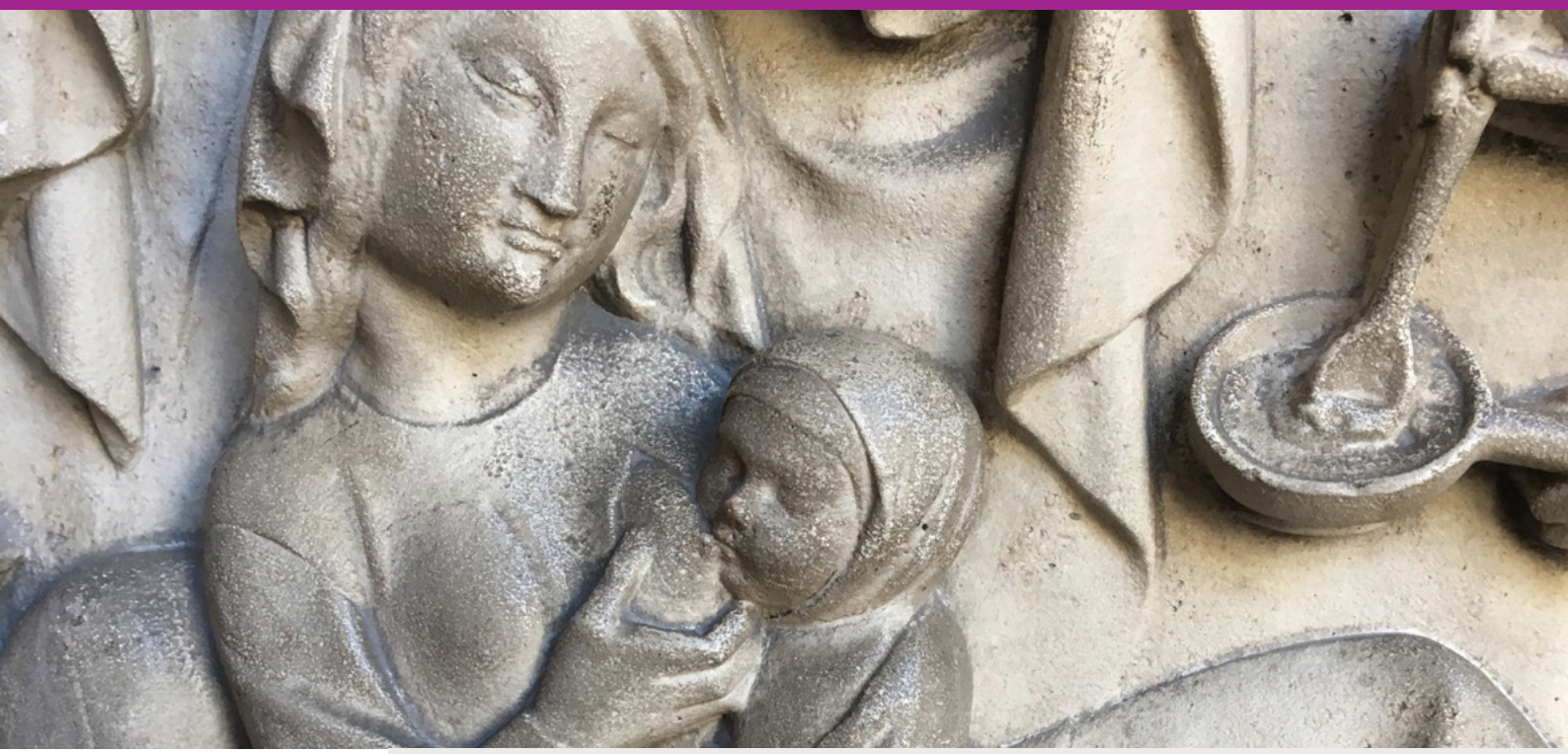
World Breastfeeding Trends Initiative (WBT*i*)

Assessment Report Australia 2023



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at the forefront
of social change

World Breastfeeding Trends Initiative (WBT*i*)
AUSTRALIA

Assessment Tool
Version 3
(September 2019)

WBT*i* Global Secretariat

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WBTi
World Breastfeeding Trends Initiative (WBT*i*)
AUSTRALIA

WBTi Assessment Tool

2019 Version 1: 2004/05

Version 2: 2014

Version 3: 2019

Design & Layout: Amit Dahiya

Revision and Update of the WBT*i* Assessment Tool 2019

This revision in 2019 is based on the new information available after the last revision in 2013.

The present updating was undertaken after receiving feedback from countries to seek clarity and to update information on some of the indicators. The WBT*i* global secretariat constituted a Technical Working Group (TWG) of experts (see below) from several countries. The TWG included experts on breastfeeding and infant and young child feeding issues and those involved in the development and implementation of this tool. The TWG was to relook and suggest any changes in contents based on availability of new information and feedback.

The global secretariat sought individuals' concurrence and choice of the indicator to work on. Eleven sub-groups were constituted: one for each indicator of policy and programmes, and one group for the indicators on the IYCF practices.

The WBT*i* Secretariat shared the feedback on earlier tools and new information with each group and followed up for clarifications with the groups and individuals. Finally, the WBT*i* Secretariat shared the revised draft tool with the TWG to review and provide feedback. This led to its finalization and the version- 3 (2019) of the tool is now available.

All this process took 4 months. The tool now has updated background information of each indicator and at places change in some questions, as well as the process for scoring make the assessment more objective yet simple to carry out.

Technical Working Group

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Contents

Acronyms

ABA	Australian Breastfeeding Association
ANBS	Australian National Breastfeeding Strategy
BFHI	Baby Friendly Hospital/ Health Initiative
BPNI	Breastfeeding Promotion Network of India
DHS	Demographic and Health Survey
FAO	Food and Agriculture Organization
GLOPAR	Global Participatory Action Research
GSIYCF	Global Strategy for Infant and Young Child Feeding
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
IFE	Infant and Young Child Feeding in Emergencies
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
LLLI	La Leche League International
MAIF	Marketing Infant Formula in Australia
MICS	Multiple Indicator Cluster Survey
MPC	Maternity Protection Convention
MSG	Mother Support Groups
NCD	Non-Communicable Disease
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council (an Australian Statutory body)
PIF	Powdered Infant Formula
WABA	World Alliance for Breastfeeding Action
WBC*i*	World Breastfeeding Costing Initiative
WBT*i*	World Breastfeeding Trends Initiative
WBT*i*AUS	World Breastfeeding Trends Initiative Australia
WHO	World Health Organization
WHA	World Health Assembly
UN	United Nations
UNICEF	United Nations Children's Fund

The World Breastfeeding Trends Initiative (WBT*i*)

About WBT*i*

The Breastfeeding Promotion Network of India (BPNI)/International Baby Food Action Network (IBFAN) South Asia and the World Breastfeeding Trends Initiative (WBT*i*) Global Secretariat launched the innovative tool in 2004 at a South Asia Partners Forum.

The WBT*i* assists countries to assess the status and benchmark the progress in implementation of the *Global Strategy for Infant and Young Child Feeding* in a standard way. It is based on the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBT*i* programme calls on countries to conduct their assessment to measure strengths and weaknesses on the ten parameters of policy and programmes that protect, promote, and support optimal infant and young child feeding (IYCF) practices. It maintains a Global Data Repository of these policies and programmes in the form of scores, color codes, report, and report card for each country. The WBT*i* assessment process brings people together and encourages collaboration, networking, and local action. Organisations such as government departments, UN, health professionals, academics, and other civil society partners (without Conflicts of Interest) participate in the assessment process by forming a core group with an objective to build consensus. All assessment countries identify gaps and provide recommendations to their policy makers for affirmative action and change. The WBT*i* Global Secretariat encourages countries to conduct a re- assessment every 3-5 years for tracking trends in IYCF policies and programme.

Vision & Mission

The WBT*i* envisages that all countries create an enabling environment for women to be successful in breastfeeding their babies optimally at home, health facilities or at workplaces. The WBT*i* aspires to be a trusted leader to motivate policy makers and programme managers in countries, to use the global data repository of information on breastfeeding and IYCF policies and programmes. WBT*i* envisions serving as a knowledge platform for programme managers, researchers, policy makers and breastfeeding

advocates across the globe. WBT*i*'s mission is to reach all countries to facilitate assessment and tracking of IYCF policies and programmes through mobilising local partnerships without conflicts of interest and building a data repository for advocacy.

Ethical Policy

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

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)**
• National Policy, Governance and Funding • Baby Friendly Hospital Initiative / Ten Steps to Successful Breastfeeding • Implementation of the International Code of Marketing of Breastmilk Substitutes • Maternity Protection • Health and Nutrition Care Systems (in support of breastfeeding & IYCF) • Counselling services for pregnant and breastfeeding mothers • Accurate and Unbiased Information Support • Infant Feeding and HIV • Infant and Young Child Feeding during Emergencies • Monitoring and Evaluation	• Timely Initiation of Breastfeeding within one hour of birth • Exclusive Breastfeeding for the first six months • Median duration of Breastfeeding • Bottle-Feeding • Complementary Feeding-Introduction of solid, semi-solid or soft foods

Each indicator used for assessment has the following components.

1. The key question that needs to be investigated.
2. Background on why the practice, policy or programme component is important.
3. A list of key criteria for assessment as a subset of questions to be considered in identifying strengths and weaknesses to document gaps.
4. Annexes for related information

Part I: Policies and Programmes: The criteria of assessment have been developed for each of the ten indicators, based on the *Global Strategy for Infant and Young Child Feeding* (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005) as well as updated with most recent developments in this field. For each indicator, there is a subset of questions. Answers to these can lead to the identification of the gaps in policies and programmes required to implement the *Global Strategy.*

Assessment can reveal how a country is performing in a particular area of action on Breastfeeding / Infant and Young Child Feeding. Additional information is also sought in these indicators, which is mostly qualitative. Such information is used in the elaborate report, however, is not considered for scoring or colour coding.

Part II: Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random national household surveys. These five indicators are based on the WHO's tool for keeping it uniform. However, additional information on some other practice indicators such as 'continued breastfeeding' and 'adequacy of complementary feeding' is also sought.

Scoring and Colour-Coding

Policy and Programmes Indicator 1-10

Once the information on the 'WBT*i* Questionnaire 'is gathered and analysed, it is then entered into the web-tool. The tool provides *scoring* of each individual subset of questions as per their weight age in the indicators 1-10 (policies and programmes). Each indicator has a maximum score of 10. Total score of ten indicators has a maximum score of 100.

The web tool also assigns *Colour- Coding* (Red/Yellow/Blue/Green) of each indicator as per *the WBTi Guidelines for Colour- Coding* based on the scores achieved.

In part II (IYCF practices)

Indicators of part II are expressed as percentages or absolute numbers. Once the data is entered, the tool assigns *Colour coding* as per the *Guidelines.*

The WBT*i* Tool provides details of each indicator in sub-set of questions, and weight age of each.

Global acceptance of the WBTi

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

WBT*i* has been published as BMJ published news in the year 2011, when 33 country WBT*i* report was launched[1]. Two peer reviewed publications in the international journals add value to the impact of WBT*i*, in Health Policy and Planning in 2012 when 40 countries had completed[2], and in the Journal of Public Health Policy in 2019[3] when 84 countries completed it.

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

1. BMJ 2011;342: d18doi: **https://doi.org/10.1136/bmj.d18** (Published 04 January 2011)
2. **https://academic.oup.com/heapol/article/28/3/279/553219**
3. **https://link.springer.com/article/10.1057/s41271-018-0153-9**
4. **https://www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/**
5. **https://www.ennonline.net/attachments/3028/Ops-Guidance-on-IFE_v3-2018_English.pdf**

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

6. https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2017.pdf?ua=1
7. https://extranet.who.int/nutrition/gina/
8. https://academic.oup.com/advances/article/4/2/213/4591629

The WBTi Guidelines for Colour-Coding (Part I and II)

Table 1: WBT*i* Guidelines for Colour-Coding for Individual indicators1-10

Table 2: WBT*i* Guidelines for Colour-Coding 1-10 indicators (policy and programmes)

Table 3: WBT*i* Guidelines for Colour-Coding Individual indicators 11-15 (Practices)

WBTi Guidelines for Indicator 11 (Initiation of breastfeeding {within 1 hour})

Percentage (WHO's key)	Colour-coding
0.1-29%	Red
29.1-49%	Yellow
49.1%-89%	Blue
89.1-100%	Green

WBTi Guidelines for Indicator 13 (Median Duration of Breastfeeding)

Months (WHO's key)	Colour-coding
0.1-18 months	Red
18.1-20 months	Yellow
20.1-22 months	Blue
22.1-24 months	Green

WBTi Guidelines for Indicator 15 (Complementary Feeding {6-8 months})

Percentage (WHO's key)	Colour-coding
0.1-59%	Red
59.1-79%	Yellow
79.1%-94%	Blue
94.1-100%	Green

WBTi Guidelines for Indicator 12 (Exclusive Breastfeeding {for first 6 months})

Percentage (WHO's key)	Colour-coding
0.1-11%	**Red**
11.1-49%	**Yellow**
49.1%-89%	**Blue**
89.1-100%	**Green**

WBTi Guidelines for Indicator 14 (Bottle-feeding {0-12 months})

Percentage (WHO's key)	Colour-coding
29.1-100%	**Red**
4.1-29%	**Yellow**
2.1%-4%	**Blue**
0.1-2%	**Green**

Assessment process followed by the country

September 2021	WBT*i*AUS Core group commence new assessment process
September 2021 to February 2022	Data collection
March 2022	Indicator report cards completed and collated
May 2022	Reference group consultation process
June-July 2022	Development of text for each indicator
July 2022	Draft report to reference group
August - October 2022	Final revisions by Core Group
November 2022	Final edit of document and Graphic Design
December 2022	Submission to IBFAN
February 2023	Feedback from IBFAN
March 2023	Feedback incorporated and sent to IBFAN
May 2023	IBFAN acceptance received

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Lactation Consultants of Australia and New Zealand

Reference Group

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WBTiAUS

In September 2017, a group of advocates, academics, clinicians, and NGO representatives came together for a *Gender Responsive Budgeting* and Breastfeeding workshop.

Gender Responsive Budgeting is a tool to analyse government budgets to assess the direct and indirect impacts on paid and unpaid spheres of the economy and the differential impacts of revenue and spending policies on men and women arising from their different situations in the economy and society. It also involves strategies for changing fiscal decision-making and priorities, by showing how different actors can influence the budget cycle to bring about changes that promote women's empowerment and gender equality.[1, 2, 3.]

The *Gender Responsive Budgeting* and Breastfeeding workshop was 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 Asia-Pacific Innovation Program (APIP) grant and the ANU Gender Institute. Dr Shoba Suri, from IBFAN, presented the background information for the WBT*i* and how it could be used in Australia, along with Alessandro Iellamo who explained the importance of the World Breastfeeding Costing initiative (WBC*i*), and from there the WBT*i*AUS Core group was formed.

The inaugural WBT*i* Assessment for Australia was published in May 2018. The group was joined by other individuals and non-government organisations as the Reference group making it a truly collaborative process. This WBT*i* Australia report is the first to explicitly incorporate gender responsive budgeting approaches. The report provided to the Australian Government a benchmark to measure future progress and was included in the 2019 Australian National Breastfeeding Strategy.

1. Budlender, Debbie, Diane Elson, Guy Hewitt, and Tanni Mukhopadhyay. *Gender-Budgets-Make-More-Cents-Country-Studies-and-Good-Practice.Pdf>*. Commonwealth Secretariat (London: 2002).
2. Sharp, Rhonda, and Ray Broomhill. *A Case Study of Gender Responsive Budgeting in Australia*. Commonwealth Secretariat (2013). **https://www.unisa.edu.au/siteassets/episerver-6-files/global/eass/hri/grb_papers_australia_comm-sec-updf_final-copy-.pdf**.
3. Stephenson, Mary-Ann. *A Guide to Gender-Responsive Budgeting.* Oxfam Women's Budget Group (2018). **https://policy-practice.oxfam.org/resources/rough-guide-to-gender-responsive-budgeting-620429/#:~:text=A%20gender%2Dresponsive%20budget%20is,justice%20and%20for%20fiscal%20justice**.

