeeding/Breastmilk expression b. Crèche	 1 0.5	
4.5) Women in informal/unorganized and agriculture sector are: a. accorded some protective measures b. accorded the same protection as women working in the formal sector	 0.5 1	 ✓
4.6) . *(more than one may be applicable)* a. Information about maternity protection laws, regulations,	0.5	✓

or policies is made available to workers. b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	0.5	✓
4.7) Paternity leave is granted in public sector for at least 3 days.	0.5	✓
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5	✓
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.	0.5	✓
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	1	✓
Total Score:	**6/10**	

Information Sources Used (1-11)

1. *Sex Discrimination Act 1984 (Commonwealth)*. https://www.legislation.gov.au/Series/C2004A02868.
2. *Fair Work Act 2009 (Commonwealth)*. https://www.legislation.gov.au/Details/C2017C00323.
3. *Paid Parental Leave Act 2010 (Commonwealth)*. https://www.legislation.gov.au/Details/C2017C00081
4. Croker, A. and S. Eldridge, *Breastfeeding friendly workplace accreditation. Creating supportive workplaces for breastfeeding women.* Breastfeeding Review, 2005. **13**(2): 17.
5. Martin, B., et al., *PPL Final Report: Name of project: Paid Parental Leave Evaluation*. 2014, Institute for Social Science Research (ISSR), University of Queensland: Brisbane. https://espace.library.uq.edu.au/view/UQ:354876/finalphase4_report_6_march_2015_0.pdf.
6. Smith, J.P., et al., *Discrimination against breastfeeding mothers in childcare.* Australian Journal of Labour Economics, 2013. **16**(1): 65.
7. Australian Breastfeeding Association. *Breastfeeding Friendly Workplace accreditation* Accessed 28 April 2018. https://www.breastfeeding.asn.au/workplace.
8. Baxter, J., A.R. Cooklin, and J. Smith, *Which mothers wean their babies prematurely from full breastfeeding? An Australian cohort study.* Acta Paediatrica, 2009. **98**(8): 1274-1277.
9. Baxter, J., *Breastfeeding, Employment and Leave: An Analysis of Mothers in 'Growing Up in Australia'.* Family Matters, 2008(80): 17.
10. Smith, J.P., et al., *Workplace support, breastfeeding and health.* Family Matters, 2013(93): 58.
11. Morris, A., J. Johns, and A. Lawless, *South Australian Breastfeeding Program. Final Evaluation Report*. 2010, South Australian Breastfeeding Program, Centre for Health Promotion, Children and Women's Health Service (CYWHS): Adelaide, South Australia http://www.flinders.edu.au/medicine/fms/sites/southgate/documents/publications/SABP%20final%20report%20June%202010.pdf.

Conclusions

In Australia, around 75% of mothers return to work in the first year postnatally, but the majority do so after the child is six months or older[8]. Mothers returning to work full time, especially in the first six months, are less likely to continue with exclusive breastfeeding. Factors that influence the reduction of breastfeeding duration among employed new mothers include; extreme time pressures, more urgent financial needs, and lack of accommodation in policy and workplaces of the heavy demands on parents providing breastfeeding, nutrition and care for infants and young children.[4,9,10] Increasing the time available for these activities, typically provided by women, such as by paid maternity leave, paternity leave, and part time employment hours, has been shown to increase the duration of breastfeeding, has helped ameliorate financial pressures and child illness and mental health problems among Australian women and children.[5]

The Sex Discrimination Act makes it unlawful to discriminate against breastfeeding women in employment or in the provision of goods and services. In the case of employment, either direct or indirect discrimination is unlawful, unless the employer can show reasonable grounds.[1]

National employment regulation (Fair Work Act) provides for 12 months unpaid leave/job protection for eligible employed women. Parents of young children can also seek reduced work hours and employers must give reasonable consideration to such requests.[2] Paid breastfeeding breaks are included in some workplace or employment agreements, particularly in the public sector. Unpaid breaks may be covered under sex discrimination legislation.[1,6]

Until the introduction of Paid Parental Leave in 2011, only around one in four women were entitled to paid maternity leave, via their employer. A total of 12 weeks was the norm.[5] Since the introduction of Paid Parental Leave, eligible employed women are entitled to a publicly funded payment equivalent to 18 weeks at the minimum female wage level, in addition to employer funded leave if offered.[3] Paid paternity leave is provided by some employers, usually for around a week, and 3 days leave is provided by the Paid Parental Leave scheme.[3]

Workplaces may voluntarily achieve breastfeeding friendly work settings, that can be accredited under programs such as the Breastfeeding Friendly Workplace Accreditation (BFWA) program administered by the ABA.[4,7]

Childcare services are licenced by state governments and only federally-accreditated services can benefit from government subsidies for childcare.[6] However, national accreditation standards intended to ensure adequate care of infant and young children do not require that services are breastfeeding friendly.[6] Breastfeeding rates are lower among children attending formal childcare and infectious illness is higher among infants attending full time care, where as children cared for by parents are more likely to be breastfed.[9] These minimum standards for childcare services fail to ensure that

standard provides support and facilities for all parents to maintain breastfeeding and have no incentive to invest in acquiring the skills and knowledge to provide effective breastfeeding support. Therefore, the current policy approach is likely to increase socioeconomic disparities in breastfeeding and widen health inequalities.

Gaps

1. The value of breastfeeding and the resources (especially of time) which women commit to it are not recognised. No national time-use survey has been conducted since 2006 to inform labour market and other policies.
2. Taking action against employers or businesses including childcare services engaged in unlawful sex discrimination is time consuming, expensive and stressful, and relies on the individual to pursue a complaint through federal or state agencies.
3. It can be difficult for individual parents to access their entitlements under the Fair Work Act if the employer is resistant. Job protection entitlements are not well known and are also difficult to enforce by individuals.
4. Likewise, entitlement to paid breastfeeding breaks is not specified in legislation but is in agreements negotiated with employers by unions or staff. Many women work in industries or workplaces which do not include entitlement to paid breastfeeding breaks in awards.
5. The amount of Paid Parental Leave being at the minimum wage is insufficient for many families to be able to afford the time away from employment to allow for six months exclusive breastfeeding. This is particularly a problem for low wage earner families.
6. The duration of publicly funded Paid Parental Leave of 18 weeks is insufficient to allow for six months exclusive breastfeeding. This means that unless employers are topping up Paid Parental Leave payments families may not be able to afford six months leave. This is particularly a problem for women working in most industries or for most employers that do not provide paid maternity leave.
7. Although the value of the Australian Breastfeeding Association's BFWA scheme is well recognised, including by employers, the Australian Government has not acted on the recommendation of the 2007 Parliamentary '*Best Start'* Inquiry on the Benefits of Breastfeeding to provide funding for expanding the scheme.
8. The BFWA and a voluntary or best practice approach cannot be relied on to achieve equity as the most disadvantaged workers including in the informal sector will not have comparable access to such conditions.

Recommendations

1. The time devoted to provision of food, nutrition and care to infants and young children, should be comprehensively and reliably measured by the Australian Bureau of Statistics to provide a more balanced picture of the productive work of mothers of infants and young children, and to better inform labour market, economic and social policymakers about trends in time spent by women and men in unpaid (non-market) production including breastfeeding and other lactation work (such as providing expressed milk, and mother-to-mother support for optimal infant and young child feeding). The Australian Time Use Survey should be

restored as a matter of urgency, and it should also be redesigned to provide reliable data on the time use of women and men with infants aged <12 months.

2. Strengthen employment protection and enforcement provisions in the Sex Discrimination Act and Fair Work Act and provide resources for agencies to act on behalf of breastfeeding mothers to enforce their entitlements.
3. Include paid breastfeeding breaks as a Minimum National Employment Standard in the Fair Work Act.
4. Increase the duration of publicly-funded Paid Parental Leave to six months
5. Provide partial Paid Parental Leave payment up to 12 months post-partum to assist families with infants financially and make flexible return to employment more practical, and to support continued breastfeeding to 12 months and beyond as recommended by the National Health and Medical Research Council's infant feeding guidelines.
6. Minimum National Employment Standards providing 12 months job protection and flexible return to work for parents of infants and young children should be more widely promoted so that all pregnant women and new parents are aware of their employment entitlements.
7. Ongoing funding of a nationwide expansion of the BFWA scheme should be provided as recommended by the Best Start Inquiry.
8. Accreditation and licensing standards for all childcare services should be revised to ensure all services provide as a minimum standard adequate facilities, staff cooperation and staff training to support exclusive and continued breastfeeding, as required by the Sex Discrimination Act.

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

Key question: *Do care providers in these systems undergo* skills training, *and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place*?