During 2020-21 in preparation for the WBT*i*AUS 2023 assessment, the ANU again partnered with WBT*i*AUS in an online program of webinars and workshops where the Australian National Breastfeeding Strategy 2019 and Beyond was assessed in detail using Gender Responsive Budgeting. The resources from this program are **available online** through the ANU Gender Institute webpage, and informed this second assessment.

Background

Australia's Government consists of a federation of six states and two 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. Within each State, local governments and agencies are also involved.

The assessment tool could be used to assess data from each state, territory, and local government. However, since the Federal Government (referred to as the Australian Government from here) 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 WBT*i* 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 responsive 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 2021, Australia had a national population of 25.4 million people[1]. First Nations people represented 3.2% of the national population, but they comprised 26.3% of the Northern Territory (NT) population.[1] In 2016, there were 311,104 births with an overall infant mortality rate of 3.1 infant deaths per 1,000 live births[2]. However, mortality rates were doubled for First Nations infants and young children under five years.[2, 3] This places a unique requirement for focused programs for First Nations peoples in the NT, compared to the country, and emphasises the vulnerability of subpopulations in a high-income country like Australia. The 2016 Lancet Breastfeeding Series confirmed that breastfeeding is a critical issue for mortality and morbidity for all population groups in all countries.[4] 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.[4]

The 2016 Lancet Breastfeeding Series also documented the extremely 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)[5], the Australian National Breastfeeding Strategy: 2010 – 2015[6], the current Australian National Breastfeeding Strategy; 2019 and Beyond[26] and the following international strategies and human rights statements.

As a member state of the World Health Organization (WHO)[7] and a founding member of the United Nations (UN)[8], 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 Code)[9]
- Convention on the Elimination of All Forms of Discrimination Against Women (1981)[10]
- Conventions on the Rights of the Child (1989)[11]
- endorsement of the Innocenti Declaration in 1990[12]
- establishment of the Baby Friendly Health Initiative (BFHI) in 1991[13]
- development of the Global Strategy on Infant and Young Child Feeding (GSIYCF) in 2003,[14] and
- the subsequent World Health Assembly (WHA) resolutions to update the Code as recently as 2020[15]

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)[16] 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.*'[16]

'*Women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding... They also have the right to excellent 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*'.[16]

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 was unusable in the 2018 assessment and is still unusable in this 2023 WBT*i* 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.[17]

To address this stagnation in breastfeeding policy and outcomes, the Australian WBT*i* assessment uses an innovative approach to link the assessment to both economic and gender equity principles. If the above statistics are considered 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, which 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.[18]

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,[19] 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.[20] This represented 58.7% of GDP for 2006 and would be a much higher amount if repeated 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, eczema and necrotising enterocolitis if exclusive breastfeeding rates at three months were to increase to 80%.[21] Furthermore, Australian studies show that around 24% of major chronic diseases are attributable to premature cessation of breastfeeding[22] and that 235 women per year are diagnosed with breast cancer and other reproductive cancers.[23]

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.[24]

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.[25] IBFAN's World Breastfeeding Costing Initiative (WBC*i*) 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 International Code of Marketing of Breast-milk Substitutes, 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.

By highlighting this gender inequity, the Australian Government can use the report to determine adequate funding for implementation of the Australian National Breastfeeding Strategy: 2019 and Beyond[26], and other associated health and economic policies. This will achieve more equitable sharing of the costs of breastfeeding between women, men, society, and governments.

Australian policy developments since the 2018 WBTi Australia Assessment

After the previous breastfeeding strategy ended in 2015, the Australian Government reviewed and released a breastfeeding strategy in 2019, the *Australian National Breastfeeding Strategy: 2019 and Beyond* (ANBS).

The WBT*i*AUS team were pleased to see the acknowledgement of the 2018 WBT*i* Australia Assessment by the Federal Government Department of Health and inclusion of the 2018 WBT*i* Australia report card[27] in the ANBS. Australia scored 25.5/100 and ranked 3rd last in the world at the time of release. It is interesting to note that the report card was included in the ANBS, with no discussion about its meaning and the implication that Australia was doing very poorly by this measure.

The ANBS[26] acknowledged that much needed to be done to protect, promote and support breastfeeding in Australia, identifying many areas where action is needed:

PRIORITY 1—STRUCTURAL ENABLERS

1.1 Action area—Community education and awareness

1.2 Action area—Prevent inappropriate marketing of breastmilk substitutes

1.3 Action area—Policy coordination, monitoring, research, and evaluation

1.4 Action area—Dietary guidelines and growth charts

PRIORITY 2—SETTINGS THAT ENABLE BREASTFEEDING

2.1 Action area—Baby Friendly Health Initiative

2.2 Action area—Health professionals' education and training

2.3 Action area—Breastfeeding-friendly environments

2.4 Action area—Milk banks

PRIORITY 3—INDIVIDUAL ENABLERS

3.1 Action area—Universal breastfeeding education, support, and information services

3.2 Action area—Breastfeeding support for priority groups

The ANBS is cited and/or its Priority Actions are included in several other Australian health strategies, including the National Obesity Strategy 2022-2032[28], the National Women's Health Strategy 2020-2030[29] and the National Action Plan for the Health of Children and Young People 2020-2030[30]. Breastfeeding targets are included in other policies. The National Preventive Health Strategy 2021–2030 [31] states that: 'At least 50% of babies are exclusively breastfed until around 6 months of age by 2025.'

The ANBS contains Action Areas with goals and indicators, and timelines, including public reporting. These were disrupted by the COVID-19 pandemic and border closures declared in Australia in March 2020 and lifted in early 2022. However, there is no evidence that the ANBS was actioned between June 2019 and August 2022:

1. The WBT*i*AUS committee found no evidence that the reporting requirements described in Table 9 of the ANBS (p.66) have been actioned. We found no published annual reports.
2. Similarly, we found no evidence that the baseline evaluation due in July 2019 to June 2020 (Table 8 of the ANBS, p.66) was funded or commenced prior to initiation of the COVID-19 pandemic response in the second quarter of 2020.
3. ANBS Appendix B p.70 National Breastfeeding Report Card contains measures but does not define annual targets.

At the time of its release in 2019, the ANBS was welcomed by Australian breastfeeding advocates, but inaction by the Federal Government has meant that Australia has again scored poorly on the 2023 WBT*i* Australia Assessment.

1. Australian Bureau of Statistics (ABS) (2022). Population: census 2021. **https://www.abs.gov.au/statistics/people/population/population-census/latest-release**
2. Australian Bureau of Statistics (ABS) (2017). Snapshot of Australia: 2016 Census Data Summary. **https://goo.gl/fz2zcH**.
3. Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework Report. **https://www.indigenoushpf.gov.au/publications/hpf-2017**
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Part I: IYCF Policies and Programmes

In Part I, each question has a possible score of 0-3 and each indicator has a maximum score of 10. Once information about the indicators is entered, the achievement on the target indicator is then rated i.e., Red, Yellow, Blue and Green based on the guidelines.

Indicator 1: National Policy, Governance and Funding

Background

The "Innocenti Declaration" adopted in 1990, recommended all governments have national breastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country along with the Code, BFHI and maternity protection policies. The *Global Strategy for Infant and Young Child Feeding* (2002) incorporated all these actions and calls for urgent action by all Member States to develop, implement, monitor, and evaluate a comprehensive policy and plan of action on breastfeeding / infant and young child feeding to achieve reduction in child malnutrition and mortality. In 2005, the Innocenti Declaration on Infant and Young Child Feeding provided five additional targets. In 2005, the World Health Assembly adopted a resolution 58.32 that calls upon member states to assure resources for plan of action to improve optimal practices. In 2007 WHO launched a 'Planning Guide for implementation of Global Strategy' that helps to develop a concrete national strategy, policy, and action plans. The Global Breastfeeding Collective led by UNICEF and WHO (2017), recommended seven policy actions to increase breastfeeding rates with emphasis on funding. The World Bank **'An Investment Framework for Nutrition (2017)'** estimated financing required to scale up a core set of interventions across low- and middle-income countries to achieve the World Health Assembly target for exclusive breastfeeding by 2025 is $5.7 billion, or approximately $4.70 for every newborn.

What has happened since the 2018 WBTi Australia report?

Global developments in breastfeeding policy

1. In 2021, the G20 Health Ministers renewed calls for governments to 'create an enabling environment that allows women to be informed of their options and supported throughout the entire breastfeeding experience' (G20, 2021).
2. WHO published reports and updated guidance to strengthen the WHO International Code of Marketing of Breastmilk Substitutes in health systems, trade forums and digital marketing:

3. 2020 Guidance for health workers, which needs to be incorporated into national dietary guidelines (WHO, 2020a).
4. 2020 Guidance on international trade agreements, which encourages governments to enact legislation of the Code, noting that 'there has never been a formal legal dispute concerning domestic implementation of the Code under an international trade agreement' (WHO, 2020b).
5. In 2022 the 75th World Health Assembly recognized that 'digital marketing presents new challenges for monitoring and enforcement of national legislation.' Recommendations to ensure that the Code 'adequately address digital marketing practices' are planned for May 2024 (WHA, 2021).

Australian Policy developments

1. After the previous breastfeeding strategy ended in 2015, the Australian Government reviewed and released a revised strategy in 2019, the *Australian National Breastfeeding Strategy: 2019 and Beyond* (ANBS). The ANBS was based on a study of the most recent research evidence on what worked to increase breastfeeding rates, and on a process which included well documented public consultations. Its three key priority areas addressed structural, setting and individual enablers, and it proposed 11 action areas:
    - Community education and awareness
    - Prevent inappropriate marketing of breastmilk
    - Policy coordination, monitoring, research and evaluation
    - Dietary guidelines and growth
    - Baby Friendly Health Initiative
    - Health professionals' education and training
    - Breastfeeding-friendly environments
    - Milk banks
    - Individual enablers
    - Universal breastfeeding education, support and information services
    - Breastfeeding support for priority groups
2. The ANBS is cited and/or its Priority Actions are included in other policies, for example the *National Obesity Strategy*, *the National Women's Health Strategy 2020-2030* and the *National Action Plan for the Health of Children and Young People 2020 – 2030* (Australian Government Department of Health 2018, 2019). Breastfeeding targets are included in other policies. For example, the *National Preventive Health Strategy 2021–2030* (Department of Health, 2021) stated that '*At least 50% of babies are exclusively breastfed until around 6 months of age by 2025*.' This target is to be achieved through the ANBS and aligns with international commitments in the WHO Global Nutrition Targets 2025 (Target 5 – Breastfeeding) and United Nations Sustainable Development Goals (SDG) Target 2.2. (United Nations, undated). It does not yet align with the more recent target for 70% of babies to be exclusively breastfed to around 6 months of age by 2030, noted in the 2019 *Global Scorecard on Breastfeeding* (WHO UNICEF 2019).
3. In 2021 the National Health and Medical Research Council commenced a review of the *Australian Dietary Guidelines (2013)* and *Infant Feeding Guidelines: Information for Health Workers 2013*. Other important reviews such as on MAIF (Australian Government Department of Health and Aged Care 2022) and on infant formula standards (FSANZ 2022) are underway. However, the details such as terms of reference are not publicly available, and there is no public registry of corporate lobbying activities or meetings of senior public officials with lobbyists to indicate the extent of industry influence in these reviews.

4. As breastfeeding women are the main stakeholders in this policy area, the lack of transparency and participative decision-making in these policy formulation and decision-making processes is concerning and contrary to expectations about gender-responsive policies and budgeting.

Criteria for Assessment –Policy and Funding	**Check all that apply**	
1.1) A national breastfeeding/infant and young child feeding policy/ guideline (stand alone or integrated) has been officially approved by the government	✔ Yes = 1	No=0
1.2) The policy recommends initiation of breastfeeding within one hour of birth and exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	Yes = 1	✔ No=0
1.3) A national plan of action is approved with goals, objectives, indicators and timelines	Yes = 2	✔ No = 0
1.4) The country (Government and others) is spending on breastfeeding and IYCF interventions[9] no funding < $1 per birth $1-2 per birth $2-5 per birth =or >$5 per birth	√ Check one which is applicable 0 ✔ 0.5 1 1.5 2.0	
Governance		
1.5) There is a National Breastfeeding/IYCF Committee	Yes = 1	✔ No = 0
1.6) The committee meets, monitors, and reviews the plans and progress made on a regular basis	Yes = 2	✔ No = 0
1.7) The committee links effectively with all other sectors like finance, health, nutrition, information, labor, disaster management, agriculture, social services etc.	Yes = 0.5	✔ No = 0
1.8) The committee is headed by a coordinator with clear terms of reference, regularly coordinating action at national and sub-national level and communicating the policy and plans.	Yes = 0.5	✔ No = 0
Total Score	**1.5/10**	

9. Enabling Women to Breastfeed Through Better Policies and Programs – Global Breastfeeding Scorecard, 2018 https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2018-methology.pdf?ua=1

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Conclusions

The ANBS policy appropriately addresses key structural barriers which prevent women and children from being able to breastfeed as recommended. This acknowledges that breastfeeding requires a supportive environment and is not the sole responsibility of individual women. Nonetheless, the ANBS has some important weaknesses, being less comprehensive than the *WHO Global Strategy on Infant and Young Child Feeding,* and its breastfeeding recommendations not aligning with evidence based WHO recommendations. The ANBS does not recommend that infants are breastfed for at least two years, The ANBS Objectives include: *'Increase the proportion of babies who: are exclusively breastfed to around 6 months of age (up to 40 per cent by 2022 and up to 50 per cent by 2025), particularly those from priority populations and vulnerable groups continue breastfeeding with appropriate complementary foods until 12 months of age and beyond for as long as the mother and child desire.*' (COAG Health Council, 2019 p.11). The ANBS excludes paid maternity leave actions; these are key policy areas for enabling women to breastfeed more exclusively and for longer duration. While the ANBS objective on ending marketing of infant formula and breastmilk substitutes is appropriate, the recommended action in this area of WHO Code implementation is weak and narrow, and the proposed process lacks transparency and is open to industry influence. The ANBS urgently needs an implementation and monitoring and evaluation plan with updated timelines and adequate funding. Furthermore, while an internal National Breastfeeding Advisory Committee (NBAC) has been appointed by the Department of Health, these arrangements have not been announced publicly and it remains inactive. The formation of a revised committee with a broader membership provides an opportunity to build on the current arrangement (which enables interjurisdictional health policy coordination), to better address the intent of this WBT*i* indicator. This could ensure that the ANBS is coordinated and monitored by key stakeholders in breastfeeding, drawing on the skills, experience and knowledge of breastfeeding women and their NGOs, as well as other health and cross sectoral expertise, and with full transparency, accountability, and independence from commercial influence.

Gaps

1.1 While Australia has introduced a publicly funded scheme for paid maternity leave in 2011, and national employment standards provide for 12 months of unpaid leave, these arrangements do

not meet ILO standards for payment of at least 14 weeks maternity leave at two thirds of previous earnings. It has been amended so that it is no longer paid maternity leave but is for the primary carer.

1.2 The ANBS targets are not consistent with the infant and young child feeding practices recommended in the WHO Global Strategy for Infant and Young Child Feeding (2003) regarding the duration of exclusive and continued breastfeeding.

In addition, the recommendations for exclusive breastfeeding for 6 months are undermined by Australian law on labelling that allows commercial complementary foods to be promoted as suitable from 4 months (Australian New Zealand Food Standards Code 2.9.2 Food for Infants). This maintains an infant feeding culture in which women's confidence in exclusive breastfeeding is undermined, and the premature introduction of commercial baby foods is inappropriately encouraged.