Guidelines for scoring			
	Scoring ✓*Check that apply*		
Criteria	**Adequate**	**Inadequate**	**No Reference**
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country[6] indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1	0
		✓	
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. *(See Annex 5b Example of criteria for mother-friendly care)*	2	1	0
			✓
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.[7]	2	1	0
		✓	
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
			✓
5.5) Infant feeding and young feeding information and skills are integrated, as appropriate, into training programmes	1	0.5	0

6 Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

7 The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)			✓
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.[8]	1	0.5	0
			✓
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	0.5	0
		✓	
Total Score:	**2.5/10**		

Information Sources Used

1. A variety of online curriculum summaries from university courses for health professionals were searched to look for breastfeeding/human lactation content. I spoke to health professionals with specialty knowledge about breastfeeding, as well as students who had recently completed study, about their knowledge of pre-registration preparation for their specialty. Individual course advisors were contacted via email when information was absent to clarify content. Curricula differ widely between education institutions and detailed course information was often difficult to discern. Undergraduate medical programs usually contain women's health components but there was no specific mention of human lactation or breastfeeding. The Australian Medical Council does not mention breastfeeding in its requirements for educational outcomes.
   The website of the Australian Health Professional Regulation Authority (AHPRA) was accessed, and a formal enquiry made about required breastfeeding capabilities for health professionals. The midwifery competency standard is the only one with mention of breastfeeding knowledge requirements.[1]
   No other health professional competency standard mentioned breastfeeding knowledge as a requirement for registration.
   Special mention should be made of the national specialist paediatric training course, which contains educational goals around infant feeding.[2]
2. There is no acknowledgement or mention of mother-friendly principles in any professional midwifery sources or obstetric college statements.
3. The Australian College of Midwives runs regular webinars each year on infant feeding/breastfeeding.[3]
   The Royal Australian College of General Practitioners runs an extensive program of professional development courses, of which topics on breastfeeding or infant feeding comprise less than 1% of sessions.

8 Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

The Australian College of Nursing and Australian College of Neonatal Nursing run their own infant feeding courses for registered nurses.

It is difficult to assess all inservice and professional development activities nationally, as many are run informally within institutions and health organisations and a number of professional bodies have education programs which are outsourced to private companies and are not accessible to the public.

4. It is the individual responsibility of organisations to express their support for the WHO Code, as there is no legal requirement for its inclusion in Australia.

   The Royal Australian College of General Practitioners[4] and the Public Health Association of Australia[5] both state support for the Code in their position statement on breastfeeding. There is no other acknowledgement of the Code in professional organisational literature or policy about breastfeeding.
5. There is no evidence of consistent inclusion of IYCF material in training material for health professionals in Australia.
6. There is no evidence of consistent programs of education being run at local levels. A small number of dedicated health professionals run in-service education in their own specialty (information obtained via personal communications).
7. There is no national policy about keeping breastfeeding mothers and their babies together when either is hospitalised.
8. A non-government organisation, the Association for the Well-being of Children in Hospital, mentions the need for admission of breastfeeding infant with sick siblings and with sick mother.[6]
9. Royal Australasian College of Physicians (RACP).[7]
10. Children's Healthcare Australia, an independent accreditation organisation for Children's Hospitals, discuss the need for children to have at least one parent with them during admission.[8]
11. Women's Healthcare Australia, a parallel organisation for maternity hospitals makes no mention of mother and child closeness or separation.
12. Special mention is made here of the position statement from the Royal Australian and New Zealand College of Psychiatry on mother and child admissions, recommending that mothers and babies remain together wherever possible during admission.[9]

References

1. Nursing and Midwifery Board of Australia, *National competency standards for the midwife*. 2006, Australian Health Practitioner Regulation Agency (AHPRA). http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx.
2. Royal Australasian College of Physicians - Paediatrics and Child Health Division, *General Paediatrics Advanced Training Curriculum, Physician Readiness for expert prqactcie (PREP) Training Program* 2013, Royal Australasian College of Physicians (RACP): Sydney.

https://www.racp.edu.au/docs/default-source/default-document-library/at-general-paediatrics-curricula.pdf?sfvrsn=2.
3. Australian College of Midwives. *Supporting Women to Breastfeed*. 2018 Accessed 28 April 2018. https://www.midwives.org.au/shop/supporting-women-breastfeed.
4. Royal Australian College of General Practitioners (RACGP), *Position Statement on Breastfeeding. Policy endorsed by the 49th RACGP Council 7 September 2007*. 2007, The Royal Australian College of General Practitioners: Melbourne. https://www.racgp.org.au/download/documents/Policies/Clinical/breastfeeding_position_statement.pdf.
5. Public Health Association of Australia, *Policy-at-a-glance - Breastfeeding Policy*. 2016, PHAA: Deakin, ACT. https://www.phaa.net.au/documents/item/1707.
6. Association for the Wellbeing of Children in Healthcare (AWCH), *Health Care Policy Relating to Children and Their Families*. 1999, Association for the Wellbeing of Children in Healthcare. http://www.awch.org.au/pdfs/AWCH_Health_Care_Policy.pdf.
7. Royal Australasian College of Physicians (RACP) - Paediatrics & Child Health Division, *Standards for the Care of Children and Adolescents in Health Services* 2008, Royal Australasian College of Physicians. https://www.racp.edu.au/docs/default-source/advocacy-library/standards-for-the-care-of-children-and-adolescents-in-health-service.pdf.
8. Children's Hospitals Australasia, *Charter on the Rights of Children and young People in Healthcare Service in Australia*. Children's Hospitals Australasia (CHA) and the Association for the Wellbeing of Children in Healthcare (AWCH): Deakin, ACT. https://children.wcha.asn.au/sites/default/files/australian_version_final_210911web.pdf.
9. Royal Australian and New Zealand College of Psychiatrists, *Position Statement 57. Mothers, babies and psychiatric inpatient treatment*. 2015, Royal Australian and New Zealand College of Psychiatrists (RACNZCP). https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-57-Mothers-Babies-Psychiatric-Inpatient-Treatme.aspx.

Conclusions

There are some encouraging signs for advocacy for mother-baby or parent-child closeness during hospitalisation, although not yet at a national policy level[7]. Apart from midwives, no other health professionals are required in their competency statements to '*protect, promote and support*' breastfeeding.[1]

There is a glaring absence of a requirement for breastfeeding training and knowledge for all health professionals who have daily contact in their practice with breastfeeding women and babies.[1,3,5,6] Inclusion of infant feeding education occurs largely on an ad hoc basis, relying on the passion and motivation of qualified individuals to organise and run learning events.[3,5,6]
There is no recognition of the concepts of mother-friendly criteria in Australia.[2]
Cross-disciplinary inclusion of IYCF principles is not recognised.[5]

Heterogeneous curriculum content limited a broader exploration of course content in university training programs for health professionals on infant feeding. While the major educational institutions and governing bodies were researched, further investigation into the variety of training curricula may reveal some good educational resources.[1]

There is still some concern about the depth and breadth of breastfeeding education for trainee midwives. Again, with great variation between training curricula, it would be helpful to gain an understanding of course content for this profession.

Gaps

1. Thirteen of the 14 professional colleges regulated by AHPRA do not have any requirement for breastfeeding input in pre-registration course content. The exception is Nursing and Midwifery which has a requirement for midwives (but not nurses).

2. Individual training curricula for health professionals are not consistent and not based on IYCF principles, differs significantly from institution to institution, and is generally conspicuous by its lack of inclusion of any breastfeeding content. Nurses, medical doctors, dietitians, physiotherapists, pharmacists, chiropractors, osteopaths and practitioners of Chinese medicine may receive some breastfeeding content in their training, but it is highly variable in nature, not mandatory for registration, and likely to depend on the availability of an adequately qualified professional.

3. Specialist professions (including obstetricians, paediatricians, general practitioners and maternal and child health [or child and family] nurses and neonatal nurses) who would be expected to provide support to breastfeeding mothers and infants in their practice, also have widely varying amounts of educational or training input about breastfeeding, with a number of these containing no input about breastfeeding at all. Professional development material for these groups is not consistently provided.

4. In Australia, there is a current culture of parents staying with and participating in the care of their hospitalised children. There is, however, nothing at a policy level to support this practice or that commits to keeping infants/young children together with their hospitalised mothers.

Recommendations

1. All health professionals likely to come into contact with breastfeeding mothers or infants/young children in their clinical practice must receive and be assessed as competent on basic breastfeeding content in their pre-registration training. The Australian healthcare professional regulation body needs to provide leadership in this area. Specialist professions need to gain expertise in the provision of breastfeeding support in line with their level of practice.

2. Widespread education is needed on mother-friendly practices and the role these play in supporting breastfeeding practice.

3. Health policy and practice throughout Australia need to have IYCF principles interwoven at every level. As an essential part of this, there must be a recognition that the requirements of the WHO Code form a minimum standard for ethical practice in areas related to infant formula or other breastmilk substitutes. This would also include a commitment to ongoing professional in-service education about breastfeeding for all healthcare professionals in regular contact with breastfeeding mothers or infants and children.

4. National government prioritisation of keeping breastfeeding dyads together when either is hospitalised is needed. The Royal Australian and New Zealand College of Psychiatry have provided an excellent precedent for this in their policy statement.

Indicator 6: Mother Support and Community Outreach - Community-based support for the pregnant and breastfeeding mother

Key question: *Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding .*

Guidelines for scoring			
Criteria	**Scoring** ✓*Check that apply*		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based ante-natal and post -natal support systems with counseling services on infant and young child feeding.	2	1	0
		✓	
6.2) All women recieve support for infant and young child feeding at birth for breastfeeding initiation.	2	1	0
	✓		
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	2	1	0
		✓	
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.	2	1	0
			✓
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	2	1	0
		✓	
Total Score:	**5/10**		

Information Sources Used (1-22)

1. World Health Organization, *Global Strategy on Infant and Young Child Feeding*. 2003. http://whqlibdoc.who.int/publications/2003/9241562218.pdf.

2. Australian Health Minister's Conference 2009, *Australian National Breastfeeding Strategy 2010-2015*. 2009, Australian Government Department of Health: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/content/aust-breastfeeding-strategy-2010-2015.
3. World Health Organization/UNICEF, *Ten Steps to Successful Breastfeeding*. 1998, World Health Organization: Geneva. https://www.unicef.org/newsline/tenstps.htm.
4. Thomson, G. and H. Trickey, *What works for breastfeeding peer support-time to get real.* European Medical Journal: Gynaecology and Obstetrics, 2013. **2013**(1): 15-22.
5. International Baby Food Action Network (IBFAN) Asia, *World Breastfeeding Trends Initiative (WBTi) Assessment Tool*. 2014: Delhi, India. http://worldbreastfeedingtrends.org/wp-content/uploads/2015/03/docs/questionnaire-WBTi-September2014.pdf.
6. Department of Health, *Clinical Practice Guidelines: Pregnancy Care*. 2018, Commonwealth of Australia: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/Content/4BC0E3DE489BE54DCA258231007CDD05/$File/Pregnancy%20care%20guidelines%205Feb18.pdf.
7. National Health and Medical Research Council, *Infant Feeding Guidelines: information for health workers (2012)*. 2013, NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/n56.
8. Australian Health Ministers' Advisory Council, *The National Framework for Universal Child and Family Health Services* 2011, Australian Government Department of Health and Ageing: Canberra. https://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/%24File/NFUCFHS.PDF.
9. Council of Australian Governments (COAG), *Investing in the Early Years—A National Early Childhood Development Strategy*. 2009, Commonwealth of Australia: Canberra. https://www.startingblocks.gov.au/media/1104/national_ecd_strategy.pdf.
10. Department of Health, *National Nutrition Policy*. 2013, Commonwealth of Australia: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/content/phd-nutrition-health.
11. Senator the Hon. Fiona Nash, *Support for Breastfeeding*. 2016, Australian Government Department of Health: Canberra. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-nash005.htm.
12. Department of Health, *National Maternity Services Plan - Provision of maternity care*. 2011, Commonwealth of Australia: Canberra.
13. Hilder, L., et al., *Australia's mothers and babies 2012*, *Perinatal statistics series no. 30. Cat. no. PER 69*. 2014, Australian Institute of Health and Welfare (AIHW): Canberra. https://www.aihw.gov.au/getmedia/674fe3d3-4432-4675-8a96-cab97e3c277f/18530.pdf.aspx?inline=true.
14. Australian Institute of Health and Welfare, *2010 Australian National Infant Feeding Survey: indicator results*. 2011, AIHW: Canberra. http://www.aihw.gov.au/publication-detail/?id=10737420927.
15. Walsh, A.D., J. Pincombe, and A. Henderson, *An examination of maternity staff attitudes towards implementing Baby Friendly Health Initiative (BFHI) accreditation in Australia.* Maternal and Child Health Journal, 2011. **15**(5): 597-609.
16. Australian Breastfeeding Association, *10280NAT Certificate IV in Breastfeeding Education course structure*. 2018, ABA. https://www.breastfeeding.asn.au/training/courses/be/structure.

17. La Leche League International, *Steps to Accreditation*. 2018: llli.org. https://www.llli.org/get-involved/steps-to-accreditation/.
18. Baby Friendly Health Initiative Australia, *Baby Friendly Health Initiative. Information for Community Health Facilities*. 2016, Australian College of Midwives (ACM): Canberra. https://2-midwives.cdn.aspedia.net/sites/default/files/uploaded-content/field_f_content_file/bfhi_information_for_community_health_facilities.pdf.
19. Australian Government, *HLT30113 - Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care*. 2015. https://training.gov.au/Training/Details/HLT30113.
20. Australian Government, *HLT40213 - Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice*. 2015. https://training.gov.au/Training/Details/HLT40213.
21. World Health Organization, *Global Targets 2025, To improve maternal, infant and young child nutrition*. http://www.who.int/nutrition/global-target-2025/en/.
22. State of Victoria Department of Health, *Postnatal Care Program Guidelines for Victorian Health Services*. 2012, State Government of Victoria. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Postnatal-Care-Program-Guidelines-for-Victorian-Health-Services.

Conclusions

The World Health Organization's *Global Strategy for Infant and Young Child Feeding*[1] and the Australian National Breastfeeding Strategy 2010-2015[2] clearly identify the need for community-based support for breastfeeding mothers. Step 10 of the BFHI[3] requires BFHI-accredited birthing facilities to '*Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic*' and the evidence shows that skilled support increases breastfeeding rates.[4]

As defined by the World Breastfeeding Trends assessment toolkit, peer support required by mothers includes providing accurate and timely information to help a woman to build confidence; providing sound recommendations based on up-to-date research; providing compassionate care before, during and after childbirth; practicing empathy and active listening, providing hands-on assistance and practical guidance. The terms counselling and peer support will be used throughout this report and have been interpreted here to mean such support.[5]

It is essential that those supporting mothers are trained and have current evidence-based knowledge and skills in breastfeeding and normal baby behavior. The traditional skills and knowledge of women in mother-to-mother support, based on their experience of breastfeeding, are not appropriately respected, recognised, valued and resourced by the health system, government or society. There are a wealth of media platforms where mothers, parents and families obtain breastfeeding information including: books, social media, formula company advertising, informal mother's groups and health professionals. Any of these may provide misleading information about breastfeeding, so it is essential that mothers, parents and families can access accurate information from qualified peer counsellors and health professionals. There is inadequate endorsement and approval by governments

and society of the value of this independent and accurate information based on women's traditional roles, experience and knowledge of infant care including breastfeeding and lactation.

All mothers in Australia have free access to antenatal, intrapartum and postnatal care through midwifery and home-visiting services. They can access formal support through routine care and the 24-hour, 7-day-a-week National Breastfeeding Helpline staffed by trained Australian Breastfeeding Association counsellors. Specialised support from a lactation consultant, however, is costly and not universally available for the duration of a mother's breastfeeding journey, although some hospitals and outpatient clinics offer breastfeeding services, and breastfeeding support is available privately.

Although some peer support and counselling services are available for mothers, they are ad hoc, and it is more effective if breastfeeding support is integrated and clear pathways to specialised support are identified. The current national guidelines only support mothers antenatally, through the *Clinical Practice Guidelines Pregnancy Care*[6], and there are no national postnatal care guidelines or public health policies that require and adequately fund peer support for mothers as a part of infant and young child feeding policies. Skilled and knowledgeable mother to mother support for breastfeeding should be fully recognised, respected and resourced as crucial to the national food system for infants and young children. Mother-to-mother support organisations are not systematically accorded access and respect (such as to hospitals providing maternity care, or through referral of mothers such as under Step 10) within the health system, whereas infant formula and baby food companies are priviledged with direct access within the health system, and are accorded considerable respect and opportunity to influence by health professionals.

The infant feeding guidelines referenced for use by health professionals are the NHMRC *Infant Feeding Guidelines. Information for health workers*. These guidelines include advice to health workers to '*support the principles of the Baby Friendly Hospital Initiative*' and identify a range of education and support services for breastfeeding.[7] However, guidelines are not mandatory and although the infant feeding guidelines provide advice to support BFHI, they may have little influence on the behaviours of health workers and their workplaces.

Other national strategies and frameworks that acknowledge the importance of support in breastfeeding include the *National Breastfeeding Strategy 2010-2015*[2] (currently under review), the *National Framework for Universal Child and Family Health Services*[8], *Investing in the Early Years—A National Early Childhood Development Strategy*[9], and the *National Nutrition Policy*[10] (currently under review).

Although these policies are either out of date, do not adequately fund peer support, do not integrate health services with peer support groups or do not recognise the need for peer support for all mothers, there is evidence of government support of some peer support services because the Federal

Department of Health continues to fund training of Australian Breastfeeding Association peer counsellors and the National Breastfeeding Helpline.[11]

Antenatal support

Antenatal care is provided as part of national maternity care and is provided in public hospital care, shared maternity care or private maternity care[12]. Almost all Australian women (94.5%) attend 5 or more antenatal visits during pregnancy[13]. As part of the *Clinical Practice Guidelines Pregnancy Care*[6], breastfeeding should be discussed in these meetings, but there is no national research that provides evidence that such discussions take place. Childbirth education classes are run locally in hospitals and by private organisations such as Calmbirth, Childbirth Education Association and a variety of online sources, although there are no national training standards for childbirth educators. The Australian Breastfeeding Association offers Breastfeeding Education Classes throughout the country. However, the success of these volunteer-run, community-based classes requires the local community's collective support of breastfeeding, depending on referrals from health professionals and access to community venues to host the classes.

Breastfeeding support at birth

According to the 2010 Infant Feeding Survey, breastfeeding initiation rates were 95.9%[14]. We can conclude from this data that almost all Australian women want to breastfeed their babies and are given support to start breastfeeding.

Postnatal support

While maternity care in Australia includes postnatal care, there are currently no national guidelines on what should be included in the delivery of the service. While BFHI-accredited hospitals are required to pass on details of local breastfeeding support groups, other hospitals are not required to do so and there may not be peer support groups to refer on to in rural, regional or remote areas.

There is some anecdotal evidence that women who birth in BFHI-accredited facilities are more likely to encounter volunteer community supporters:

'A BF accredited hospital had engaged the whole community with the support of the local ABA and this supported the hospital'

'…the ABA group here…have had a lot of influence in the whole town of you know just making it normal (midwife)'.[15]

There is also a toll-free 24-hour, 7-day-a-week National Breastfeeding Helpline available to all mothers with access for the hearing impaired and a national translation service. However, access may be restricted for those without access to a phone, limited English or those who prefer alternative communication methods, such as social media or face-to-face counselling.