1.3 The ANBS contains Action Areas with goals and indicators, and timelines, including public reporting. These were disrupted by the COVID 19 pandemic and border closures declared in Australia in March 2020 and lifted in early 2022. However, there is no evidence that the ANBS was actioned between June 2019 and August 2022, although we understand that progress was made in the preparation of terms of reference for the review of the MAIF Agreement, and the commencement of the NHMRC Dietary Guidelines review as part of a wider process:

- The WBT*i*AUS committee found no evidence that the reporting requirements described in Table 9 of the ANBS (p.66) have been actioned. We found no published annual reports.
- Similarly, we found no evidence that the baseline evaluation due in July 2019-June 2020 (Table 8 of the ANBS, p.66) was funded or commenced prior to initiation of the COVID 19 pandemic response in the second quarter of 2020.
- ANBS Appendix B p. 70 National Breastfeeding Report Card contains measures but does not define annual targets.

1.4 The ANBS does not fully meet the definition of a policy because it fails to include specific additional allocation of adequate resources. It is also not fully transparent about policy and funding decision-making processes.

At the time the ANBS was released in 2019, the Minister for Health announced $10 million of funding. However, most of this funding was not allocated in accordance with the ANBS Action Plan, and there is no indication that it was additional funding for the ANBS implementation. Instead, of the $10 million, $2m was allocated for a one-off grant to the Australian Red Cross Blood Service for creating a 'centralised donor milk bank service' and $8.29m was allocated over four years to the Australian Breastfeeding Association (ABA) (Department of Health. 2019). This latter allocation did not reference the ANBS and maintained previous funding for ABA volunteers to continue providing breastfeeding counselling support to mothers 24 hours a day 7 days a week, as a free call to its **National Breastfeeding Helpline**. The ABA funding which is approximately $2m annually maintained existing funding for telephone and internet services which are free to callers, training, and development of 400+ volunteer counsellors and community educators, and in-service training for health care professionals (Australian Government Department of Health. 2021).

Australia has a federal system of government and federal-state financing arrangements may be a barrier to transparency and gender equitable funding of maternity care services such as BFHI (Stewart, Smith, Guzman 2019). While **State health ministers made a statement in 2012** encouraging hospitals to adopt BFHI, no funding was allocated to this, despite new national **healthcare funding agreements** being negotiated between the federal and state governments since that time. Recent research shows a cost of around $25000 per hospital. (Pramono, 2021)

Other government funding for breastfeeding projects is announced by national and State/Territory governments on an ad hoc basis, but it is not clear how or if these are part of the ANBS implementation plan. For example, in 2019 the NSW Government granted $12.2m to Tresillian, a parenting service provider, for new centers for *'babies with feeding and sleeping issues, as well as for parents with post-natal depression*' (Raper, 2021).

1.5 The arrangements for the implementation of the ANBS are weak and lack transparency and accountability. The ANBS *'national breastfeeding advisory committee*' (NBAC) has an advisory role but does not meet the WBTi criteria of a National Breastfeeding Committee which is intended to lead and coordinate cross-sectoral implementation of breastfeeding policies and programmes.

The ANBS states that the Department of Health is to establish a *'national breastfeeding advisory committee*' to *'provide advice to the Department of Health on implementation, monitoring, surveillance, research and evaluation activities*.'

The proposed membership of the NBAC does not exclude industry but states that it is to *'include representatives from other Australian Government agencies; states and territories; health professional associations; women's and children's hospitals; maternal, child and family health services; breastfeeding support services; women's organisations; researchers; consumers; and data experts*' (pp. 55-56). It states that 'The ANBS does not specify the regularity of NBAC meetings but states that it '*would report annually on implementation to AHMAC (the Australian Health Minister's Advisory Council)*.'

The NBAC fulfils an important need for coordination and adequate funding of breastfeeding policy in a federated system. For example, breastfeeding policy is used to illustrate Federal-State financing issues cited in a gender budgeting submission to the Victorian Parliament (Stewart et al, 2019).

1.6 However, at the time the assessment was done (June 2022), the WBTiAus committee could find no evidence that the NBAC was effective. We found no terms of reference or reports of ANBS plans and progress. Membership, terms of reference, meeting plans, reporting responsibilities and budget were not available for public scrutiny.

This crucial and ongoing gap in leadership on the nationwide and cross-sectoral implementation of ANBS presents an important opportunity in 2022 to improve the governance, transparency, and accountability of ANBS implementation, while enhancing inclusivity and its effectiveness in achieving gender equity. This could involve creating an *Australian National Breastfeeding Strategy Action Coalition* (ANBSAC), which should be constituted as an independent committee such as an expanded WBT*i*Aus, and similarly free from commercial influence. This national breastfeeding coalition would be supported by a secretariat and funded by the National Cabinet (formerly the Council of Australian Governments). The ANBSAC could be tasked with and provided with funding to assist with preparing the 2025 WBT*i* Assessment Report, which is the international benchmark for the ANBS. Such an arrangement would be like the NZ Breastfeeding Authority (Martis and Stufkens, 2013). The work of ANBSAC would include, for example, monitoring and reporting on ANBS outcomes on implementing the **International Code of Marketing of Breast-milk Substitutes**, and revised Infant Feeding Guidelines to align with WHO IYCF recommendations, guidelines and guidance, including all **relevant resolutions of the World Health Assembly** ABA may be considered as the appropriate organisation to host such a secretariat as the leading breastfeeding NGO in Australia, and given its pioneering and active role in WBT*i*Aus.

1.7 N/A. No evidence is available in the public domain on the structure, function or intersectoral role of the NBAC.

1.8 N/A. Unable to comment on the leadership and governance of the NBAC and its coordinating role at national and subnational levels and communication of ANBS plans.

Recommendations

WBT*i* Australia recommends that the Australian Government Department of Health demonstrate their commitment to enabling women and children to breastfeed, through providing political leadership on ANBS and its implementation by:

1. Revising the ANBS implementation/Action plan and timelines and make these publicly available.
2. Providing a specific line item for implementation of the ANBS in the federal budget, and each State and Territory jurisdiction to do the same from 2023. The ANBS should be included in the meeting agenda for Australian health ministers at least twice a year.
3. Negotiating an addition to the **National Health Reform Agreement** that includes relevant ANBS breastfeeding targets as performance indicators and provides defined federal funding to states and territories to support their costs of implementation of ANBS Actions on BFHI. Evidence is that this cost is minimal, and it also aligns importantly with effective implementation of the Code in Australia (see Indicator 3).
4. Supporting the establishment of an independent body or action coalition, ANBSAC, to advocate for and monitor the implementation of the Australian National Breastfeeding Strategy (ANBS) and funding a secretariat to support its work.

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

Background

The Joint WHO/UNICEF Statement: *Protecting, promoting, and supporting breastfeeding: the special role of maternity services,* in 1989 developed the *'Ten Steps to Successful Breastfeeding'*. The *Innocenti Declaration* of 1990 called upon governments to ensure that all maternity services fully implement all the *Ten Steps.*

The *Ten Steps* became the cornerstone of the Baby-friendly Hospital Initiative (BFHI) launched in 1992 with the aim to protect, promote and support breastfeeding in health facilities, and included among other steps having a written policy, competence training of the staff, and implementing the International Code of Marketing for Breastmilk Substitutes (the Code). The BFHI designation process was introduced to reflect changes in health policy and care practices. Several countries-initiated action on BFHI and made progress demonstrating change. The *Global Strategy for Infant and Young Child Feeding* emphasized the need for implementation monitoring and reassessment of already designated facilities. In 2009, revised, updated, and expanded integrated care material for implementation of the BFHI[11] were developed. It contained a training course of 20 hours for all health workers. The 2009 BFHI material included specific new modules for the support of non-breastfeeding mothers and for mother-friendly care and recommendation for baby-friendly expansion up to complementary feeding. The focus on compliance with the Code was reinforced.

In 2018, WHO using updated evidence, developed the implementation guidance for the revised Baby-friendly Hospital Initiative and revised the *Ten Steps*.[12]According to WHO only 10% births have been taking place in BFHI designated facilities and new guidance addressed this to promote expansion to many more hospitals. The revised *Ten Steps* include all the earlier concepts categorising these into *Critical management procedures* (Step1 and 2) and *Key clinical practices (Step 3- 10)*. Implementation of the International Code of Marketing of Breastmilk Substitutes is explicit under Step 1. The new guidance lays emphasis on integration of the *Ten Steps* into the national or hospital standards of care with nine principles (Annex-2.1) for implementing it and guides countries that currently have a well-functioning

11. https://www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse/en/

12. https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/

designation programme. The new guidance "*...should not be viewed as a reason to discontinue a successful programme…*" Annex-2.4)

The present version of the WBT*i* tool Indicator 2 has used both the old and the revised *Ten Steps* (2018) to reach out to every country at whatever state of implementation they are. See Table 4 for the 2009 and 2018 *Ten Steps.*

Table 4 The *Ten Steps* from 2009 and revised in 2018

Ten Steps 2009	**Ten Steps 2018**
Every facility providing maternity services and care for newborn infants should: 1. Have a written breastfeeding policy that is routinely communicated to all health care staff. 2. Train all health care staffs in the skills necessary to implement this policy. 3. Inform all pregnant women about the benefits and management of breastfeeding. 4. Help mothers initiate breastfeeding within a half-hour of birth. (Interpreted since 2009 as: Place babies in skin-to-skin contact with their mother immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.) 5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants. 6. Give newborn 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 breastfeeding on demand. 9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants. 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	**Critical management procedures** • Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions. • Have a written infant feeding policy that is routinely communicated to staff and parents. • Establish ongoing monitoring and data-management systems. • Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding. **Key clinical practices** • Discuss the importance and management of breastfeeding with pregnant women and their families. • Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth. • Support mothers to initiate and maintain breastfeeding and manage common difficulties. • Do not provide breastfed newborns with any food or fluids other than breast milk, unless medically indicated. • Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day. • Support mothers to recognize and respond to their infants' cues for feeding. • Counsel mothers on the use and risks of feeding bottles, teats and pacifiers. • Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Annex 2.2 explains the Ten Steps in lay terms and 2.3 compares the old and new Ten Steps in operational terms. For skill training and counselling one can refer to the WHO or other courses and guidelines given in the Annexes, or the WHO/UNICEF revised training material published at the end of 2019.

Assessment criteria

2.1) In total 70 out of 266 maternity hospitals (both public & private) have been designated/accredited/awarded/measured for implementing 10 steps within the past 5 years.

Quantitative Criteria for assessment

Criteria for assessment	√ Check 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 score 2.1	**2/5**

Qualitative Criteria for assessment

Criteria for assessment	√ Check the one that applies	
2.2) There is a national coordination body/mechanism for BFHI / to implement *Ten Steps* with a clearly identified focal person.	✔ Yes = 1	No=0
2.3) The *Ten Steps* have been integrated into national/regional/ hospital policy and standards for all involved health professionals.	Yes = 0.5	✔ No=0
2.4) An external assessment mechanism is used for accreditation /designation/awarding/evaluating the health facility.	✔ Yes = 0.5	No=0
2.5) Provision for the reassessment[13]have been incorporated in national plans to implement *Ten Steps*.	✔ Yes = 0.5	No=0

Criteria for assessment	√ Check the one that applies	
2.6) The accreditation/designation/awarding/measuring process for BFHI/implementing the *Ten Steps* includes assessment of knowledge and competence of the nursing and medical staff.	✔ Yes = 1	No=0
2.7) The external assessment process relies on interviews of mothers.	✔ Yes = 0.5	No=0
2.8) The International Code of Marketing of Breastmilk Substitutes are an integral part of external assessment.	✔ Yes = 0.5	No=0
2.9) Training on the *Ten Steps* and standard of care are included in the pre-service curriculum for nurses, midwives and doctors and other involved health care professionals.	Yes = 0.5	✔ No=0
Total Score (2.2 to 2.9)	**4/5**	

Total Score (2.1 to 2.9)	**6/10**

Additional Information

BFHI governance in Australia has been with the Australian College of Midwives (ACM) since 1995. BFHI is facilitated at ACM with a full-time administration employee and an expert advisory group. Hospital Accreditation is aligned to the revised Ten Steps. Critical to BFHI is respect and compliance with the WHO Code of Marketing of Breast-milk Substitutes. There have been concerns over the years about ACM event sponsorship with non-WHO code compliant companies. This has raised concerns about a perceived conflict of interest for ACM as a business with the need to seek out sponsorship as an income stream when hosting events. The ACM position statement on infant feeding states that it aligns with the WHO code and that the ACM does not advertise or endorse formula, bottles or teats. The position statement can be found here **https://midwives.org.au/Web/Web/About-ACM/ACM_Position_Statements.aspx**

Information Sources Used

Information used for the criteria 2 assessment can be found here.

2.1 BFHI Australia. 2020. About BFHI and Accredited Facilities. **https://bfhi.org.au/about/**

2.2 Conversations with Australian College of Midwives dedicated BFHI Program lead Yoshni Jeelall. BFHI Handbook **https://bfhi.org.au/wp-content/uploads/2021/09/BFHI-Handbook-Maternity-Facilities-Last-Revised-Feb-2021.pdf**. and webpage information on accreditation of Maternity facilities at **https://bfhi.org.au/maternity-facilities/**

2.3 The *Ten Steps* have **not** been integrated into national/regional/hospital policy and standards for all involved health professionals.

2.4 Conversations with Australian College of Midwives dedicated BFHI Program lead Yoshni Jeelall. BFHI Handbook **https://bfhi.org.au/wp-content/uploads/2021/09/BFHI-Handbook-Maternity-Facilities-Last-Revised-Feb-2021.pdf**. And webpage information on accreditation of Maternity facilities at **https://bfhi.org.au/maternity-facilities/**

2. 5 Maintaining BFHI accreditation with reassessment every 3 years is embedded with regular independent rereview. Details can be found at **https://bfhi.org.au/accreditation/**

2. 6 The BFHI handbook can be found at **https://bfhi.org.au/wp-content/uploads/2021/09/BFHI-Handbook-Maternity-Facilities-Last-Revised-Feb-2021.pdf** and further accreditation information at **https://bfhi.org.au/maternity-facilities/**

2. 7 The BFHI handbook can be found at **https://bfhi.org.au/wp-content/uploads/2021/09/BFHI-Handbook-Maternity-Facilities-Last-Revised-Feb-2021.pdf** and information on interviewing mothers **https://bfhi.org.au/accreditation/**

2. 8 This is clearly stated in the BFHI handbook **https://bfhi.org.au/wp-content/uploads/2021/09/BFHI-Handbook-Maternity-Facilities-Last-Revised-Feb-2021.pdf**

2. 9 Only one profession "Midwifery" includes training on the Ten Steps and standard of care for breastfeeding women in pre-service curricula documents.

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Conclusions

In Australia, almost all women initiate breastfeeding. Yet despite having a population of birthing women who are largely motivated to breastfeed Australia is unable to achieve breastfeeding rates that align with WHO and NHMRC targets (COAG, 2019a; WHO & UNICEF, 2014). The first national infant feeding survey (ANIFS) indicator results, from 2010, revealed that 96% of infants started life with breastmilk yet by 5 months of age only 15% were exclusively breastfed (AIHW, 2011). Since 2010 there has been an absence of reliable national data collection of breastfeeding rates across Australia. However, data from NSW and Victoria indicate that around one in three newborns receive commercial milk formula in hospital (Amir 2020).

Australia's low rates of exclusive breastfeeding inevitably increase health system costs (NHMRC 2013). There has been some progress in implementing the Baby Friendly Health Initiative (BFHI) since 2018 in Australia. In 1997, two of 475 facilities had ever been accredited and by 2022 this has risen to 70 out of 266 maternity hospitals (26%) (BFHI Australia, 2022). This is only a slight increase from 22% in 2017 (ANBS 2019). BFHI is designated as a Priority Action Area (2.1) in the 2019 Australian National Breastfeeding Strategy (ANBS). The ANBS states that 'prioritisation, stakeholder collaboration and adequate resourcing of the BFHI are required'. However, there continues to be no funding of BFHI implementation in Australia, and there is no integration of the *Ten Steps* into the Australian health system standards of care. Only one woman in four gives birth each year in a BFHI-accredited maternity and newborn care service. Women in remote or regional areas, or socio-economically disadvantaged areas, will have even less access.

This creates health inequities for women and children and expansion of BFHI in Australia has been negatively influenced by intangible government support and suboptimal capacity building (ANBS 2019).