In the community, counsellors who volunteer with the Australian Breastfeeding Association are trained in counselling skills for infant and young child feeding, breastfeeding and the timely

introduction of high-quality family foods (Certificate IV Breastfeeding Education).[16] However those who volunteer as a Leader with La Leche League are not required to complete a nationally-accredited certificate and instead go through a process of accreditation.[17] These volunteer groups are not adequately resourced and or supported by local health professionals in all regions.

Remote areas which depend on Aboriginal Health Workers for maternal and infant health support face a knowledge gap because training on infant and young child feeding is not required for a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care, though it is offered as a non-compulsory course in Certificate IV and above. In some areas an Aboriginal Liaison Officer may work in a community health clinic alongside GPs and other health workers. Not all states require these workers to have any formal qualifications or training, therefore it is unlikely that they will have the required knowledge and skills around infant and young child feeding.[19, 20]

A range of national strategies, frameworks and guidelines recognise the importance of quality trained peer support to a woman's breastfeeding journey. The national antenatal care guidelines offer adequate instruction for health professionals to offer breastfeeding education to expectant parents, there is support in hospital for breastfeeding initiation and all mothers with access to a telephone can access the National Breastfeeding Helpline. The training and support of such community workers and volunteers, however, is inadequately prioritised and poorly funded.

In order to reach the WHO target of 50% of babies exclusively breastfed to six months by 2025,[21] the federal government must: require and fund breastfeeding education for community workers and peer support volunteers through national infant and young child feeding policies; expand funding for the National Breastfeeding Helpline to include digital counselling platforms, further outreach and education of priority groups and proactive services to reach mothers before there is a problem; develop national postnatal guidelines that integrate health services with community breastfeeding support and monitor and evaluate all breastfeeding-related initiatives.

The Federal government could use *Victoria's Postnatal Care Program Guidelines for Victorian Health Services*[22] as a guide. These guidelines were developed to ensure health services provide breastfeeding advice and support according to the *Ten Steps to Successful Breastfeeding* as specified in the Baby Friendly Health Initiative.

Beyond the training of peer supporters and increased funding for peer support initiatives, the government must invest in research and evaluation of such strategies and policies to determine if they are: making a difference to breastfeeding rates; providing services that mothers want and that mothers are satisfied with the services and establishing breastfeeding as the normal way to feed infants and young children.

Only then will mothers and babies have adequate support in the early years.

Gaps

1. The experience, knowledge and skills of women in mother to mother support for breastfeeding are not adequately recognised, respected or resourced by governments and society or in the health system.

2. In most areas, health services do not systematically and in a timely manner link mothers with peer support community-based counselling and specialised health services for pregnant and breastfeeding women and there is no overall infant and young child health and development policy.

3. There is currently no national health workforce planning and training requirement for breastfeeding education and/or counselling training for the range of health workers and community workers that may be in contact with women after birth.

4. BFHI accreditation of community health facilities is inadequate, leading to a lack of integration between health professionals and community workers across Australia.

5. There is a lack of funding and prioritisation to provide trained peer breastfeeding counselling support in a variety of formats, including supporting social media platforms, drop-in clinics and outreach services.

Recommendations

1. The crucial contribution of women's skills, knowledge and experience of mother-to-mother support for breastfeeding and lactation should be endorsed, recognised, and adequately resourced including by health policymakers and health systems such as through health policies and via Step 10 of BFHI. Women should also be more fully resourced by governments and health and education agencies to invest in enhancing their knowledge, skills and qualifications for delivering breastfeeding and lactation support.

2. Develop an Infant and Young Child Feeding policy and/or a National Breastfeeding Policy that includes trained peer breastfeeding counselling support of breastfeeding families with targets and measurable outcomes, an implementation plan and adequate funding.

3. Integrate national health service delivery to include both professional and volunteer breastfeeding support, that meets local needs, and provide clear access to specialised support when required.

4. Require all community workers who work with families and young children to undertake training in breastfeeding education, for example through a Registered Training Organisation such as the Australian Breastfeeding Association.

5. Make BFHI accreditation mandatory for community health facilities.

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Indicator 7: Information Support

Key question: *Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?*

Guidelines for scoring			
Criteria	**Scoring** ✓***Check that apply***		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts or interest are avoided.	2	0	0
			✓
7.2a) National health/nutrition systems include individual counseling on infant and young child feeding	1	.5	0
			✓
7.2b) National health/nutrition systems include group education and counseling services on infant and young child feeding	1	.5	0
			✓
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
			✓
7.4. IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	2	1	0
			✓
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF).[9]	2	0	0
			✓
Total Score:	**0/10**		

[9] to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging.

Information Sources Used **(**1-9)

1. Department of Health. *Breastfeeding*. 1 November 2017 Accessed 6 May 2018. http://www.health.gov.au/breastfeeding.
2. National Health and Medical Research Council, *Infant Feeding Guidelines: information for health workers (2012)*. 2013, NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/n56.
3. National Health and Medical Research Council (NHMRC). Accessed 6 May 2018. https://www.nhmrc.gov.au/.
4. UNICEF, *Infant and Young Child Feeding - Programming Guide*. 2011, United Nations Children's Fund: New York. https://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf.
5. World Health Organization, *International Code of Marketing of Breast-milk Substitutes*. 1981, WHO: Geneva. www.who.int/nutrition/publications/code_english.pdf.
6. Department of Health. *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992 (MAIF Agreement)*. Accessed 6 May 2018. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm.
7. Australian Breastfeeding Association. 2018 Accessed 6 May 2018. https://www.breastfeeding.asn.au/.
8. Raising Children Network (Australia). Accessed 6 May 2018. http://raisingchildren.net.au/.
9. NSW Health, *Breastfeeding in NSW: Promotion, Protection and Support. Policy Directive PD2011_042*. 2011, NSW Government. http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_042.pdf.

Conclusions

There is no national IEC strategy at all in Australia for improving infant and young child feeding that ensures all information and materials are free from commercial influence and potential conflicts of interest are avoided as part of the Australian Government's obligations under the Convention on the Rights of the Child (CRC).[1,2]

The Raising Children Network is a social media-based online information resource for parents which is funded by government. This provides some breastfeeding information, but there is no stated commitment to content reflecting IYCF principles.[8]

There are no national nutritional systems that provide group education and counselling services on IYCF.[6]

The Australian Breastfeeding Association, a volunteer-based mother-to-mother support organisation, provides education and information resources via its own website.[7]

Gaps

1. There is no IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence and potential conflicts of interest are avoided as part of the commitment in the CRC.

2. Information provided about infant feeding by government sources currently do not include a commitment to IYCF principles.

Recommendations

1. National breastfeeding policy must include an IEC strategy to improve IYCF that includes group education and counselling for all levels of government as part of their commitment in CRC.

2. The Department of Health must ensure that all information provided to parents relating to IYCF includes information on the risks of artificial feeding and complies with the government's commitment to CRC.

3. A national IEC program must include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula.

Indicator 8: Infant Feeding and HIV

Key question: Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice?

Guidelines for scoring			
Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV	2	1	0
		✓	
8.2) The infant feeding and HIV policy gives effect to the International Code/National Legislation	1	0.5	0
		✓	
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
			✓
8.4) HIV Testing and Counselling (HTC)/ Provide 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.	1	0.5	0
	✓		
8.5) Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV positive mothers.	1	0.5	0
		✓	
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	1	0.5	0
			✓
8.7) HIV positive breastfeeding mothers, who are supported through provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.	1	0.5	0
		✓	
8.8) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of	1	0.5	0

exclusive breastfeeding and continued breastfeeding in the general population.			✓
8.9) On-going monitoring is in place 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.	1	0.5	0
			✓
Total Score:	**3.5/10**		

Information Sources Used (1-9)

1. Australian Federation of AIDS Organisations (AFAO). *Mother-to-child*. 2017 Accessed 6 May 2018. https://www.afao.org.au/about-hiv/hiv-prevention/mother-to-child/.
2. World Health Organization. *Infant and young child feeding*. Fact Sheets 2018 Accessed 6 May 2018. http://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding.
3. World Health Organization, *Guidelines on HIV and infant feeding. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence*. 2010, WHO: Geneva. http://apps.who.int/iris/bitstream/handle/10665/44345/9789241599535_eng.pdf?sequence=1.
4. World Health Organization, *WHO Guidelines: Updates on HIV and Infant Feeding* 2016, WHO: Geneva. http://www.who.int/maternal_child_adolescent/documents/hiv-infant-feeding-2016/en/.
5. Tawia, S. *Mother-to-child transmission of HIV: what do we know in 2015?* 2015 Accessed 2 April 2018. https://www.breastfeeding.asn.au/mother-to-child-transmission-of-hiv-what-do-we-know-in-2015.
6. National Health and Medical Research Council, *Infant Feeding Guidelines: information for health workers (2012)*. 2013, NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/n56.
7. Department of Health. *HIV and pregnancy*. Pregnancy, Birth and Baby 2017 Accessed 2 April 2018. https://www.pregnancybirthbaby.org.au/hiv-and-pregnancy.
8. Kent, G., *HIV/AIDS, infant feeding, and human rights*. Food and Human Rights in Development. Volume I Legal and institutional dimensions and selected topics, ed. W.B. Eide and U. Kracht. 2006, Antwerp, Belgium: Intersentia. 391-424.
9. Morrison, P., K. Israel-Ballard, and T. Greiner, *Informed choice in infant feeding decisions can be supported for HIV-infected women even in industrialized countries.* AIDS, 2011. **25**(15): 1807-1811.

Conclusions

Women are particularly vulnerable to HIV/AIDS, and relatedly may experience gender-based violence, discrimination, lack of respect and inadequate access to health care during pregnancy, childbirth and postnatally. In 2015 in Australia, 20% of HIV notification cases were attributed to heterosexual sex; 75% of cases were receiving treatment.[1]

WHO released guidelines in July 2010 advising that, in countries that have opted to promote and support breastfeeding together with antiretroviral therapy (ART), mothers living with HIV who are on ART and adherent to therapy should breastfeed exclusively for the first 6 months, and then add

complementary feeding until 12 months of age.[4] In 2016, WHO updated their guidance to confirm that breastfeeding with complementary feeding may continue until 24 months of age or beyond.[3,4] Previously, WHO advice was to breastfeed for 12 months, but then stop breastfeeding if a nutritionally adequate and safe diet could be provided.

The new guidance is based on scientific evidence that shows ART is very effective at preventing HIV transmission through breastfeeding as long as the mother is adherent to therapy. The new evidence means that mothers living with HIV and their children can benefit from the many advantages of breastfeeding – such as improved growth and development – in the same way as mothers who do not have HIV and their children.

WHO recommendations emphasise the need for health systems to therefore achieve quality HIV services that reliably provide ART and continue to care for mothers living with HIV. Researchers have estimated that when mothers receive ongoing ART and their newborn babies receive a week of antiretroviral therapy and are exclusively breastfed for six months, the postnatal risk of HIV transmission is 1% or less.[5] Guidance about infant prophylaxis following birth usually suggests four weeks or six weeks.

It has been reported that the British HIV Association and the Children's HIV Association have recently revised infant feeding guidelines for British HIV-infected mothers. These organisations recommended artificial feeding for most mothers diagnosed with HIV, but also recognise that a woman on effective triple antiretroviral therapy, with repeated undetectable viral load at delivery, may choose to exclusively breastfeed for the first six months of her baby's life.

Current policy in Australia is that breastfeeding should be avoided by women with HIV/AIDS. Advice for health workers in the NHMRC *Infant Feeding Guidelines* is that breastfeeding is contraindicated when a mother is known to be HIV positive (specialist advice is needed for each individual case).[6, 7]

The most recent NHMRC *Infant Feeding Guidelines* have not been updated to reflect the current (2016) WHO recommendations and improved technologies and treatments. Nor do the Guidelines include consideration of women's own values and preferences about breastfeeding, or the known adverse implications for women's long term reproductive health of not breastfeeding. Questions have been raised[8,9] about whether the mother's right to make an informed choice should be suspended and whether the State and others are obligated to provide specific kinds of information.

Pregnancy testing and treatment is available for many, but not all, pregnant women due to gender-based barriers to access, such as care burdens and lack of financial resources or support from partners. Women diagnosed as HIV-positive who wish to breastfeed may be pressured, coerced or required by health workers and others to avoid or cease breastfeeding their infants.

There is no provision in Australia for evaluating the effects of interventions to prevent HIV/AIDS transmission on infant feeding practices and overall health outcomes for mothers and children.

Gaps

1. NHMRC *Infant Feeding Guidelines* have not been updated for current evidence-based knowledge and international guidelines on infant feeding and HIV/AIDS.

2. The need to respect women's own rights, values, preferences and autonomous informed choices about childbirth and infant feeding are not acknowledged in the *NHMRC Infant Feeding Guidelines* on HIV/AIDS.

3. Women identified with HIV/AIDS, who decide they prefer to breastfeed, may not have access to adequate information or support for an informed choice to optimally breastfeed, from health workers or others.

4. Gender-based and discriminatory barriers to treatment and treatment adherence may not be addressed under current policies and practices.

5. Systems for monitoring and evaluation of the long-term maternal and child health and other outcomes of current policy interventions are not established.

Recommendations

1. Update the NHMRC *Infant Feeding Guidelines* to reflect the most recent WHO guidance on improved technologies and evidence based approaches to preventing mother to child transmission of HIV/AIDS.

2. Acknowledge, within the NHMRC *Infant Feeding Guidelines*, a mother's right to make an informed decision to breastfeed her child.

3. Women identified with HIV/AIDS who decide they prefer to breastfeed should be supported to optimally breastfeed in line with current treatment recommendations.

4. A mother's decision to breastfeed, where there is a risk of mother-to-child transmission of HIV/AIDs, should not constitute grounds for automatic referral to child protection agencies.

5. Policies and practices should ensure consideration should also given to addressing gender based barriers (such as care burdens, lack of financial resources and intimate partner violence) to testing during pregnancy, treatment adherence and health care access.

6. Health care services and maternity care facilities should have clear written policies in place and communicated to women and their families that ensure dignity and respectful treatment of all women, regardless of HIV status.

7. Evaluation of the long term maternal and child health and other outcomes of current policy interventions should be conducted.

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?*

Guidelines for scoring			
Criteria	**Scoring** ✓**Check that apply**		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
			✓
9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
			✓
9.3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers:	1	0.5	0
a) basic and technical interventions to create an enabling environement for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding			✓
b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsollicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	0.5	0
			✓
9.4) Resources have been allocated for implementation of the	2	1	0

emergency preparedness and response plan			✓
9.5) a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	1	0.5	0
		✓	
b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
			✓
Total Score:	**0.5/10**		

Information Sources Used

1. Australian Health Minister's Conference 2009, *Australian National Breastfeeding Strategy 2010-2015*. 2009, Australian Government Department of Health: Canberra. http://www.health.gov.au/internet/main/publishing.nsf/content/aust-breastfeeding-strategy-2010-2015.
2. National Health and Medical Research Council, *Infant Feeding Guidelines: information for health workers (2012)*. 2013, NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/n56.
3. Commonwealth of Australia, *COMDISPLAN- Australian Government Disaster Response Plan*. 2017. Not publically available.
4. Council of Australian Governments (COAG), *National Strategy for Disaster Resilience*. 2011, Australian Institute for Disaster Resilience (AIDR): Canberra. https://knowledge.aidr.org.au/resources/national-strategy-for-disaster-resilience/.
5. Department of Health, *Australian Health Management Plan for Pandemic Influenza*. 2014, Commonwealth of Australia: Canberra. https://www.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/%24File/AHMPPI.pdf.
6. Australian Institute for Disaster Resilience (AIDR). *Australian Disaster Resilience Handbook Collection* Accessed 6 May 2018. https://knowledge.aidr.org.au/collections/handbook-collection/.
7. South Australian Department for Families and Communities, *National guidelines for managing donated goods: strengthening the nation's disaster resilience*. 2011, Government of South Australia: Adelaide. http://www.dcsi.sa.gov.au/__data/assets/pdf_file/0004/1894/national-guidelines-for-managing-donated-goods.pdf.
8. National Critical Care and Trauma Response Centre, *Australian Medical Assistance Team Training (AusMAT). Version 3*. 2011, National Critical Care and Trauma Response Centre: Darwin. http://www.nationaltraumacentre.nt.gov.au/sites/default/files/PDFs/AUSMAT_2011_web.pdf
9. Australian Breastfeeding Association, *10243NAT Diploma of Breastfeeding Management*. 2018, ABA. https://www.breastfeeding.asn.au/system/files/content/INFO-precourse-diploma-V3.2-201804.pdf.

10. Australian Animal Welfare Advisory Committee, *National Planning Principles for Animals in Disasters*. 2014. http://www.ava.com.au/sites/default/files/AVA_website/FINAL%20National%20Planning%20Principles%20for%20Animals%20in%20Disasters.pdf.

National Documents Searched (1-10)

In addition to these national documents, all state and territory emergency preparedness plans, response plans and other guidance that could be identified (including sub-plans and health plans) were searched as well as a sample of local government emergency plans. A total of more than 200 documents were included in the search. Key informants in federal and states/territories were also consulted.

Conclusions

In any emergency, women, infants and young children are likely to be disproportionately affected, yet provision for women's specific needs and interventions addressing their particular vulnerabilities around the care of their infants and young children is essentially absent from emergency preparedness and response plans.

Emergency planning and management in Australia is complicated by the government structure as a federation of states and territories. Each state and territory government has the responsibility for planning for the response and recovery for any emergency within their borders. The Federal Government provides leadership and financial and non-financial assistance to the states with planning expertise, response guidance and physical support (including via the Australian Defence Force).

The Australian national infant feeding guidance, the NHMRC *Infant Feeding Guidelines for Health Workers*, states that emergency preparedness plans should be made for IYCF-E.[2] However, the Australian government Disaster Response Plan (COMDISPLAN) does not indicate that IYCF-E is an area in which the Federal Government holds expertise or could provide assistance.[3] The Federal Department of Health is not noted as having any advisory capacity for IYCF-E.[3] The National Strategy for Disaster Resilience does not identify health-related actions that build resilience such as breastfeeding.[4] The Federal Department of Health holds responsibility for health-related national emergency plans but does not have any planning or guidance related to IYCF-E.[3] The Department of Health's Australian Health Management Plan for Pandemic Influenza repeatedly identifies infants as a vulnerable group but contains no mention of breastfeeding as a measure promoting resilience and does not consider infant feeding management in the context of a pandemic.[5] The Australian National Breastfeeding Strategy (2010-2015) contains no mention of IYCF-E.[1]

The Federal Government funds Emergency Management Australia which produces the Australian Disaster Resilience Handbook Collection.[6] This purpose of this collection is to align '*national*

disaster resilience strategy and policy with practice, by guiding and supporting jurisdictions, agencies and other organisations and individuals'. The Community Recovery Handbook identifies children as a vulnerable group, but contains no mention of IYCF-E. The Disaster Health Handbook indicates that infant formula is needed in evacuation centres but provides no detail on how provision should be managed or what other resources are required for formula-fed infants. It also does not adjust water requirements for formula-fed infants. It contains no mention of breastfeeding or the need for infant feeding support. The federally-funded National Guidelines for Managing Donated Goods[7] discusses the challenges associated with donations in emergencies. While it identifies that infant formula and baby food are products needed by emergency-affected populations, it does not identify specific issues related to the donation of infant formula and other infant feeding products.