Applying a gender lens, (specifically to the rights of women), breastfeeding outcomes and resourcing of BFHI implementation suggests that government budgets are not giving sufficient priority or adequate resources for the specific maternity care needs of women. This includes support to establish exclusive breastfeeding before discharge from maternity and newborn care services. There is insufficient attention and recognition given to breastfeeding education, training, and workplace support of the predominantly female health care workforce. Investing in BFHI accreditation in Australia has been demonstrated to have a high rate of social return (Pramono 2022).

While more than 9 out of 10 women start breastfeeding, several factors impact on the lower numbers of women exclusively breastfeeding at discharge from maternity services. Factors related to poor hospital practices can be addressed by BFHI. Increasing birth intervention, high acuity, and high caesarean section rates, also interfere with opportunities for immediate mother-to-infant skin to skin contact after birth and the early initiation of breastfeeding (Burns, Fenwick, Sheehan, & Schmied, 2013; Stevens, Schmied, Burns, & Dahlen, 2016). There are substantial impediments to proper breastfeeding support at the early establishment phase of breastfeeding, in both hospital and community settings. These include the fact that only one quarter of hospitals, and two community services, are BFHI accredited. Non-BFHI accredited hospitals do not currently have to adhere to the *Ten Steps* to successful breastfeeding. The National Safety and Quality Health Service (NSQHS) standards do not recognise the importance of the BFHI for quality health service delivery (Australian Commission on Safety and Quality in Health Care, 2017 (updated May 2021)). Hospitals that do not provide care based on the evidence-based quality criteria recommended by WHO and UNICEF, known as the *Ten Steps to Successful Breastfeeding*, can still be accredited as "safe" and providing high "quality" care. The ANBS identified the importance of "working with the Australian College of Midwives and the Australian Commission on Safety and Quality in Health Care to facilitate BFHI accreditation for all maternity and newborn care facilities and community health settings" as a priority target (COAG, 2019a). We could find no evidence of action towards this priority area to date.

Quality maternity care, according to BFHI, requires healthcare professionals who have adequate pre-service education and training in breastfeeding. This review of Indicator 2 highlights that only one Australian health professional discipline – midwifery - has embedded education on the *Ten Steps* and the importance of BFHI in pre-service curricula (ANMAC, 2021). Pre-service curricula documents for nursing and medicine made no reference to breastfeeding information or education (ANMAC, 2015, 2019a, 2019b; Australian Medical Council, 2012, 2015, 2019). Action Area 2.2, of the ANBS, highlights the need for integration of breastfeeding content into undergraduate health professional education (COAG, 2019a, p. 41). Future iterations of health professional curricula should name breastfeeding as a priority area for undergraduate and postgraduate learning and teaching. However, currently this is only the case with midwifery curricula, and there is no evidence that the ANBS Action Area 2.2 is being resourced for implementation.

Gaps

1. Access to baby-friendly maternity and newborn care is not universally available, only one in four maternity facilities are BFHI accredited. There is still no national health care funding agreement to support BFHI implementation, or any evident political commitment to doing so.
2. National Safety and Quality Health Service (NSQHS) standards do not currently recognise the Baby Friendly Health Initiative as part of an overall quality health service delivery. The *Ten Steps* have

not been integrated into national, state, or local hospital policy or standards for health professionals involved in providing maternity care.

3. Only one health professional discipline – midwifery - has embedded education on the *Ten Steps* and the importance of BFHI in pre-service curricula and there are currently inconsistent educational requirements for health workers on BFHI, and breastfeeding education and training, across Australia.
4. Access to skilled health professionals, such as midwives or IBCLC, impacts breastfeeding rates. Only 10 - 15% of women have access to continuity of care from a midwife in Australia despite the known benefits of midwifery continuity of care on breastfeeding duration rates.
5. Activity based funding levels for maternity care may be insufficient to ensure sufficient time and continuity of care to support mothers and babies to establish exclusive breastfeeding before hospital discharge.
6. Breastfeeding advocacy within health services remains dependent on key champions such as IBCLCs who have limited access to resources to support advocacy and to work to the full scope of practice. The lack of recognition of IBCLCs, and the low levels of staffing in maternity care services, reduces the support available for women in the health care system.
7. Many hospitals offer disabling breastfeeding environments for staff who return to work breastfeeding, even BFHI accredited hospitals, and this can limit the availability of support for breastfeeding for women using health care services.

Recommendations

These recommendations mirror many of the Australian National Breastfeeding Strategy recommendations (COAG, 2019a).

1. That the Commonwealth Government urgently negotiate a funding agreement with state and territory governments to include the cost of all Australian maternity care facilities obtaining and maintaining BFHI status, and that all Australian governments immediately state their commitment to 100% BFHI implementation by 2030 to underpin achievement of the breastfeeding target for 50% exclusive breastfeeding.
2. That the Commonwealth Government negotiate a funding agreement with state and territory governments that requires them to report on performance indicators on the number of accredited maternity services under the Baby Friendly Health Initiative.
3. That the Commonwealth Government establish and adequately fund a National Task Force to develop and implement a time-bound strategy to increase the number of BFHI institutions in the country.
4. That the *Ten Steps* are integrated into national hospital accreditation standards by 2025.
5. That the Australian Commission on Safety and Quality in Health Care work with the Australian College of Midwives to facilitate BFHI accreditation for all maternity and newborn care facilities and community health settings by 2030.
6. That training on the *Ten Steps* and standard of care are included in the pre-service curriculum for health care professionals. Including agreed core curriculum, skills matrix and national competency standards for all health professionals supporting breastfeeding women.
7. All women should have access to skilled breastfeeding support from health practitioners, regardless of their economic means.
8. That all public hospitals meet the Australian Breastfeeding Association Breastfeeding Friendly Workplace accreditation standards.

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

Background

The World Health Assembly (WHA), the forum that governs the World Health Organization (WHO) and sets its health policies, adopted the International Code of Marketing of Breastmilk Substitutes as a recommendation in 1981 through resolution WHA 34.22. The resolution stresses that the adoption of and adherence to the Code is a minimum requirement, and countries are expected to give effect to the principles and aim of the Code in their entirety. For the Code to take legal effect at the national level, it must first be translated into legislation, regulations, or other suitable measures as appropriate to the social and legislative framework of the implementing country. Several relevant subsequent World Health Assembly resolutions, which strengthen the International Code have been adopted since then and have the same status as the Code. These resolutions keep the Code up to date with evolving marketing trends and the latest scientific knowledge. When implementing the Code nationally, legislators must ensure that the subsequent WHA resolutions are also incorporated into law.

The *"Innocenti Declaration"* 1990 calls for all governments to take action to implement all the articles of the *International Code of Marketing of Breastmilk Substitutes* and the subsequent World Health Assembly resolutions. An important aim of the Code is to bring an end to misleading information about infant and young child feeding and contribute to the provision of safe and adequate nutrition for infants. It calls on Member States to protect, promote and support breastfeeding, ensure the proper use of breastmilk substitutes, when these are necessary, while ensuring full, frank, and independent information and appropriate marketing and distribution. The "State of the Code by Country" by the ICDC, documents countries' progress in implementing the Code and provides important and relevant information on the type of action taken.

According to WHO 136 out of 194 Member States have adopted code related legal measures, however just 35 countries incorporate all or most of the provisions of the Code in law.[14]

Criteria for Assessment *(Legal Measures that are in Place in the Country)*	
	Score
3a: Status of the International Code of Marketing *√ Check that applies up to the questions 3.9. If it is more than one, tick the higher one.*	
3.1 No action taken	☐ 0
3.2 The best approach is being considered	0.5
3.3 Draft measure awaiting approval (for not more than three years)	☐ 1
3.4 Few Code provisions as 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* See note in Conclusions
3.8 All articles of the Code as law	☐ 5
3.9 Relevant provisions of World Health Assembly (WHA) resolutions after the Code are included in the national legislation[15] Provisions based on 1 to3 of the WHA resolutions as listed below are included Provisions based on more than 3 of the WHA resolutions as listed below are included	☐ 6
Total score 3a	**4/6**

3b: Implementation of the Code/National legislation *Check that applies. It adds up to the 3a scores.*	
3.10 The measure/law provides for a monitoring system independent from the industry	☐ 1
3.11 The measure provides for penalties and fines to be imposed on violators	☐ 1
3.12 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 3b	**1**

Total Score (3a + 3b)	**5 /10**

Information Sources Used

3a: Status of the International Code of Marketing

3.7 Some articles of the Code as law

Australian Government. Federal Register of Legislation. *Australia New Zealand Food Standards Code – Standard 2.9.1 - Infant formula products*. **https://www.legislation.gov.au/Series/F2015L00409**

Australian Government. Federal Register of Legislation. *Australia New Zealand Food Standards Code – Standard 2.9.2 - Food for infants.* **https://www.legislation.gov.au/Details/F2017C00334**

Australian Government. Federal Register of Legislation. *Australia New Zealand Food Standards Code –Standard 1.2.7- Nutrition, health and related claims*. **https://www.legislation.gov.au/Details/F2018C00942**

3b: Implementation of the Code/National legislation

3.12 Compliance with the measure is monitored and violations reported to concerned agencies

Australian Government Department of Health and Aged Care. *Marketing in Australia of Infant Formulas (MAIF) Complaints Committee.* **https://www.health.gov.au/committees-and-groups/maif-complaints-committee**

Conclusions

The Code exists:

1. to support the reproductive rights that women hold in relation to breastfeeding and the right of the child to health (Gribble & Gallagher, 2014; Gribble et al, 2011).
2. because of the unique vulnerabilities of new mothers and infants, and the acceptance by governments that decisions about feeding of infants and young children should not be influenced by exploitative marketing.

As a member of the World Health Assembly (WHA), Australia has the obligation to implement the Code in its entirety but very few of the provisions of the Code and subsequent WHA Resolutions have been given effect in legislation (see Table 1). This leaves substantial gaps in the regulation of the promotion, labelling and packaging of commercial breastmilk substitutes and foods marketed for infants and young children (0-36 months) in Australia (House of Representatives Standing Committee on Health and Aging, 2007).

Table 1. List of key Code provisions legislated in Australia

Source: WHO (2022) Marketing of breast-milk substitutes: national implementation of the International Code, status report 2022 – Asia/Oceania Region. **http://apps.who.int/iris/bitstream/handle/10665/354581/9789240051249-eng.pdf?sequence=1&isAllowed=y**

Scope includes breastmilk substitutes to 36 months	No
Prohibitions	
Informational/educational materials from industry	No
Advertising	No
Promotional devices at point of sale	No
Use of health care facility for promotion	No
Gifts or incentives to health workers	No
Free or low-cost supplies in any part of the health care system	No
Sponsorship of meetings of health professionals or scientific meetings	No
Nutrition and health claims on label	Yes
Pictures that may idealise the use of infant formula	Yes
Monitoring and Enforcement	
Identifies who is responsible for monitoring compliance	Yes
Defines sanctions for violations	Yes

A voluntary, industry self-regulated Code of Practice, the *Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement (1992)* (the MAIF Agreement) that claims to give effect to the Code is in place (Australian Government Department of Health and Aged Care, 2022a). This measure is unenforceable, and its scope is limited. The MAIF Agreement only applies to infant and follow-on formula for children aged 0 to 12 months and excludes toddler milk drinks and commercial baby foods as well as bottles and teats (NOUS Group, 2012) Retailers are not included and not all manufacturers and importers are signatories (Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), 1994; Knowles, 2001). Transparency around the interpretation and monitoring of the MAIF Agreement is minimal (Nous, 2017) and when a breach is found to have occurred there is no penalty imposed (Australian Government Department of Health and Aged Care, 2022b).

Australia has partly implemented the Code recommendations for labelling about infant and follow-on formula for children aged 0 to 12 months, in *Australia and New Zealand Food Standards (FSANZ) Code – Standard 2.9.1- Infant formula products* (Australian Government, 2022a) which is legislated, and has penalties for breaches. This Standard includes labelling requirements for infant formula products and specifically prohibits some types of claims, images, and symbols on product labels. A*ustralia*

New Zealand Food Standards Code – Standard 1.2.7 - Nutrition, health, and related claims (Australian Government, 2022b) states a nutrition content or health claim must not be made about infant formula.

However:

- such labelling restrictions are limited to infant formula products from 0 to 12 months and do not include milk and other drinks and foods marketed for toddlers (Australian Government, 2022b) from 13 months to 36 months, and
- there is evidence that nutrition and health claims are being made about infant formula (Berry & Gribble, 2016), indicating a failure of monitoring and/or enforcement.
- there is also evidence of inappropriate claims being used to market infant and toddler foods other than infant formula (Simmonds et al., 2021).

Of great concern, is the fact that A*ustralia New Zealand Food Standards Code – Standard 2.9.2 - Food for infants* (Australian Government, 2022c) continues to permit labelling of commercial baby foods as suitable for children from 4 months of age. Many infants are introduced to commercial baby foods between 4 and 6 months (Australian Institute of Health and Welfare (AIHW), 2011), reducing exclusive breastfeeding.

The Code places particular responsibilities on governments to monitor and enforce Code measures which the Australian government has not met. The WBT*i*AUS assessment is based on the absence of publicly available evidence of monitoring or sanctions for Code violations under the Food Act or other relevant law in Australia. The lack of comprehensive and effective government monitoring and enforcement of the Code measures reduces government costs but places an additional unpaid work burden on women and breastfeeding NGOs (mostly staffed by women, many of whom volunteer). (Smith et al., 2021a; Smith et al., 2021b) Reducing the costs of monitoring and enforcement for government regulators such as FSANZ and Australian Competition and Consumer Commission (ACCC) is a strategy that shifts costs away from government and mostly onto women and NGOs.

Additionally, there are no effective measures addressing Code provisions regarding the use of health care facilities for promotion, giving gifts or incentives to health workers, sponsoring health professional meetings, or providing free or low-cost formula supplies through the health system or in emergency response. The National Health and Medical Research Council (NHMRC) *Infant Feeding Guidelines* (NHMRC, 2012) draw attention to the need for health workers to be aware of their responsibilities under the Code but these guidelines and are not systematically or regularly communicated to health workers or their professional associations and are not enforced.

Gaps

1. The *International Code of Marketing of Breast-milk Substitutes* (the Code*)* and all subsequent WHA resolutions have not been adopted or implemented in full.
2. Despite many review recommendations to strengthen Code implementation by widening its scope and improving monitoring and enforcement, the MAIF Agreement is substantially unchanged since first introduced. Provisions which implement the Code in Australia are decades out of date. Implementation including Ministerial accountability has been weakened in the past decade.
3. The MAIF Agreement is severely limited in its capacity to prevent promotion of breastmilk substitutes or protect breastfeeding.
    - Compliance is voluntary, and it does not apply to retailers of infant formula such as supermarkets, pharmacists, online retailers, or exports.
    - Its scope excludes toddler milks, complementary foods marketed for infants and young children 0-36 months, and bottles and teats, and dummies.

- It does not prohibit samples or free or low-cost formula supplies to health or education facilities.

4. Legislated food standards which prohibit health or nutrition claims on infant formula product labelling and packaging do not include toddler milk drinks in their scope.
5. Labelling requirements under *Standard 2.9.2* of the Food Standards Code permit promotion of commercial baby food products for infants from 4 months and does not align with the NHMRC *Infant Feeding Guidelines* recommendation that a baby should be exclusively breastfed for the first six months.
6. Food law prohibitions on nutrition content or health claims, both direct and implied, about infant formula and toddler milk appear not to be adequately enforced. There is also inadequate regulation and lack of consumer protections regarding claims on infant and toddler foods.
7. Health workers and facilities do not have current education or information about their obligations under the Code, are not held accountable for meeting these professional responsibilities (WHO, 2020). See also Indicator 2 regarding implementation of BFHI/*Ten Steps*.
8. The Australian government has financed the administrative support costs of the industry's MAIF for three decades yet has provided no funding to civil society for its monitoring of Code breaches. This imbalance in resourcing shifts the real costs of monitoring Code implementation to overburdened mothers of infants and young children and volunteers in breastfeeding and public health NGOs.
9. The NHMRC *Infant Feeding Guidelines* are outdated and poorly communicated to health workers as well as being unenforceable and failing to ensure accountability of health professionals.

Recommendations

1. The Australian Federal Government should amend its implementation of the *International Code of Marketing of Breastmilk Substitutes* to reflect all subsequent WHA resolutions, replace MAIF with mandatory measures such as regulation or legislation, and ensure coordinated action to enforce the Regulations are put in place.
2. The Australian Government should enact legislation or other effective measures to implement the Code and subsequent WHA resolutions in full, with appropriate enforcement regarding the gaps above, such as by:
    - Replacing the formula industry's voluntary MAIF Agreement with a mandatory "*Code of Conduct on IYC Foods*" prescribed as a regulation under the Competition and Consumer Act 2010, and enforced by the ACCC, with a scope to include all commercial milk formula products and commercial foods marketed for infants and young children 0-36 months as per the Code, and with substantial penalties for companies breaching the *Code of Conduct on IYC Foods* whether in Australia or in overseas markets. This *Code of Conduct on IYC Foods* could be implemented separately from replacing the MAIF with such an instrument for manufacturers and importers of infant formula.
    - Developing and legislating a mandatory Code of Conduct as above to regulate marketing and promotion of feeding implements such as bottles, teats, and dummies within the scope of the Code ("*Code of Conduct on Bottles, Teats and Dummies*").
    - Developing a mandatory Code of Conduct to regulate all retailers' (e.g., supermarkets, pharmacists, online stores) marketing and promotion of products within the scope of the Code ("*Code of Conduct on Retailing IYC foods, bottles, teats and dummies*") including digital marketing, and marketing in overseas markets.

- Funding the ACCC to establish a dedicated unit within the ACCC to protect the interests and safety of these uniquely vulnerable consumers by ensuring compliance with the above Codes of Conduct.
- Amending the Competition and Consumer Act 2010 to require the ACCC to report annually on the performance of these functions and exercise of its powers in relation to these Codes of Conduct.
- Developing a Policy Guideline on the expectations of the Australia and New Zealand Food Regulation Ministerial Council that prohibits any health or nutrition claims on toddler milk or infant or toddler foods. This should be separate from the current Guideline on infant formula.
- Developing a Policy Guideline on the expectations of the Australia and New Zealand Food Regulation Ministerial Council that labelling of baby food products under *Standard 2.9.2* of the Food Standards Code should give priority to aligning with WHO and NHMRC recommendations for 6 months of exclusive breastfeeding over any fair trade considerations, and that labelling not refer to any earlier infant age than 6 months, that packages carry a warning that any use before 6 months is likely to displace superior nutrition from breastfeeding, and that labelling of all baby food products for infants aged < 12 months indicate serving sizes which are demonstrated to be consistent with continued breastfeeding duration to at least 12 months.
- Funding FSANZ to establish a dedicated unit for ensuring compliance with the relevant Food Standards on labelling for IYC food products and amending the Food Act to require FSANZ to report annually on the performance of its functions and exercise of its powers in relation to IYC food products for children 0 to 36 months.
- The MAIF Complaints Committee and its taxpayer-funded secretariat within the Department of Health be replaced by an *Independent WHO Code in Australia Panel* comprising public health, consumer, and breastfeeding NGO representatives and free from commercial influence, and supported by a secretariat which is adequately funded, to
    a. Conduct regularly, monitoring of the extent of all breastmilk substitutes and IYC food marketing in Australia using the WHO Net Code **protocol** for periodic monitoring of compliance with the International Code and
    b. Receive and refer complaints regarding the marketing in Australia of products within the scope of the International Code to ACCC or FSANZ and
    c. Provide advice on Australia's implementation of the Code to the Australian Government Minister for Health and Ageing, including on any further or updated measures to protect breastfeeding and safe infant feeding and the aims of the Code
- NHMRC Infant Feeding Guidelines be updated to fully incorporate recent guidance published by WHO for health workers (World Health Organization (WHO), 2020) and these be regularly communicated to health workers via their health professional associations and health facility.

3. All health worker organisations should include Code compliance as part of their professional ethical standards, and compliance with the Code and related guidance for health workers should be enforced as a mandatory standard for registration and accreditation by the Australian Health Practitioner Regulation Agency (AHPRA).

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Indicator 4: Maternity Protection

Background

Women have the right to adequate support to be able to breastfeed their babies. The Convention of Rights of the Child and The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), an international treaty adopted in 1979 by the United Nations General Assembly protect these rights of women. The Innocenti Declarations (1999, 2005) and WHO Global Strategy for IYCF (2002) call for provision of imaginative legislation to protect the breastfeeding rights of working women and further monitoring of its application consistent with ILO Maternity Protection Convention No 183, 2000 and Recommendation 191. The ILO's Maternity Protection Convention (MPC) 183 specifies that women workers should receive:

1. Health protection, job protection and non-discrimination for pregnant and breastfeeding workers
2. At least 14 weeks of paid maternity leave
3. One or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed

Furthermore, Recommendation 191 encourages facilities for breastfeeding to be set up at or near the workplace.

The concept of maternity protection involves 7 aspects:
1) the scope (in terms of who is covered); 2) leave (length; when it is taken, before or after giving birth; compulsory leave); the amount of paid leave and by whom it is paid – employer or government; 3) cash and medical benefits; 4) breastfeeding breaks; 5) breastfeeding facilities; 6) health protection for the pregnant and lactating woman and her baby; 7) employment protection and non-discrimination.

Only a limited number of countries have ratified C183, but quite a few countries have ratified **C103** and/or have national legislation and practices, which are stronger than the provisions of any of the ILO Conventions.

Maternity protection for all women implies that women working in the informal economy should also be protected too. The Innocenti Declaration 2005 calls for urgent attention to the special needs of women in the non-formal sector.

Adequate maternity protection also recognizes the father's role in nurturing and thus the need for paternity leave. Paternity leave policies should prioritise women's access to paid maternity leave for the first 6 months, ensuring that paternity leave quotas are not being used to leverage women back to work during the first year of a child's life. Currently, needing to return to work is a common reason for women to stop breastfeeding. Policies should prevent marketing of milk formula as the counterpart to paternity leave and equality in infant care work.

What has happened since the 2018 WBT*i* report?

Global developments

- In 2021, the WHO/UNICEF Global Breastfeeding Collective's 7 Call to Action Priorities included Maternity Protection in the Workplace and Enacting Paid Family Leave and Workplace Policies. Currently, only 11% of countries meet the ILO recommended standard. The Collective target for 2030 is to have at least 25% of countries following the ILO recommendation. The ILO target should be considered a minimum. ILO recommends mothers should have paid leave for a period of 6 months after birth to align with WHO health recommendations for exclusive breastfeeding for 6 months and continued breastfeeding to two years and beyond.
- Governments have continued to promote increasing women's labour force participation as a way of reducing the gender pay gap, but progress has been slow. At the **2014** Summit in Brisbane, G20 Leaders committed to **reduce the gender gap** in labour force participation by 25 per cent by 2025. The 2017 OECD report *The Pursuit of Gender Equality: An Uphill Battle* found that the median full-time working woman in Australia earns 87 cents to every man's dollar.
- The 2022 ILO Report *Care at Work* counted Australia among the small number of countries where maternity cash benefits provided through flat-rate payments may be below the ILO standard of two-thirds of previous earnings for a sizeable share of mothers.
- Australia is reported also by the ILO as among the few high-income countries where breastfeeding breaks remain unpaid, and rights to breastfeeding breaks and facilities at work are not specified in national legislation.

Australian developments

The Australian Human Rights Commission's submission to the UN CEDAW Committee in 2018 recommended the government commit to funding Australia's time-use survey, to ensure data on the extent and distribution of unpaid work and its intersection with paid work. In 2019, the Australian Government announced it would reinstate the Time Use Survey (TUS) in 2020-21.

The Australian Government released the Australian National Breastfeeding Strategy: 2019 and Beyond (ANBS) in June 2019. The ANBS calls for supportive employment arrangements or workplace settings to empower mothers to breastfeed. Action area 2.3 includes recommendations for Commonwealth, States and territories, employers, and early childhood education and care providers to:

- Implement the Breastfeeding Friendly Workplace (BFW) program in all government agencies, with a requirement that all Commonwealth, State, and Territory government departments seek BFW accreditation from the ABA.
- Recognize employers that provide support for women to breastfeed, for example, through the Workplace Gender Equality Agency's Employer of Choice for Gender Equality citation.
- Pilot and evaluate a breastfeeding-friendly early childhood education and care program that encourages centers to recognise the needs of breastfeeding mothers and their infants.

The national Paid Parental Leave (PPL) scheme has provided a total of up to 20 weeks or 100 payable days of payments. The scheme introduced in 2011 improved maternal mental health and increased breastfeeding at 12 months and at 6 months among disadvantaged mothers so reducing social inequities in breastfeeding.[2,10] From 2020, changes were made to the previous requirement that PPL be taken in an 18-week block. Currently 12 weeks must still be taken as one continuous block, but 6 weeks can be taken across 24 months, including if working part time. A new 'dangerous jobs' provision for PPL eligibility was introduced.

In October 2022, the Australian Government **announced changes to PPL**. The Australian Government is increasing the length of the Paid Parental Leave scheme to 26 weeks by 2026. The total number of weeks available will gradually rise from 20 to 26 (i.e., six months), with two weeks being added in July of 2024 2025 and 2026. Currently, parents are eligible for 18 weeks of Parental Leave Pay for the primary carer and 2 weeks of Dad and Partner Pay for dads and partners[12] but uptake by fathers is low because the minimum wage payment making lengthy 'daddy leave' unaffordable for many families. From 1 July 2023, Parental Leave Pay and Dad and Partner Pay will be combined into a single 20-week payment, and gender-neutral claiming will be introduced which will allow either parent to claim the payment. The changes will include a 'use it or lose it' provision for both parents which is said 'to support families and incentivise both parents to access it'. The Government has not identified how the increased allocation will be shared between parents. There is no paternity leave policy prioritising women's access to paid maternity leave for the first 26 weeks, and to continue breastfeeding as recommended to 2 years and beyond. This has been referred to the **Women's Economic Equality Taskforce** for further advice.

Paternity leave is provided by some private employers, and it is proposed that from March 2023, PPL eligibility is not affected by employer-provided leave entitlements.

Women working in the informal/unorganised and agricultural sector continue to be eligible for paid maternity leave through the PPL scheme if they can provide evidence that they meet the required minimum hours of employment. Women in these sectors may have access to the protections of the SDA and the FWA in some circumstances.

The ANBS notes that 'under the National Employment Standards in the *Fair Work Act 2009*, employees with 12 months' service have a right to request flexible working arrangements in a range of circumstances, including when an employee is the parent, or has the responsibility for the care, of a child who is school aged or younger. All modern awards contain provisions that supplement the right to request flexible working arrangements in the National Employment Standards'. The ANBS also reports that the Fair Work Ombudsman provides information on best-practice actions that employers can implement to support employees who are breastfeeding.

Occupational health and safety laws provide health protection for pregnant and breastfeeding workers and require information about hazardous workplace conditions. Reviews have shown that women's experience of alternative work at the same wage is sometimes not properly provided for. Since 2020, PPL can be paid to eligible pregnant women having to leave dangerous jobs.

The SDA prohibits employment discrimination and the FWA provides for job protection. The SDA makes it unlawful to discriminate against breastfeeding women in employment or in the provision of goods and services, including childcare.[3-5] In the case of employment, either direct or indirect discrimination against breastfeeding mothers is unlawful, unless the employer can show reasonable grounds.

In the State of NSW, from 1 October 2022 there are also changes to parental leave for those working in the public sector. An additional two weeks of leave is now payable to NSW government employees who are single parents or where each parent has exhausted any paid parental leave offered by their employer.

In 2019 the ANBS included a Priority Action on breastfeeding friendly environments, which included for the Commonwealth government and the States and Territories to implement the BFWA program in government agencies. It also gave responsibility to employers and governments to recognise employers that provide support for breastfeeding mothers, such as through the Workplace Gender Equality Agency's Employer of Choice for Gender Equality citation. The ANBS included a Priority Action for governments and early childhood education and care providers to pilot and evaluate a breastfeeding friendly early childhood education and care program that encourages centers to recognise the needs of breastfeeding mothers and their infants.

Criteria for Assessment	**Scores**
4.1) Women covered by the national legislation are protected with the following weeks of paid maternity leave: • Any leave less than 14 weeks • 14 to 17weeks • 18 to 25 weeks • 26 weeks or more	*Tick the one which is applicable* 0.5 1 ✔ 1.5 2
4.2) Does the national legislation provide at least one breastfeeding break or reduction of work hours? • Unpaid break • Paid break	*Tick the one which is applicable* ✔ 0.5 ☐ 1
4.3) The national legislation obliges private sector employers to • Give at least 14 weeks paid maternity leave • Paid nursing breaks.	*Tick one or both* ☐ YES (0.5) ✔ NO (0) ☐ YES (0.5) ✔ NO (0)
4.4) There is a provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in workplaces in the formal sector. • Space for Breastfeeding/Breastmilk expression • Crèche	*Tick one or both* ☐ YES (1) ✔ NO (0) ☐ YES (0.5) ✔ NO (0)
4.5) Women in informal/unorganized and agriculture sector are: • Accorded some protective measures • Accorded the same protection as women working in the formal sector	*Tick the one which is applicable* ✔ 0.5 ☐ 1
4.6) a. Accurate and complete information about maternity protection laws, regulations or policies is made available to workers by their employers on commencement.	*Tick one or both* ✔ YES (0.5) ☐ NO (0)
b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	✔ YES (0.5) ☐ NO (0)

Criteria for Assessment	Scores
4.7) Paternity leave is granted in public sector for at least 3 days.	*Tick the one which is applicable* ✔ YES (0.5) NO (0)
4.8) Paternity leave is granted in the private sector for at least 3 days.	*Tick the one which is applicable* ✔ YES (0.5) NO (0)
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	*Tick the one which is applicable* ✔ YES (0.5) NO (0)
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	*Tick the one which is applicable* ✔ YES (1) ☐ NO (0)
Total Score	**6/10**

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Conclusions

Policies which overemphasize early maternal return to work after childbirth to achieve gender equality goals adds to pressures on new mothers to reduce or stop breastfeeding, may increase their overall (paid plus unpaid) work burden, and risks reversing gains to women's and children's health achieved by PPL since 2011. Addressing the gender wage gap requires policies which reduce the burden of women's unpaid domestic and care work and support women's advancement in labour markets without reducing their opportunity to breastfeed as recommended. Policy must be based on evidence from data on time use and breastfeeding practices.

Recently announced and prospective changes to PPL may reduce women's maternity leave entitlements if they are a couple and may result in mothers experiencing pressure to take less leave in the first 6 months

after childbirth. Increased PPL for sole parents will further increase the opportunity for breastfeeding and is an improvement to PPL. Introducing a household income test for PPL, taxing the individual's income at normal rates, will impose higher effective marginal tax rates on secondary earners which is mostly the mother. At present, expanding PPL in ways which reward couples for sharing PPL during the first 6 months may increase flexibility but be at the expense of improving paid maternity leave entitlements and protecting optimal breastfeeding as funding for any expansion comes from the same Budget envelope. Policies rewarding fathers for sharing caregiving responsibilities can result in gender inequity if it means mothers take longer unpaid leave.

Achieving gender equality without undermining breastfeeding and the health of women and children also requires all workplaces and childcare environments to be 'breastfeeding friendly'. We found no evidence of any requirement for employers to make accurate and complete information about maternity leave entitlements available on commencement of employment. There are some systems for monitoring compliance with the SDA and the FWA, and to seek review of administrative decisions about PPL access, or discrimination under the SDA. SDA and FWA processes may be time consuming and costly to access.