The Australian government funds the Australian Medical Assistance Team (AMAT) which deploys health workers and logisticians following disasters in the Asia Pacific region. The Training Handbook for AMAT workers identifies infants, young children and mothers as vulnerable groups requiring special assistance. It contains detailed guidance on IYCF-E based upon the Operational Guidance for Infant and Young Child Feeding in Emergencies (OG-IFE) and the Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.[8]

The Australian Government also provided funding to the Australian Breastfeeding Association (ABA) for the initial development of their Diploma of Breastfeeding Management which includes a comprehensive training module on IYCF-E for health workers. This module is based on the OG-IFE however, the availability of training is currently limited to ABA volunteers or those undertaking the ABA Diploma of Breastfeeding Manangement.[9]

Analysis of state and territory emergency plans indicates an absence of a coordinated response for IYCF-E. While children may be recognised as a vulnerable group, no state or territory designates an agency responsible for IYCF-E nor identifies what actions should be taken regarding IYCF-E. State and territory Departments of Health do not include IYCF-E in their emergency plans. States and territories devolve aspects of emergency response to local governments to differing degrees, however the absence of apportioning of specific responsibility for IYCF-E, means that comprehensive IYCF-E plans are also absent at a local level. Minor aspects of IYCF-E planning are present in some jurisdictions, predominantly in lower level plans or optional guidance such as those dealing with the the management of evacuation centres.

The absence of a coordinated response for the needs of infants is in stark contrast to the consideration of the needs of animals in emergencies. As noted in COMDISPLAN, the Federal Government provides expertise in relation to animals through the Department of Agriculture.[3] As a result, the Department of Agriculture facilitated the formation of the National Advisory Committee for Animals in Emergencies. This Committee has a goal '*to work collaboratively to incorporate animals into emergency management planning at all levels of government, and to encourage those responsible for animals in emergencies to accept their responsibilities*.'[10] It includes a broad spectrum of stakeholders from all levels of government, animal welfare organisations and emergency management organisations. The Committee has developed the National Planning Principles for Animals in Emergencies guidance and, throughout Australia, emergency planning for animals is

comprehensive with clear designation of organisations responsible for emergency management of animals and of the actions required in emergency planning and response.

Gaps

1. The Australian government has not taken up a leadership role in IYCF-E and no Federal Government agency has taken responsibility for supporting IYCF-E.

2. There is no national emergency management policy on IYCF-E and no national guidance on IYCF-E.

3. In the absence of federal leadership, no agency has a designated responsibility for IYCF-E and IYCF-E emergency planning is absent at state/territory and local government level.

4. Training on IYCF-E exists, but is not readily available to emergency workers or managers.

Recommendations

1. Federal Department of Health to be designated in the COMDISPLAN as the resource agency providing advice and expertise on IYCF-E.

2. Federal Department of Health to convene and appropriately fund a national advisory committee on IYCF-E with the purpose of incorporating the needs of mothers, infants and young children into emergency management planning at all levels of government, and to ensure that appropriate agencies take responsibility for IYCF-E. This committee must include a broad range of stakeholders from all levels of government, health organisations and emergency management organisations.

3. Indicators related to IYCF-E to be included in the National Breastfeeding Strategy.

4. Australian Institute for Disaster Resilience to produce a Disaster Resilience Handbook on IYCF-E and integrate cross-cutting IYCF-E issues into other Handbooks (e.g. Disaster Health, Planning for Spontaneous Volunteers, Evacuation Planning).

5. Orientation and training on IYCF-E to be required for Defence personnel involved in emergency management and response.

6. Existing Australian education and training on IYCF-E (e.g. ABA and National Critical Care and Trauma Centre, Darwin) to be made available to all relevant health and emergency workers.

Indicator 10: Mechanisms of Monitoring and Evaluation System

Key question: *Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices?*

Guidelines for scoring			
Criteria	**Scoring** ✓ **Check that apply**		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
		✓	
10.2) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions	2	1	0
			✓
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels	2	1	0
			✓
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers	2	1	0
			✓
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	2	1	0
			✓
Total Score:	**1/10**		

Information Sources Used (1-4)

1. Australian Institute of Health and Welfare, *2010 Australian National Infant Feeding Survey: indicator results*. 2011, AIHW: Canberra. http://www.aihw.gov.au/publication-detail/?id=10737420927.
2. Australian Institute of Health and Welfare, *National Perinatal Data Collection 2010-2015*. 2017, AIHW: Canberra. https://www.aihw.gov.au/reports/mothers-babies/perinatal-data-visualisations/contents/data-visualisations.
3. Department of Health, *Final Progress Report: Australian National Breastfeeding Strategy 2010-2015*. 2016, Commonwealth of Australia. http://www.health.gov.au/internet/main/publishing.nsf/Content/D94D40B034E00B29CA257BF0001CAB31/$File/ANBS-2010-2015-Final-Progress-Report%20.pdf.
4. Australian Institute of Health and Welfare, *National Core Maternity Indicators data visualisations*. 2013, AIHW: Canberra. https://www.aihw.gov.au/reports/mothers-babies/ncmi-dynamic-data-displays/contents/dynamic-data-displays.

Conclusions

The monitoring and evaluation of major infant and young child feeding programmes is either of poor value, only available on local populations or non-existent. As Australia has no national breastfeeding policy with associated funding for a national coordinator and comprehensive IYCF programmes, there is no agreement upon the definitions of breastfeeding terminology such as 'exclusive' and 'predominantly', or indicators such as the timing of the introduction of solids.[4]

The frequency of data collection at a national level is non-exisistent, but there are various mechanisms or points in time where data could be collected locally and amalgamated nationally in a timely manner to be able to evaluate IYCF programmes.[3] Such mechanisms that could be used include the various scheduled well-baby or vaccination visits - scheduled throughout a child's first years and using appropriate definitions and indicators in the national health survey conducted by the Australian Bureau of Statistics.[2] National coordination of data collection and reporting is essential for effective monitoring and evaluation of IYCF programmes to guide planning and investment decisions.

Gaps

1. Monitoring and Evaluation compoenents are inadequate with inconsistent definitions and indicators for data, input and collection systems.

2. Data collection on breastfeeding is not done on an enduring basis, therefore it is not able to be reported on or used to guide planning and investment decisions.

3. The data that is collected nationally and subnationally is inadequate due to poor integration of IYCF programs between hospitals and child and family services and inconsistent indicators.

4. Monitoring of IYCF practices is not integrated, with consistent definitions and indicators, into a national nutritional surveillance system.

Recommendations

1. That the Federal Government adopt the WHO Global Data Bank definitions and indicators for breastfeeding and establish monitoring of these indicators at both national and local levels.

2. A National IYCF Advisory Committee is established and tasked with working with the Department of Health and the Australian Institute of Health and Welfare to establish a sustainable and standardised national data collection system and include appropriate breastfeeding definitions in the national health survey.

3. That the data acquired be made available routinely and in a timely manner to enable effective monitoring and evaluation of IYCF programmes at local and national levels.

Indicator 11: Early Initiation of Breastfeeding

Key question: *What is the percentage of babies breastfed within one hour of birth? Score 0*

Guideline:

Indicator 11	***Key to rating adapted from WHO tool* (see Annex 11.1)**	**IBFAN Asia Guideline for WBTi**	
Initiation of Breastfeeding (within 1 hour)		***Scores***	***Colour-rating***
	0.1-29%	3	**Red**
	29.1-49%	6	**Yellow**
	49.1-89%	9	**Blue**
	89.1-100%	10	**Green**

Data Source (including year):

There is no national data relating to this statistic in the past five years or potentially ever.

Summary Comments :

Australia must establish a national, regular and consistant data collection and monitoring system for Infant feeding.

Indicator 12: Exclusive Breastfeeding for the First Six Months

Key question: *What is the percentage of babies 0<6 months of age exclusively breastfed[10] in the last 24 hours?* ***Score 0***

Guideline:

Indicator 12	***Key to rating adapted from WHO tool* (see Annex 11.1)**	**IBFAN Asia Guideline for WBT*i***	
		Scores	***Colour-rating***
Exclusive Breastfeeding (for first 6 months)	0.1-11%	3	**Red**
	11.1-49%	6	**Yellow**
	49.1-89%	9	**Blue**
	89.1-100%	10	Green

Data Source (including year):

There is no national data relating to this statistic in the past five years. It was last collected in 2010 in the National Infant Feeding Survey.

Summary Comments :

Australia must establish a national, regular and consistant data collection and monitoring system for Infant feeding.

[10] Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (2)

Indicator 13: Median Duration of Breastfeeding

Key question: *Babies are breastfed for a median duration of how many months?* ***Score 0***

Guideline:

Indicator 13	***Key to rating adapted from WHO tool* (see Annex 11.1)**	**IBFAN Asia Guideline for WBT*i***	
		Scores	***Colour-rating***
Median Duration of Breastfeeding	0.1-18 **Months**	3	**Red**
	18.1-20 ’’	6	Yellow
	20.1-22 ’’	9	**Blue**
	22.1- 24 or beyond ’’	10	Green

Data Source (including year):

There is no national data relating to this statistic in the past five years. It was last collected in 2010 in the National Infant Feeding Survey.