Gaps

1. As no Time Use Survey was conducted in Australia between 2006 and 2021, policies on PPL and gender equality have been developed without evidence on how the time cost of unpaid care work is shared, or on how PPL altered the sharing of care or domestic work among parents of infants and young children. Recent changes giving increased flexibility for either parent to take PPL are made without consideration of data on the overall paid and unpaid work hours of families with infants and young children and could make them more vulnerable to marketing of commercial baby foods and milk formula targeting time-pressed mothers and busy families. The changes may increase women's overall workload if it increases the need for breastfeeding mothers to express their milk, and if fathers or partners do not fully take up the housework and childcare when they access PPL.
2. The 18 week duration of publicly funded PPL is insufficient to allow for six months exclusive breastfeeding. Australia may no longer meet the ILO standard for paid maternity leave of 14 weeks as this is no longer guaranteed to the birth mother; the maternity leave quota has been reduced to 12 weeks. Proposed 'use it or lose it' PPL provisions may increase pressure for women to return to work soon after childbirth and may reduce breastfeeding. The amount of the publicly funded payment to eligible parents (the primary caregiver) is low as it is set at the statutory minimum wage which is below the ILO standard of two thirds of previous earnings, and it also excludes compulsory employer superannuation contributions (which further widens the gender gap in retirement incomes for women).There is social and gender inequity in the amount of financial support available to parents as PPL is in addition to employer funded leave if offered.[1] There is no universal scheme to provide maternity protection measures across the formal and informal sector. There is not a clear process for coordinating state and territory employer policy changes with development of national policies on paid parental leave and with national and state and territory policies on breastfeeding.
3. Breastfeeding friendly workplaces and childcare are not mandated and are therefore not available to all. Paid breastfeeding breaks are still not legislated nationally in Australia. Entitlement to paid 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. Women in lower quality jobs are less likely to experience a supportive workplace for breastfeeding. Although the value of the Australian Breastfeeding

Association's BFW 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 or on the ANBS Action on BFW to provide funding for expanding the scheme. There is no specific ANBS budget to implement breastfeeding friendly environments. There is no publicly available information indicating whether ANBS Priority Actions on workplace or childcare policies have been implemented. National childcare accreditation standards intended to ensure adequate care of infant and young children do not require that services are 'breastfeeding friendly', such as by staff having specific knowledge or skills on breastfeeding support, or services having supportive policies or facilities for women to breastfeed or express and store breastmilk. Policies of relying on voluntary measures by employers or services may widen gaps and inequity in access to breastfeeding friendly workplaces and childcare, as the most disadvantaged workers, including in the informal sector, will not have comparable access to such conditions.

4. Job security is not protected for those taking parental leave, especially women. 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.
5. Enforcement agencies are not widely promoted and are under resourced or limited in capacity for tracking and enforcing compliance and supporting women and families to access their entitlements. Acting 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.

Recommendations

1. Prioritise resourcing for ABS to monitor and analyse whether the 2022 PPL changes are in practice resulting in more gender equitable sharing of care and domestic work burdens among parents of infants and young children, and publicly commit to adequate funding for the TUS to continue as one of the Tier 1 'foundational' statistical collections of the ABS, along with a regular update of the 2010 Australian National Infant Feeding Survey (see Indicator 10).
2. Draw on accumulating evidence from the Australian Bureau of Statistics' 2021 Australian Time Use Survey (TUS) about the sharing of unpaid care and domestic work by parents of infants and young children in developing PPL policies, to ensure the announced 2022 changes in PPL do not increase women's overall work burdens or increase pressures on women to reduce or stop breastfeeding.
3. Increase the duration of publicly funded PPL guaranteed to the birth mother ('mummy quota') to at least six months as the priority to align with the period of exclusive breastfeeding as recommended by WHO, NHMRC, and other health authorities.
4. Extend PPL payment to 12 months post-partum to support continued breastfeeding to 12 months and beyond as recommended by the National Health and Medical Research Council's infant feeding guidelines.
5. Transition the amount of PPL to the level of two-thirds of average weekly earnings instead of the current minimum wage basis to increase the contribution of PPL to gender equity and improve gender equality in utilisation of PPL.
6. Introduce payment of superannuation for those on paid parental leave payments.
7. Include paid breastfeeding breaks and related ILO standards for workplace facilities for breastfeeding as a Minimum National Employment Standard in the Fair Work Act.

8. Ongoing funding of a nationwide expansion of the BFW scheme should be provided as recommended by the Best Start Inquiry and in all government workplaces as in the Priority Actions of the ANBS.
9. 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 and systematically promoted so that all pregnant women and new parents and employers are aware of maternity protection entitlements.
10. 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.
11. Accreditation and licensing standards for all childcare services should be revised to ensure all services provide as a minimum standard adequate breastfeeding facility, 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)

Background

It has been documented that many health and nutrition workers do not have the opportunity to gain adequate skills in counselling for infant and young child feeding, which is essential for the success of breastfeeding, as well as lacking knowledge in IYCF.

Ideally, new graduates of health provider programmes can support recommended IYCF practices from the outset of their careers. All providers who interact with mothers and their young children need to acquire the basic attitudes, knowledge, and skills necessary to integrate breastfeeding counselling, lactation management, and other aspects of IYCF into the care they give. The topics can be covered at various levels during education and employment. In addition, the policies of the institutions in which the providers work need to be supportive.

- *For standards and guidelines for institutions, such as hospital maternity departments, see Annex 5.2, Examples of criteria for mother-friendly care*
- *To review standards for curricula, or session plans for medical, nursing and nutrition courses see the WHO Education Checklist (Annex 5.1)*

Criteria for assessment	√ Check ONE that applies in each question		
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country[16] indicates that IYCF curricula or session plans are adequate/ inadequate (See Annex 5.1)	20 out of 25 content/ skills are included • 2	5-20 out of 25 content/ skills are included ✔ 1	Fewer than 5 content/skills are included ☐ 0
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been disseminated to all facilities and personnel providing maternity care. (See Annex 5.2)	Disseminate to> 50% facilities ☐ 2	Disseminate to 20-50% facilities ☐ 1	No guideline, or disseminated to < 20% facilities ✔ 0
5.3) There are in-service training programmes available providing knowledge and skills related to IYCF for relevant health/nutrition care providers.[17]	Available for all relevant workers ☐ 2	Limited availability ✔ 1	Not available ☐ 0
5.4) Health workers are trained in their responsibilities under the Code and national regulations, throughout the country.	Throughout the country ☐ 1	Partial coverage ☐ 0.5	Not trained ✔ 0
5.5) Infant and young child feeding information and skills are integrated, as appropriate, into training programmes not covered in 5.1 but where the care providers may have some contact with families with infants and young children. (Training programmes such as diarrhea control, HIV, NCDs, Women's Health etc.)	Integrated in > 2 training programmes ☐ 1	1-2 Training programmes ☐ 0.5	Not integrated ✔ 0
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.[18]	Throughout the country ☐ 1	Partial Coverage • 0.5	Not provided ✔ 0
5.7) Health policies provide for mothers and babies to stay together when one of them is hospitalised.	Provision for staying together for both ☐ 1	Provision for only one of them: mothers or babies ✔ 0.5	No provision ☐ 0 0
Total Score	**2.5/10**		

16. 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.

17. The types of health providers that should receive training may vary from country to country but should include providers who care for mothers and children in fields such as pediatrics, OB-Gynae, nursing, midwifery, nutrition, and public health.

18. Training programmes can be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction. Partial could mean more than 1 provinces covered.

Information Sources Used

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Australian Pharmacy Council Ltd, Accreditation Standards for Pharmacy Programs in Australia and New Zealand, 2020.

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Australian Medical Council Ltd, Accreditation Standards for Primary Medical Education Providers and their Program of Study and Graduate Outcome Statements, 2012

The Royal Australian College of Physicians, Basic Training Program Curriculum, Paediatrics and Child Health, 2013

The Royal Australian College of Physicians, General Paediatrics Advanced Training Curriculum, 2013

Conclusions

The score for this indicator remains unchanged from the 2018 Australia WBTI assessment.

One of the ten objectives of the Australian National Breastfeeding Strategy (ANBS) in 2019 was to 'increase the proportion of health professionals who receive adequate, evidence-based breastfeeding education and training that is free from commercial influence,' and Action Area 2.2 of the Strategy on Health professionals' education and training foreshadowed two detailed actions. Health professional associations, universities, and the commonwealth and states and territory governments were given responsibility to:

- Provide and support access to education and training in breastfeeding for all health professionals who care for women and children, by supporting development of breastfeeding content in undergraduate and graduate education and training for health professionals, and by considering development of a core curriculum, skills matrix, and national competency standards.
- Support development of clinical care tools for primary health care services through promoting development of evidence-based breastfeeding guidelines/resources and clinical care tools for health professionals caring for women and children.

The ANBS also called for the Infant Feeding Guidelines for Health Workers and the Australian Dietary Guidelines to be updated and promoted to health professionals and the public, to address problems of inaccurate nutrition and growth advice from health professionals and confusion caused by the ASCIA guidelines on Infant Feeding and Allergy Prevention. There needed to be accurate, authoritative, and evidence-based messaging around the introduction of complementary foods from around 6 months, that was free from commercial influence.

There is no evidence of action being taken to initiate or coordinate the implementation of these policies.

Midwives remain the only health professionals in Australia who are required for their registration to undertake any learning about breastfeeding and breastfeeding support in their everyday practice and in their pre-registration education.

Concerningly, the Australian National Midwifery Practice Standards were reviewed and revised in 2018 and the responsibilities of the profession to "protect, promote and support breastfeeding" were not maintained. Instead, midwives are now required in Practice Standard 1 to support "women's wellbeing by providing safe, quality midwifery health care using the best available evidence and resources, with the principles of primary health care and cultural safety as foundations for practice" (**NMBA, 2018**). The accreditation standards for education of all midwives in Australia were also reviewed and revised since the last assessment and were published in 2021 (**ANMAC, 2021**). Under 3.13 -part B about postnatal care experience, midwifery students are required to undertake "Experiences in supporting women to feed

their babies and in promoting breastfeeding in accordance with best-practice principles advocated by the Baby Friendly Health Initiative". This implies that accredited university courses must provide theoretical input for students in this area as well, but there is no comment here about the kind of detail that is required in curricula, or that Infant and Young Child Feeding principles be utilized.

The course accreditation requirements for Australian pre-registration nursing students were also examined (**NMBA, 2019**). As expected, there is no specific mention of requirements for pre-registration nursing students to receive basic breastfeeding information. Standard 3.5-part B does require that "there is integrated knowledge of care across the lifespan and across contexts of nursing practice" (NMBA, 2019). This offers potential to argue for nursing curricula to include breastfeeding content to meet the requirements of this standard.

For this assessment an examination of professional and accreditation standards for undergraduate medical and pharmacy programs was undertaken (Australian Medical Council, 2012; Australian Pharmacy Council Ltd, 2020). There are no specific stated requirements for course content about breastfeeding or human lactation in either of these accreditation guides. Accreditation standards for midwifery pre-registration education programs were also reviewed (ANMAC, 2021). Student midwives undertake postnatal and intrapartum care that includes an informed understanding of support for the breastfeeding dyad. The specialist health professional training programs for both obstetrics and paediatrics were reviewed with no significant changes found since the last report (RANZCOG, 2022; RACP, 2013). Both areas of specialisation require some knowledge of how to support breastfeeding and to manage breastfeeding problems. In addition, there remains no acknowledgement or mention of mother-friendly principles in any professional midwifery or obstetric sources or professional college statements. Where guidelines or a commitment to protecting mother and baby closeness during hospitalisation have existed, these have been challenging to uphold during the COVID-19 pandemic, particularly in maternity, neonatal, and paediatric settings.

Gaps

1. There has been little change in the state of play for Australian health professionals receiving pre-registration education about breastfeeding and breastfeeding support. Midwives remain the only health professionals with stated pre-registration requirements for breastfeeding support knowledge and clinical experience. As indicated above, accreditation standards for nursing and medicine training both include principles of health promotion and health advocacy which could be useful in arguing the need for inclusion of basic breastfeeding education in their respective pre-registration curricula.
2. The Australian National Breastfeeding Strategy (2019) highlights the education and training of health professionals as an action area and recommends the introduction of pre-practice education and professional development education about breastfeeding for all clinicians working with women and children. The Strategy also states that clinical guidelines for breastfeeding should be developed for all health professionals providing care for women and children. There is no indication of action as yet.
3. Women comprise around three quarters of the health workforce in Australia, around half of general obstetricians and gynecologists, and more than 98% of midwives. **The WHO in its 2019 report on gender inequalities in the health workforce** argues, that care was typically *Delivered by women, led by men*. Those who deliver most of the care in all settings face barriers at work not faced by their male colleagues. The gender dynamics of the health workforce not only undermines women's own well-being and livelihoods, but it also constrains progress on gender equality, and negatively impacts health systems and the delivery of quality care. Such gendered power systems are likely to influence the low policy priority and funding allocation given to addressing health professional education and training gaps and affecting the quality of maternity care in Australia.

4. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) published their Gender Equity and Diversity policy in 2021: commitment to 40% male 40% female and 20% "flexible" leadership profile in the College. **Gender-Equity-and-Diversity-Policy.pdf (ranzcog.edu.au)**
5. In one review of the OBGYN workforce (Angstmann, Woods et al. 2019), the authors calculated that 83% of female OBGYN trainees were female. While the future would appear to be female, this does not guarantee a feminist approach to medical management of pregnancy, childbirth, and infant feeding.
6. We found no sign of adoption of mother-friendly principles in Australia.

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Angstmann, M., et al. (2019). "Gender equity in obstetrics and gynaecology – where are we heading?" Australian and New Zealand Journal of Obstetrics and Gynaecology 59(2): 177-180.

Recommendations

Proactive approaches to creating change in health professional education on lactation and breastfeeding are urgently needed.

1. Action should be taken to initiate or coordinate the implementation of the ANBS policies which have been endorsed by all Australian governments. In particular, the education and training of health professionals needs to be initiated as per Action Area 2.2.
2. Participating in the regular community consultation processes for each discipline or college in the national health professional registration authority (AHPRA) is recommended for advocacy to progress ANBS actions relevant to this indicator.
3. Writing to and meeting with individual health professional organisations and passionate individuals to discuss ways to enact the programs and practice changes included in this indicator is called for.
4. Ministers of health and education should be encouraged to actively support the need for appropriate training for health professionals in this area and hold responsibility for actioning the ANBS. It is reasonable to work towards changes for pre-registration, and practising, specialist health professionals, concurrently.

Indicator 6: Counselling Services for Pregnant and Breastfeeding Mothers

Background

Key interventions to improve feeding practices include implementing "*Ten Steps*" of the BFHI, skilled counselling of women and community mobilisation. Removing barriers to optimal practices, that women face at home, hospitals or at workplace is the key to success.

Counselling to improve breastfeeding and infant and young child feeding practices and related support for women is essential for success in optimal breastfeeding practices. Support by peers in community and mothers support groups have shown positive results. The quality of interaction and counseling are critical issues.

Women need counselling services and support during pregnancy, at birth and postpartum. At the community level appropriate support from community volunteers or health workers under the health systems can offer and ensure sustained support to mothers. Community support workers must have adequate training to acquire the optimal knowledge and skills for giving support. It is necessary to have appropriate counseling in the community to motivate and increase a mother's confidence to breastfeed and provide home based complementary feeding. Sometimes, the mother support group (MSG) composed of a few successful mothers and others of the same community is helpful and so is the support from health professionals and health care workers.

Another important area is to consider the people living in remote areas where services are difficult to provide and receive. There is also a need to provide adequate information to support maternal nutrition without which IYCF action by mothers may be suboptimal. The principle of "feed the mother so she can feed the child" is an important policy principle.

The activities in these contexts include woman-to-woman support, individual or group counselling, home visits or other locally relevant support measures and activities that ensure woman have access to adequate, supportive, and respectful information, assistance, and counselling services for improving

breastfeeding and optimal infant and young child feeding practices. Provision of counselling services on breastfeeding and infant and young child feeding within the health care system needs a review.

What has happened since the 2018 WBTi Australia report?

The Australian National Breastfeeding Strategy: 2019 and beyond (ANBS)

In 2019, after the publication of the 2018 WBT*i* Australia assessment, the Australian National Breastfeeding Strategy: 2019 and beyond[1] was finalised and released.

The following ANBS Priorities and Action areas highlight what the Australian Government Department of Health has identified as currently deficient and in need of improvement including: education of health professionals, antenatal education of mothers and postnatal access to breastfeeding support, education, and counselling.

2.2 Action area—Health professionals' education and training

Action	Detail	Responsibility
Provide and support access to education and training in breastfeeding for all health professionals who care for women and children	• Support the development of breastfeeding content in undergraduate and graduate education and training for health professionals. • Consider the development of a core curriculum, skills matrix, and national competency standards.	Health professional associations Universities Commonwealth and all states and territories
Support the development of clinical care tools for primary health care services	• Promote the development of evidence-based breastfeeding guidelines/resources and clinical care tools for health professionals caring for women and children.	Commonwealth and all states and territories

3.1 Action area—Universal breastfeeding education, support, and information services

Action	Detail	Responsibility
• Provide mothers with antenatal education about the significance of breastfeeding for their babies and themselves	• Empower mothers to reach their breastfeeding goals through provision of evidence-based information and breastfeeding education classes.	Health services Health professionals

Action	Detail	Responsibility
Provide breastfeeding education for a mother's primary support network, including fathers/ partners and grandmothers	• Encourage fathers/partners, grandmothers, and other carers to attend breastfeeding education classes. • Improve access to interactive tools (phone-based applications, web-based tools etc.) that support breastfeeding.	Health services Health professionals
Strengthen programs that provide mother-to-mother support and peer counselling	• Fund the National Breastfeeding Helpline to provide breastfeeding education and peer counselling. • Improve access to interactive tools (phone-based applications, web-based tools etc.) that support breastfeeding.	Commonwealth and all states and territories
Enhance postnatal support for breastfeeding	• Support the implementation of postnatal care guidelines that include sustained lactation support through the National Strategic Approach to Maternity Services. • Ensure that skilled breastfeeding support (peer or professional) is proactively offered to women who want to breastfeed. • Continue funding for perinatal mental health programs such as **MumSpace**. • Develop and implement strategies to address postpartum depression.	Commonwealth and all states and territories Health services
Support Primary Health Networks to promote breastfeeding	• As part of broader prevention activities, support Primary Health Networks to protect, promote and support breastfeeding.	Commonwealth Primary Health Networks

The Australian National Breastfeeding Strategy: 2019 and beyond was endorsed by all Health Ministers, Federal, State and Territory in 2019[2].

In 2019, the Australian Breastfeeding Association (ABA) was funded for a further 4 years to run and staff the National Breastfeeding Helpline. The National Breastfeeding Helpline forms an integral part of the ANBS. Additionally, funding was granted for IT infrastructure, running a national Registered Training Organisation which trains ABA volunteers, and supporting a volunteer workforce[3].

In the ANBS there is an Action area: *Universal breastfeeding education, support and information services* which states the National Breastfeeding Helpline should be funded to provide breastfeeding education and peer counselling. However, the National Breastfeeding Helpline funding currently provided is not guaranteed and must be applied for, every four years, through an open, competitive grant system. This makes it difficult for ABA to plan for service continuity and creates an atmosphere of uncertainty within the Association.

The COVID-19 pandemic raised challenges to mother-to-mother breastfeeding support. In response to the needs of expectant parents and breastfeeding women and the pandemic conditions, including lockdowns:

- ABA developed an online alternative to its well-established face-to-face Breastfeeding Education Classes (BECs) – Breastfeeding Education Live sessions (BELs)[4]. BELs were available from May 2020, and, to date, more than 800 pregnant women and their partners/support people have attended ABA BELs.
- ABA local breastfeeding support groups offer mothers an online alternative to their face-to-face group meetings and continue to support breastfeeding mothers around Australia[4].

Context: Breastfeeding is a human right

Women have the right an enabling environment to breastfeed[5] and infants and young children have the right to be breastfed[6]. Breastfeeding and breastmilk are the biological norm for babies and young children and have been identified by several international conventions and agreements as a fundamental human right.

By becoming a party to the United Nations *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW)[7], Australia committed to take all appropriate measures, including introducing legislation and temporary special measures, so that women could enjoy all their human rights and fundamental freedoms. Article 12 of (CEDAW) requires that women have equal access to health services in relation to pregnancy and postnatal care and that mothers have the right to make decisions about their own lives and their children's (including infant and young child feeding decisions).

Pregnancy, birth, and lactation are a part of the same continuum, and breastfeeding is a biological process that has reproductive health implications and reproductive rights associated with it. According to the 1994 Cairo Programme of Action on Population and Development consensus, *'Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health'* [8]. Short duration of breastfeeding harms women's reproductive health by exposing them to increased rates of maternal depletion, anaemia, closely spaced births, ovarian and breast cancers[5].

Obligations of the United Nations (UN) *Convention on the Rights of the Child* Article [249] include: the child's right to the highest attainable standards of health by providing mothers with appropriate antenatal and postnatal health care and educating parents about child health and nutrition specifically, the

advantages of breastfeeding. As a signatory to the Convention, Australia is obliged to ensure a healthcare system and society that is conducive for women to breastfeed their babies and young children.

A 2016 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[10] supported increased efforts to protect, promote and support breastfeeding:

Breastfeeding is a human rights issue for both the child and the mother. 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.***

We 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. States should take all necessary measures to protect, promote, and support breastfeeding…

…States should foster women's informed decision-making, including through access to objective and accurate information on the benefits of breastfeeding…[10]

Australian mothers have the right to receive information, education, and counselling, both antenatally and postnatally, to understand the importance of breastfeeding to their child's health and their own health. They also have the right to be supported in both their intent to breastfeed and their efforts to breastfeed their infants and young children by all health workers they encounter during pregnancy, birth and postnatally.

Criteria of assessment	**√ Check ONE that applies in each question**		
6.1) Pregnant women receive counselling services for breastfeeding during ANC.	>90% ✔ 2	50-89% 1	<50% 0
6.2) Women receive counselling and support for initiation breastfeeding and skin to contact within an hour birth.	>90% 2	50-89% ✔ 1	<50% 0
6.3) Women receive post-natal counselling for exclusive breastfeeding at hospital or home.	>90% 2	50-89% ✔ 1	<50% 0
6.4) Women/families receive breastfeeding and infant and young child feeding counselling at community level.	>90% 2	50-89% ✔ 1	<50% 0
6.5) Community-based health workers are trained in counselling skills for infant and young child feeding.	>50% 2	<50% ✔ 1	No Training 0
Total Score:	**6/10**		

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6.3) Women receive post-natal counselling for exclusive breastfeeding at hospital or home.

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Conclusions
2023 WBTi Australia assessment

Counselling services for breastfeeding during antenatal care

Antenatal care is provided in public hospital care, shared maternity care or private maternity care. In 2018, almost all Australian women (94%) attended 5 or more antenatal visits during pregnancy and 88% of Aboriginal and/or Torres Strait Islander women attended at least 5 or more antenatal visits[11].

The Australian Government Department of Health developed the *Clinical Practice Guidelines Pregnancy Care* (*Pregnancy Care Guidelines*) [12] and breastfeeding should be discussed during antenatal visits, but the uptake and implementation of the *Pregnancy Care Guidelines* is not being monitored and evaluated. Specifically, whether the *Pregnancy Care Guidelines* are having a measurable effect on mothers' intentions to breastfeed, breastfeeding initiation and early exclusive breastfeeding rates, particularly in priority groups, are not being monitored and evaluated.

Childbirth education classes, which include breastfeeding information, are run locally in hospitals and by private childbirth education organisations, although there are no national training standards for childbirth educators. The Australian Breastfeeding Association offers Breastfeeding Education Classes both face-to-face and online that are available to expectant mothers, their partners and support people across Australia.

Since 2009, the Australian Government[13] has managed the Australian Nurse–Family Partnership Program (ANFPP)[14] which supports Aboriginal or Torres Strait Islander women or women whose partners are Aboriginal or Torres Strait Islander, and who are pregnant with their first baby, to become the 'best mum possible'. Nurses make home visits to provide guidance during early pregnancy, the baby's infancy and into toddlerhood. The ANFPP aims to improve child health and development by working with parents to support them to be the best parents possible[15].

Nationally, 95% of babies born to clients of the ANFPP were initially breastfed, and at one of the three sites delivering services in 2013-14, 68% of infants for clients of the programme were still being breastfed at 6 months of age.[16]

The ANFPP operates in four States and two Territories across Australia. [17]. The program appears to be somewhat successful in terms of breastfeeding rates, but no recent data regarding breastfeeding rates could be found and coverage is not 'universal'.

In the absence of information about whether pregnant women are receiving antenatal counselling about breastfeeding, what we do know is the percentage of Australian mothers initiating breastfeeding:

- The 2010 Australian National Infant Feeding Survey[18] found that 96% of mothers initiated breastfeeding.
- The National Health Survey (2017-18)[19] found that 93% of children aged 0 to 3 years had received breastmilk, that is, breastfeeding had been initiated.

Almost all Australian mothers initiate breastfeeding indicating they understand the importance of breastfeeding and likely received some counselling for breastfeeding antenatally. They want to breastfeed but need support to do so.

Counselling and support for initiation of breastfeeding and skin-to-skin contact within an hour of birth

These data are still not collected at the national level, even though the Australian government was alerted in 2018, after the first WBTiAUS assessment, that 'early initiation of breastfeeding' is important to the health and wellbeing of babies after birth and for ongoing breastfeeding success. The planned *National Breastfeeding Report Card* will collect data on the: *Proportion of babies put to the breast within one hour of birth with an annual target of 95%.*[20]

The only national data we have was collected as part of the 2010 Australian National Infant Feeding Survey[18] and the evidence looked promising. In 2010, three in four mothers/carers reported that their child was given the opportunity to independently find the mother's breast by being placed in skin-to-skin contact with them. When mothers, whose children were placed skin-to-skin, were asked how soon after birth this happened, 73% reported it occurred immediately after birth or within a few minutes, and 92% within an hour.

In contrast, a 2019 survey of Australian mothers by researchers in QLD[21] who had a full understanding of the sequence of events post birth that promote breastfeeding — immediate, uninterrupted skin-to-skin contact for at least 60 minutes and breastfeeding in the birth setting (pronuturance) — found that only 21.8% of mothers surveyed experienced pronuturance. Pronuturance was less likely after a caesarean birth* with only 2.3% experienced pronuturance and after induction of labour* (14.9%). Low rates of pronuturance were due to lack of skin-to-skin information provided in the antenatal period; babies being wrapped; women wearing clothing and non-urgent caregiver interruptions including weighing the baby or facilitating the mother to shower.

* In 2019, 36% of Australian mothers had caesareans and 35% of labours were induced[22]

It appears that, at least recently, many Australian women aren't receiving counselling and support for initiation of breastfeeding and skin-to-skin contact within an hour after birth, and this is exacerbated by the high numbers of induced labours and caesarean births.

Post-natal counselling for exclusive breastfeeding at hospital or home

There is no national data collected about exclusive breastfeeding rates in hospital or once the mother has returned home. In Australia, only 26% of hospitals and maternity services are BFHI-accredited which means that 74% of hospitals and maternity services have not made a formal commitment to support mothers to (exclusively) breastfeed their babies in line with the evidence-based *Ten Steps to Successful Breastfeeding*[23].

The effects of this lack of health system or institutional level commitment to counsel for and support exclusive breastfeeding in hospital is seen in the perinatal statistics of both New South Wales (NSW) and

Victoria. In NSW in 2019, the percentage of infants fully breastfed at the time of discharge from hospital was 71.1% (a decrease from 78.9% in 2015)[24]. So, almost 30% of infants born in NSW hospital in 2019 were supplemented with infant formula despite short length of stays, on average just 2.8 days. In Victoria in 2018, the percentage of mothers initiating breastfeeding was 95.7%, but 29.4% of 'term breastfed babies' were given infant formula in hospital. Overall, private hospitals had a higher rate of use of infant formula compared with public hospitals, 37.8% and 27.0% respectively ($p < 0.001$)[25].

Australia has many models of maternity care, most of which provide postnatal care in the home to some degree[26], often provided by the midwives in the hospital where the infant was born. Smaller numbers of women will have access to maternity care provided by small teams of midwives, familiar to them, who will continue care at home. There is strong Australian evidence that midwifery-led continuity of care has favourable outcomes, but breastfeeding outcomes were not measured[27].

Since approximately 30% of infants leave hospital having been given infant formula, and as most mothers will be supported at home by hospital midwives, it is unlikely that exclusive breastfeeding rates at home will be higher than those documented in hospital.

Community counselling for breastfeeding and infant and young child feeding

While maternity care in Australia includes postnatal care, there are still no national evidence-based guidelines or standards for postnatal care[#], despite the ANBS identifying in 2019 that postnatal care guidelines should be implemented.

[#]In 2019, the authors of the Australian Maternity Services Strategy called for national evidence-based guidelines for postnatal care to be developed and implemented[28].

The Australian Breastfeeding Association has a network of local groups that meet face-to-face to support mothers to breastfeed. More than 140 ABA local groups are in every state in Australia and are run by trained breastfeeding counsellors and educators[29]. Mothers can attend meetings for free but are encouraged to become ABA members which has a cost associated with it[30].

Until 2018, BFHI-accredited hospitals were required to foster the establishment of breastfeeding support and pass on details of local breastfeeding support groups to mothers. This requirement was weakened in 2018, so that now BFHI-accredited hospitals are only required to '*Coordinate discharge so that parents and their infants have timely access to ongoing support and care*'[31]. This requirement doesn't explicitly state that a mother should be referred on to the local breastfeeding support group in their community and a referral to a Maternal Child and Family Health nurse (who may or may not have qualifications in breastfeeding support) may appear to satisfy this requirement.

There is a cost-free 24-hour, 7-day-a-week National Breastfeeding Helpline[32], currently staffed by ABA trained breastfeeding counsellors, available to all mothers with access to a telephone and accessible to the hearing impaired and those requiring translation into languages other than English. For those with limited access to a telephone or those who prefer alternative communication methods such as a web-based 'chat' service, social media or face-to-face counselling, ABA provides a web-based *LiveChat* service[33] and face-to-face support through ABA local groups[29].

In the ANBS there is an Action area: *Universal breastfeeding education, support and information services* which states the National Breastfeeding Helpline should be funded to provide breastfeeding education and peer counselling[1]. The National Breastfeeding Helpline is operated 24/7 by volunteers who have extensive experience in breastfeeding and nationally recognised qualifications in breastfeeding counselling. However, the National Breastfeeding Helpline funding currently provided to meet the financial expenses of operating the Helpline is not guaranteed and must be applied for, every four years, through an open, competitive

grant system. This makes it difficult for ABA to plan for service continuity and creates an atmosphere of uncertainty within the Association. The competitive funding model and low level of funding to cover basic infrastructure of the National Breastfeeding Helpline also fails to recognise and sustain the substantial cultural capital represented by women's own knowledge and experience of breastfeeding.

Specialised support from an International Board-Certified Lactation Consultant (IBCLC) is available privately[34]. Some women may be able to access this support for free through the hospital or outpatient clinic where they gave birth for a limited time[35]. But such services are limited in scope and availability and private services are costly. Again, this is a lack of recognition of the value of women's knowledge on breastfeeding.

Community-based health workers are trained in counselling skills for infant and young child feeding

Step 10 of the *WHO Tens Steps to Successful Breastfeeding* states: Coordinate discharge so that parents and their infants have timely access to ongoing [breastfeeding] support and care.

In the community, breastfeeding counsellors who volunteer with the Australian Breastfeeding Association are specialists in breastfeeding information and support. They are trained in counselling skills for breastfeeding, infant and young child feeding and the timely introduction of high-quality family foods (Certificate IV Breastfeeding Education, a nationally accredited qualification)[32]. ABA breastfeeding counsellors also participate in ongoing professional development. A smaller number of people volunteer as a Leader with La Leche League in Australia[36].

Maternal Child and Family Health (MCaFH) nurses around Australia do provide breastfeeding assessment and infant and young child feeding support. MCaFH nurses are registered nurses with postgraduate qualifications in MCaFH nursing and *'may have additional breastfeeding…qualifications'*[37].