Summary Comments :

Australia must establish a national, regular and consistant data collection and monitoring system for Infant feeding.

Indicator 14: Bottle feeding

Key question: *What percentage of breastfed babies 0-12 months of age, who are fed with any foods or drinks (even breastmilk) from bottles?* ***Score 0***

Guideline:

Indicator 14	***Key to rating adapted from WHO tool* (see Annex 11.1)**	**IBFAN Asia Guideline for WBTi**	
Bottle Feeding (0-12 months)		**Scores**	**Colour-rating**
	29.1-100%	3	**Red**
	4.1-29%	6	**Yellow**
	2.1-4%	9	**Blue**
	0.1-2%	10	**Green**

Data Source (including year):

This data has not been collected on a national level in the past five years**.**

Summary Comments :

Australia must establish a national, regular and consistant data collection and monitoring system for Infant feeding

Indicator 15: Complementary feeding --- Introduction of solid, semi-solid or soft foods

Key question: *Percentage of breastfed babies receiving complementary foods at 6-8 months of age?*
Score 0

Guideline

Indicator 15	WHO's	IBFAN Asia Guideline for WBTi	
	Key to rating	***Scores***	***Colour-rating***
Complementary Feeding (6-8 months)	0.1-59%	3	**Red**
	59.1-79%	6	Yellow
	79.1-94%	9	**Blue**
	94.1-100%	10	Green

Data Source (including year):

This data has not been collected on a national level in the past five years. It was last collected in 2010 in the National Infant Feeding Survey.

Summary Comments :

Australia must establish a national, regular and consistant data collection and monitoring system for Infant feeding

Summary Part I: IYCF Policies and Programmes

Targets:	Score **(25.5 Out of 100)**
1. National Policy, Programme and Coordination	**0**
2. Baby Friendly Hospital Initiative	**5.5**
3. Implementation of the International Code	**1.5**
4. Maternity Protection	**6**
5. Health and Nutrition Care Systems	**2.5**
6. Mother Support and Community Outreach	**5**
7. Information Support	**0**
8. Infant Feeding and HIV	**3.5**
9. Infant Feeding during Emergencies	**0.5**
10. Monitoring and Evaluation	**1**

IBFAN Asia Guidelines for WBT*i*

Total score of infant and young child feeding policies and programmes (indicators 1-10) are calculated out of 100.

Scores	**Colour- rating**
0 – 30.9	**Red**
31 – 60.9	**Yellow**
61 – 90.9	**Blue**
91 – 100	**Green**

Conclusions *(Summarize the achievements on the various programme components, what areas still need further work)*[11] **:**

The WBTi assessment tool reveals both strengths and weaknesses in a country's commitment to breastfeeding promotion and support and this assessment indicates that there is much room for improvement in the way that Australia supports and encourages women to breastfeed.
Australian breastfeeding families benefit from the rich legacy of 50 years of mother-to-mother breastfeeding support, advocacy and promotion provided by the Australian Breastfeeding Association (ABA, formerly the Nursing Mothers Association of Australia). The past and ongoing

[11] In this summary sheet analysis is done based on what are the SCORES and where your country or region stands in terms of Infant and young child feeding practices individually or combined. It is good to analyze this with team of stakeholders. Find out reasons and draw a list of recommendations for your health and nutrition managers and policy makers.

work of ABA is brought into stark relief in a number of the WBTi Indicators and reflects the extraordinary impact that the organisation has had on national breastfeeding behaviours.

The assessment also reveals a paucity of national legislation and formal processes to ensure that breastfeeding is seen as a priority in the public health agenda of our nation. Assessment of national breastfeeding policy, program and co-ordination reveals an absence of legislated and formalised leadership in defining breastfeeding as a public health priority. Australia lacks a formal breastfeeding policy and a government-aligned national body to provide leadership on breastfeeding matters. In addition, Australia's national infant and child dietary recommendations do not accurately reflect global WHA IYCF guidelines. There is also problematic variation, duplication and gaps between states on matters of breastfeeding promotion, support and education structures. Baby-friendly accreditation in Australia is run by the Australian College of Midwives. While many of the requirements of Indicator 2 are met or partially met, there are significant problems with stagnation in the number of accredited facilities in Australia, as well as a need for change to bring the accreditation in line with global standards.

The WHO Code for Marketing of Breastmilk Substitutes needs to be embedded in national breastfeeding guidelines. Current infant feeding recommendations do not reflect WHO Code principles. The MAIF agreement is not sufficiently robust to have an impact on infant formula and marketing in its own right. Currently MAIF operates as little more than a complaints department for consumers and breastfeeding advocates with limited commitment to bringing industry practice into line with the WHO Code or WHA recommendations.

Maternity Protection is well-considered by the Australian government, with paid maternity leave in place. Stronger commitment is needed to fully support the needs breastfeeding mothers, including flexible workplace arrangements and recognition of the unpaid work that breastfeeding mothers contribute to national budgets in terms of maternal and infant disease prevention and child well-being. Countrywide expansion of the Breastfeeding Friendly Workplace Accreditation scheme would significantly improve the working conditions of thousands of breastfeeding mothers and in turn, the well-being of our nation's young children.

With the exception of midwives, there is currently no compulsory requirement for Australian healthcare professionals who could be expected to provide care for breastfeeding mothers and infants in their daily work to have gained basic breastfeeding knowledge prior to registration. Medical specialisations such as paediatrics, obstetrics and neonatology that work intensively with breastfeeding dyads have minimal or no infant feeding competency requirements in their training curricula. Professional development opportunities for health care professionals are inconsistent and quality of content and delivery are not assured by IYCF principles. The presence of the infant formula industry in providing education to health care professionals is of particular concern. Specific pre-practice education requirements need to be formally adopted by the national health care professional regulation body.

The Australian Breastfeeding Association offers a network of peer counsellors across Australian communities and a nationwide breastfeeding helpline. Their contribution to the requirements of Indicator 6 is significant, but there is a requirement in the indicator for documented government support to ensure these services are universal and assured for all breastfeeding women and families in Australia.

There is a complete lack of will and commitment on behalf of the Australian health care system to provide a national and universalised education and information plan to educate the population about breastfeeding.

While the Australian healthcare system has an excellent record for the testing and treatment of HIV positive childbearing women and their children, there are gaps in the way that women are counselled about infant feeding choices, with a reliance on the blanket rule of HIV-positive women not being allowed to breastfeed. There is scope for more consideration of women's personal feeding choices. There is a nationwide failure to address strategic planning for breastfeeding in emergency situations. Planning bodies dedicated to the management of emergency situations are fragmented by state boundaries with significant variation in commitments and priorities. Strategic planning for breastfeeding in emergency situations is a priority, but remains unacknowledged by the relevant organisations.

Monitoring and evaluation systems that track breastfeeding behaviours at a national level are necessary for assessing breastfeeding as a health behaviour and for planning and evaluating existing breastfeeding services. Australia lacks a systematic approach to gathering, recording or evaluating breastfeeding data.

The WBTi assessment tool has revealed a number of Australia's strengths, particularly in the areas of maternity protection and the detection and monitoring of HIV for pregnant and breastfeeding women. It also clearly reveals a general lack of formal and national leadership in the way breastfeeding is monitored, supported and promoted. The WBTi assessment enables articulation of the areas where improvement is most needed, making an excellent starting point from which to go about setting priorities for change.

Summary Part II: Infant and young child feeding (IYCF) practices - 0/50

IYCF Practice	Result	Score
Indicator 11 Starting Breastfeeding (Initiation)	____x__ %	0
Indicator 12 Exclusive Breastfeeding for first 6 months	____x__ %	0
Indicator 13 Median duration of Breastfeeding	____x__ %	0
Indicator 14 Bottle-feeding	____x__ %	0
Indicator 15 Complementary Feeding	____x__ %	0
Score Part II (Total)		**0/50**

IBFAN Asia Guidelines for WBT*i*

Total score of infant and young child feeding Practice (indicators 11-15) are calculated out of 50.

Scores	Colour-rating
0 – 15	**Red**
16 - 30	**Yellow**
31 - 45	**Blue**
46 – 50	**Green**

Conclusions *(Summarize which infant and young child feeding practices are good and which need improvement and why, any further analysis needed)*[12] **:**

These Indicators could not be assessed because Australia has no national infant feeding data relating to these statistics available in the last five years. The last national infant feeding survey was completed in 2010 and so does not meet criteria for use.

There is a need for the Federal Department of Health in collaboration with national data-collecting agencies to undertake nationwide breastfeeding surveys on a three to five year rotation.
In this way, vital information about the infant feeding habits of Australian babies and children can inform service planning and delivery, promotional strategies and direct priorities.

[12] In this summary sheet analysis is done based on what are the SCORES and where your country or region stands in terms of Infant and young child feeding practices individually or combined. It is good to analyze this with team of stakeholders. Find out reasons and draw a list of recommendations for your health and nutrition managers and policy makers.

Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes - 25.5/150

Total score of infant and young child feeding **practices, policies and programmes (indicators 1-15)** are calculated out of 150. Countries are then rated as:

Scores	Colour- rating
0 – 45.5	**Red**
46 – 90.5	**Yellow**
91 – 135.5	**Blue**
136 – 150	**Green**

Key Gaps

- Although Australia is a signatory to the Convention on the Status of Women and Convention on the Rights of the Child, public policy approaches breastfeeding protection, promotion and support as a nutrition or health policy issue, not as enabling the realisation of the human rights of mother and child to breastfeed.

- National infant feeding guidelines do not recommend exclusive breastfeeding *to* six months of age, nor do they recommend to continue breastfeeding *to two years and beyond*.

- Food regulations continue to permit statements referring to six months as the minimum age for introducing commercial baby foods, thus confusing and undermining recommendations to introduce complementary foods from six months.

- Australia does not have a National Breastfeeding Committee/ IYCF Committee that includes non-government stakeholders across multiple sectors, including health, nutrition, breastmilk banks, food standards and labelling, workplaces, maternity protection, human rights, education and community engagement.

- Training requirements are currently inconsistent for health workers in BFHI and so thecommittee cannot confirm the programme is at least 20 hours for all applicable clinical workers.

- The government is not meeting it's responsibilities under the WHO Code for monitoring and enforcement of compliance regarding health and nutrition claims for foods for infants and young children (0-36months) as is required under the WHO Code and subsequent WHA resolutions.

- The amount of Paid Parental Leave being at the minimum wage is insufficient for many families to be able to afford the time away from employment to allow for six months exclusive breastfeeding. This is particularly a problem for low wage earner families.

- Although the value of the ABA's Breastfeeding Friendly Workplace Accreditation scheme is well recognised, including by employers, the Australian Government has not acted on the recommendation of the 2007 Parliamentary '*Best Start'* Inquiry on the Benefits of Breastfeeding to provide funding for expanding the scheme.

- Thirteen of the 14 professional colleges regulated by AHPRA do not have any requirement for breastfeeding input in pre-registration course content. The exception is Nursing and Midwifery which has a requirement for midwives (but not nurses).

- The experience, knowledge and skills of women in mother-to-mother support for breastfeeding are not adequately recognised, respected or resourced by governments and society or in the health system.

- There is a lack of funding and prioritisation to provide trained peer breastfeeding counselling support in a variety of formats, including supporting social media platforms, drop-in clinics and outreach services.

- Information provided about infant feeding by government sources currently do not include a commitment to IYCF principles.

- NHMRC infant feeding guidelines have not been updated for current evidence-based knowledge and international guidelines on infant feeding and HIV/AIDS.

- There is no national emergency management policy on IYCF-E and no national guidance on IYCF-E.

- Monitoring and evaluation components are inadequate with inconsistent definitions and indicators for data, input and collection systems.

- Monitoring of IYCF practices is not integrated, with consistent definitions and indicators, into a national nutritional surveillance system.

Key Recommendations

- National breastfeeding policy to adopt WHO recommendations for exclusive breastfeeding to six months and thereafter continued breastfeeding to two years or beyond, and for this to be widely communicated to health workers.

- Establish and fund a National IYCF Advisory Committee that appoints a National IYCF Coordinator. Ensure that stakeholder representation on the Committee excludes industry and includes non-government groups and stakeholders across multiple sectors, and operates with full transparency to the public.

- That the Federal Government task and fund the National IYCF Advisory Committee to establish an independent, WHO Code-compliant body to administer, maintain, monitor and expand BFHI with support from UNICEF Australia as required by Australia's obligations under the WHO Code *Article Health Care Systems* and *Article 7 Health workers*.

- The Australian Government should meet its obligations to enact legislation or other effective measures to implement the WHO Code and subsequent WHA resolutions in full with appropriate enforcement regarding the gaps above, including (but not limited to):
    - FSANZ regulation of marketing of food for infants and young children 0-36 months,
    - MAIF scope of products, retailing, compulsory membership of MAIF etc,
    - NHMRC Infant Feeding Guidelines,

- health facility policy and practice compliance with WHO Code in respect to the marketing, purchase and use of breastmilk substitutes.

- Strengthen employment protection and enforcement provisions in the Sex Discrimination Act and Fair Work Act and provide resources for agencies to act on behalf of breastfeeding mothers to enforce their entitlements.

- Increase the duration of publicly funded Paid Parental Leave to six months.

- All health professionals likely to come into contact with breastfeeding mothers or infants/young children in their clinical practice must receive and be assessed as competent on basic breastfeeding content in their pre-registration training. The Australian healthcare professional regulation body needs to provide leadership in this area. Specialist professions need to gain expertise in the provision of breastfeeding support in line with their level of practice.

- Develop an Infant and Young Child Feeding policy and/or a National Breastfeeding Policy that includes trained peer breastfeeding counselling support of breastfeeding families with targets and measurable outcomes, an implementation plan and adequate funding.

- Integrate national health service delivery to include both professional and volunteer breastfeeding support, that meets local needs, and provide clear access to specialised support when required.

- The Federal Health Department must ensure that all information provided to parents relating to IYCF includes information on the risks of artificial feeding and complies with the government's commitment to CRC.

- Update NHMRC *Infant Feeding Guidelines* to reflect the most recent WHO guidance on improved technologies and evidence-based approaches to preventing mother to child transmission of HIV/AIDS.

- Policies and practices should ensure consideration should also be given to addressing gender-based barriers (such as care burdens, lack of financial resources and intimate partner violence) to testing during pregnancy, treatment adherence and health care access.

- Federal Department of Health to convene and appropriately fund a national advisory committee on IYCF-E (could be within the recommended National IYCF Advisory Committee) with the purpose of incorporating the needs of mothers, infants and young children into emergency management planning at all levels of government, and to ensure that appropriate agencies take responsibility for IYCF-E. This committee must include a broad range of stakeholders from all levels of government, health organisations and emergency management organisations.

- Existing Australian education and training on IYCF-E (e.g. ABA and NCCTC) to be made available to all relevant health and emergency workers.

- That the Federal Government establish the WHO Global Data Bank definitions and indicators for breastfeeding to be monitored at both national and local levels.

- The National IYCF Advisory Committee (recommended above), to be tasked with working with the Department of Health and the Australian Institute of Health and Welfare to establish a sustainable and standardised national data collection system and include appropriate breastfeeding definitions in the national health survey.

Appendix

Examples of inconsistencies in breastfeeding objectives in state and territory infant feeding policies and guidelines

New South Wales

New South Wales (NSW) Department of Health breastfeeding policy aims to '*increase the proportion of infants 'exclusively' breastfed to six months*', which is a clearer objective than that in the *Australian National Breastfeeding Strategy 2010-2015* (and consistent with WHO recommendations). However, with respect to continued breastfeeding, NSW policy contains no recommended period, other than a vague objective '*To increase the duration of breastfeeding*.' (page 1, Department of Health Policy Directive *Breastfeeding in NSW: Promotion, Protection and Support* PD2011_042 dated 21 June 2011 http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_042.pdf).
However other NSW policy documents follow the *Australian Dietary Guidelines* (*NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018* (NSW Ministry of Health 2013 http://www.health.nsw.gov.au/heal/Publications/nsw-healthy-eating-strategy.pdf).

Victoria

In contrast, the Victorian Department of Health and Human Services '*Nutrition and healthy eating - policies, strategies and guidelines*' webpage refers to the NHMRC *Infant Feeding Guidelines* and the *Australian National Breastfeeding Strategy 2010-2015*. https://www2.health.vic.gov.au/public-health/preventive-health/nutrition/nutrition-and-healthy-eating-policies-strategies-and-guidelines

However, a combination of recommendations from WHO and NHMRC *Infant Feeding Guidelines* are used in Victorian guidelines for health professionals which states in the introduction that '*Australian and international guidelines recommend that infants be exclusively breastfed until around six months of age, and that mothers continue breastfeeding with the addition of appropriate complementary foods for up to two years or beyond*'. However, for breastfeeding exclusivity these guidelines make explicit the differences in these recommendations (page 17) (*Promoting Breastfeeding. Victorian Breastfeeding Guidelines*. State of Victoria. Department of Education and Early Childhood Development 2014)
http://www.education.vic.gov.au/Documents/childhood/professionals/health/brestfeedguidelines14.pdf

South Australia

The South Australian (SA) government provides parents with a mix of recommendations on breastfeeding duration. WHO recommendations are provided in *Breastfeeding Your Baby*. SA Health. 2016. Child and Family Health Service, Department for Health and Ageing, Government of South Australia. http://www.cyh.com/library/breastfeeding_your_baby_A5_2016.pdf
Similarly, the Women's and Children's Health Network (WCHN) as the state's '*leading provider of health services for children, young people and women' advises parents that breastmilk…contains all the food and drink your baby needs for the first six months of life. Together with other foods, it is very good for the next six months and into the second year as well.*'
However, the NHMRC *Infant Feeding Guidelines* which state to breastfeed exclusively to '*around 6 months*' are referred to in a SA government website *Healthy eating for babies and young children* (SA Health. Undated).
http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/healthy+living/h

ealthy+eating/healthy+eating+at+different+ages+and+stages+of+your+life/healthy+eating+for+babies+and+young+children) and a Fact Sheet produced by the SA Food Safety and Nutrition Branch of SA Health (*Feeding babies and food safety* Public I1-A1 SA Food Safety and Nutrition Branch, SA Health 2015).
http://www.sahealth.sa.gov.au/wps/wcm/connect/5514158047d940a7ac79adfc651ee2b2/Feeding+babies+and+food+safety+Fact+Sheet.pdf?MOD=AJPERES&CACHEID=5514158047d940a7ac79adfc651ee2b2&CACHE=NONE