Remote areas which depend on First Nations health workers for maternal and infant health support face a knowledge gap because training on infant and young child feeding is not required for the Certificate III in *Aboriginal and/or Torres Strait Islander Primary Health Care* (HLT30113). However, it is covered in an elective unit of competency in the Certificate IV and Diploma*: Monitor early childhood growth and development* (HLTAHW039).

The effect of the COVID -19 pandemic on counselling services for the pregnant women and breastfeeding mothers

Antenatal education

During the COVID-19 pandemic in Australia, maternity and maternal and family health services for pregnant women and mothers of very young babies have been severely disrupted. The substantial changes in care delivery for pregnant and postpartum women during the pandemic reduced woman-centred care and, in most cases, care was perceived as impersonal and incomplete[38].

An Australian study undertaken in the first wave of the pandemic found that women were concerned and distressed by the impact of COVID-19 on their maternity care and support to breastfeed, particularly the perceived and real lack of access to health care[39].

During the first wave of the pandemic, Australian women reported they felt distressed and alone due to rapid changes to their maternity care. Limited face-to-face contact with health practitioners and altered models of care often required women to accommodate significant changes and to coordinate their own care[40].

Hospital-based services such as face-to-face childbirth education classes stopped, and health services were slow to offer pregnant women online alternatives. Only a third of women received antenatal education (947, 29%), mostly face-to-face and via video[40].

In contrast, the Australian Breastfeeding Association was able to quickly develop an online alternative to its well-established Breastfeeding Education Classes (BECs) – Breastfeeding Education Live sessions (BELs). BELs were available from May 2020, and, to date, more than 800 pregnant women and their partners/support people have attended ABA BELs[4].

Counselling and support for initiation of breastfeeding and skin-to-skin contact within an hour birth

We have evidence that during the pandemic breastfeeding rates in hospitals in the Australian state of Victoria were not being reported, although they may still have been collected[41].

Postnatal counselling for exclusive breastfeeding at hospital or home

MCaFH nurse services were altered, and pregnant women and mothers reported receiving very little support during pregnancy and when they went home which impacted on their experience of breastfeeding support: face-to-face appointments quickly changed to telehealth appointments and face-to-face visits were limited to 15 minutes[42].

Community counselling for breastfeeding and infant and young child feeding

Australian health services were slow to offer mothers alternatives to the usual support groups offered via MCaFH nursing services (face-to-face mother's groups). In contrast, ABA local breastfeeding support groups quickly offered mothers online alternatives to their face-to-face group meetings and continued to support breastfeeding mothers around Australia.[4]

The numbers of calls to the cost-free 24-hour, 7-day-a-week National Breastfeeding Helpline, staffed by ABA-trained breastfeeding counsellors increased by 12% during the first wave of the pandemic. At the beginning of the COVID-19 pandemic, it quickly became apparent that mothers were calling the National Breastfeeding Helpline because their usual supports and services were not available, or they were too concerned and anxious about exposure to the SARS-CoV-2 virus to leave their homes[4].

The continued, uninterrupted provision of the National Breastfeeding Helpline clearly filled the gap when local, face-to-face services were delayed or cancelled, or when mothers were fearful of exposure to the SARS-CoV-2 virus. The ABA volunteers continued to do their volunteer work even though they were experiencing the challenges of the COVID-19 pandemic themselves.

Community-based health workers are trained in counselling skills for infant and young child feeding

ABA trainee breastfeeding counsellors continued their studies throughout 2020 and 2021, even though they were experiencing the challenges of the COVID-19 pandemic themselves.

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 in Australia. The National Breastfeeding Helpline staffed by ABA volunteers providing mother-to-mother support is not fully funded by the Australian Government despite it being

recognised as a vital service in the ANBS. The current 40% shortfall in funding will not cover the increased costs of service delivery and the current high rates of inflation.

2. There is no current requirement for pre-service training in breastfeeding or infant and young child feeding principles for health professionals/workers and community workers who will be caring for breastfeeding women and/or infants in their professional role including Maternal and Child Family Health Nurses and First Nations health workers.
3. 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.
4. Baby Friendly Health Initiative (BFHI) accreditation of hospitals and maternity facilities is low and inadequate, leading to the exposure of vast numbers of Australian babies to infant formula in hospital and a lack of integration between health professionals and community across Australia. BFHI accreditation of community health facilities are virtually non-existent.

Recommendations

1. The crucial contribution of women's skills, knowledge, and experience of mother-to-mother support for breastfeeding and lactation should be recognised, endorsed and adequately resourced including by health policymakers and health systems such as through health policies and via *Step 10* of BFHI. Full funding of the National Breastfeeding Helpline, staffed by ABA volunteers providing mother-to-mother support, would be one way for the government to recognise women's unpaid contribution to Australian health services.
2. Fund and implement the ANBS, importantly, the Priorities and Action areas that the Australian Government Department of Health has identified as currently deficient and in need of improvement including: education of health professionals, antenatal education of mothers and postnatal access to breastfeeding support, education, and counselling.
3. Educate hospital/maternity facility-based health professionals about the importance of skin-to-skin, early breastfeeding initiation, and exclusive breastfeeding in hospital and at home. See Indicator 5: Health and Nutrition Care Systems (in support of breastfeeding & IYCF) for recommendations.
4. Require all health professionals/workers and 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. Acknowledge that the Australian Breastfeeding Association currently provides crucial breastfeeding education and peer counselling for pregnant women and breastfeeding mothers and the Association should receive continuous funding to staff the National Breastfeeding Helpline including the training of breastfeeding counsellors and educators (as acknowledged in the ANBS Action area: *Universal breastfeeding education, support and information services* which states the National Breastfeeding Helpline should be funded to provide breastfeeding education and peer counselling).
6. Integrate national health service delivery to include both professional and volunteer breastfeeding support, that meets local needs, and provides clear access to specialised support when required.
7. Make BFHI accreditation mandatory for hospitals, maternity facilities, and community health facilities.
8. Unless and until BFHI accreditation is mandated and accredited, all hospitals and maternity facilities should refer mothers to Australian Breastfeeding Association – the only health and community workers actually and specifically trained to support mothers to breastfeed.

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Indicator 7: Accurate and Unbiased Information Support

Background:

Women and caregivers have the right to accurate, unbiased information needed to make informed decisions about breastfeeding. Information Education and Communication (IEC) strategies which are free from commercial influence are important aspects of a comprehensive programme to support women in improved infant and young child feeding practices and protect their own and their child's health.

Information strategies are more likely to lead to positive behavior change if they are supported by counselling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. IEC strategies are comprehensive when they ensure that all information channels convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels.

The World Health Assembly has adopted eight resolutions to safeguard infant and young child feeding practices from commercial interests and to support the breastfeeding rights of women and children. When programs take place within a commercial context (influenced or funded by the infant feeding industry), they can undermine the effectiveness of any campaign and lead to unwise decision making. Thus, it is important to keep the IEC free from any conflicts of interest. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal (counseling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community. Since counselling is dealt with in Indicator 6, this indicator 7 is focused on the type and frequency of information.

Criteria for assessment and scoring

The table shows the six criteria for assessing countries and the score applied. The maximum total score for the indicator is 10.

Criteria for assessment	Check that applies	
7.1) There is a national IEC strategy for improving infant and young child feeding.	YES 2	NO ✔ 0
7.2) Messages are communicated to people through different channels and in local context.	YES 1	No ✔ 0
7.3) IEC strategy, programs and campaigns like WBW are free from commercial influence.	YES 1	No ✔ 0
7.4) Breastfeeding/IYCF IEC materials and messages are objective, consistent and in line with national and/or international recommendations.	YES 2	No ✔ 0
7.5) IEC programmes (e.g., World Breastfeeding Week) that include infant and young child feeding are being implemented at national and local level.	YES 2	No ✔ 0
7.6) IEC materials/messages include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF). [20]	YES ✔ 2	No 0
Total Score:	**2/10**	

20. 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. This is to minimize health hazards. Parents 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.

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Comments

7.1 The updated **Australian National Breastfeeding Strategy (ANBS): 2019 and Beyond**[3] includes education and awareness, including antenatal education as the 10th action area in the implementation plan.

The strategy noted:

- There is a need for greater ante- and post-natal education and support
- The importance of research, health professional training, policy making and messaging on the introduction of complementary foods that is free from commercial influence

However, to date, the ANBS has not been funded and actioned.

7.2 National, State and Territory Government websites[2, 6] respond to the search word 'breastfeeding' by providing a varied range of information, from information in line with International IYCF recommendations, to listed links to supportive websites[1, 7]

The Australian Breastfeeding Association, a volunteer-base, mother-to-mother support organisation, provides education and information resources via its own website. Links to the ABA are provided on Government websites, Nationally and in other Jurisdictions.[1]

The Raising Children's Network[7] is a social media-based online information resource for parents which is funded by the Government. This provides some breastfeeding information.

7.3 There is no IEC strategy being implemented for IYCF programs and campaigns like WBW. Australia expects the PIF industry to be responsible with their commercial influence,[4] which is not consistent with national or international IYCF recommendations.

7.4 Using the strategy that seekers of breastfeeding/IYCF information are likely to start their search on the Internet, a random Internet search was conducted using search words applicable to a consumer, and to a health professional.

The search word 'breastfeeding' guided the seeker to reliable NGO and GO websites[1, 2, 6] with

information in line with national and/or international recommendations,[1, 2, 3, 5, 8, 9, 10] however links to commercial, and less reliable information websites were easily accessed by further scrolling.

Search words like 'how to breastfeed', guided the seeker to NGO's, GO's,[1, 2, 6] as well as commercial and less reliable information websites, providing information that was not objective, or in line with national and/or international recommendations.[1, 2, 3, 5, 8, 9, 10]

7.5 There is no strategy being implemented for IEC programs that include IYCF at a national and local level.

7.6 Evidenced based, IEC materials/ messages that are available through reliable, or government supported/owned sources, include some information on the risks of artificial feeding in line with WHO/ FAO Guidelines on preparation and handling of PIF[5, 6, 7]

Conclusions

1. Australia has a National Breastfeeding Strategy[3], that acknowledges the need for IEC to improve action on IYCF. However, to date, the ANBS[3] remains unfunded and unactioned. By contrast, the Australian infant food industry has a large marketing budget to support its sales of around a billion dollars a year, and the 'marketing' of breastfeeding is left to under-resourced NGOs and individual women.
2. Because women breastfeed for free, and it is not a profitmaking activity, no agency is 'marketing' breastfeeding through provision of suitable IEC strategies.
3. A national education campaign on IYCF (breastfeeding and complementary feeding) in Australia has not been prioritised by the Australian Government. Yet by their attendance and participation, senior government officials and Ministers publicly supported an industry conference promoting its role in information and education on infant and young child feeding.
4. The Australian Government does not provide an authoritative voice on IYCF (breastfeeding and complementary feeding). Therefore, women, their families, and health professionals, are exposed to the marketing activities of the PIF and associated industries when making important decisions about infant feeding. The Australian Government expects the PIF, and associated industries, to be voluntarily responsible with their commercial influence,[4] which is not consistent with National or International IYCF recommendations or reality.[1, 3, 5, 8, 9, 10]

Gaps

Despite having launched the Australian National Breastfeeding Strategy,[3] there is no national IEC strategy in Australia being implemented for improving infant and young child feeding (breastfeeding and complementary feeding).

1. There are no national IEC strategies in Australia being implemented to ensure that breastfeeding and complementary feeding materials are free from commercial influence and potential conflicts of interest.
2. There are no national IEC strategies in Australia being implemented to ensure that IYCF (breastfeeding and complementary feeding) information is comprehensive, consistent, appropriate, and accessible, to targeted audiences at national, community, family, and facility level.
3. Most of the quality and reliable breastfeeding information and education in Australia is provided by the Australian Breastfeeding Association, which depends on the unpaid labour of volunteer breastfeeding counsellors and educators.

Recommendations

1. The Australian Government should provide an authoritative and leading voice to support optimal IYCF (breastfeeding and complementary feeding), consistent with national and international IYCF recommendations on the public health importance of breastfeeding.[1, 3, 5, 8, 9, 10]
2. The Australian Government should as a priority commit funding in the 2023 budget to action the National Breastfeeding Strategy,[3] underpinned by a suitable funding agreement with state and territory jurisdictions, and including a National IYCF (breastfeeding and complementary feeding) IEC campaign. Australia has a very successful record in National Health Education campaigns, such as sun safety and smoking cessation campaigns, to draw on, and the Australian Government should fund the necessary research to inform effective public awareness and social marketing approaches.
3. A budget for social marketing of breastfeeding should be approved at a level that matches industry budgets for marketing commercial infant and young child food products in Australia
4. The National Health and Medical Research Council, Infant Feeding Guidelines: information for health workers[5] should be updated, and promoted to health professionals, to assist with IYCF (breastfeeding and complementary feeding) IEC strategies that are comprehensive, and convey concise, consistent, appropriate, action-oriented messages to families.

Indicator 8: Infant Feeding and HIV

Background

In 2010, WHO for the first-time recommended ARV drug interventions to prevent postnatal transmission of HIV through breastfeeding. WHO adopted a public health approach, recommending that national authorities should promote and support one feeding practice for all women living with HIV accessing care in the health facilities. WHO advised countries to choose a national approach for their ARV option for Prevention of Mother to Child Transmission (PMTCT) based on operational considerations. WHO also recommended that countries, while deciding upon the feeding option to be recommended, should avoid harm to infant feeding practices in the general population by counselling and support to mothers known to be HIV-infected. Health messages to the general population should be carefully delivered so as not to undermine recommended breastfeeding practices among the general population.[21]

The 2013 WHO consolidated guidelines on the use of ARV drugs recommended one of two approaches: (a) providing ART during pregnancy and counseling for breastfeeding to women living with HIV who are otherwise not eligible for ART (Option B); or (b) providing lifelong ART for all pregnant and breastfeeding mothers living with HIV regardless of their CD4 count or clinical stage (Option B+).[22]

In the past few years, a significant amount of new research evidence and programmatic experience on infant feeding in women living with HIV have emerged, which has led to a major shift in the policies on infant feeding counseling to the women and their families. Infant feeding recommendations to mothers living with HIV now aim for greater likelihood of HIV free survival of their children and not just prevention of transmission of HIV to the offspring. WHO has updated its infant feeding recommendations for HIV settings in 2016[23] which says, "practicing mixed feeding is not a reason to stop breastfeeding in the presence of Anti-retroviral (ARV) drugs", though all efforts should be made to

21. WHO: Rapid advice: infant feeding in the context of HIV, November 2009. Available at: **http://www.who.int/hiv/pub/paediatric/advice/en/**
22. World Health Organization (2013). Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Available at: **http://www.who.int/hiv/pub/guidelines/arv2013/en/**
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counsel mother to do exclusive breastfeeding." Updated guidelines also recommend "mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence."

Policies and programs to implement this effectively will require HIV Testing and Counselling (HTC) to be available and offered routinely to all mothers. Furthermore, support should be provided to ensure ARVs are made accessible to all breastfeeding mothers as per the national recommendations, with support and follow-up being provided to all mothers, regardless of HIV status.

In an emergency situation in countries that recommend exclusive breastfeeding with ARVs for mothers living with HIV, the recommendation should remain unchanged, even if ARVs are temporarily not available.

In countries that recommend formula feeding for mothers living with HIV, great care should be taken to ensure that Code-compliant infant formula is available only for those infants who need it. National authorities and/or the authority managing the emergency should establish whether the recommendation for formula feeding is still appropriate given the circumstances.

Health staff dealing with mothers and infants require preparation to face the circumstances they are likely to encounter in emergency situations, including supporting the women living with HIV.

What has happened since 2018

HIV policy internationally

WHO recommendations on HIV and infant feeding have not been updated since 2016.

In some high-income countries (Belgium, UK, USA) there have been calls for infant feeding policy to include options to breastfeed for mothers who are HIV positive and receive treatment, while others remain doubtful that the evidence is sufficient or the risks manageable: *'National or international recommendations for HIV-infected mothers who choose to breastfeed in industrialized countries remain unclear and discordant'* (Bansaccal et al 2020). Other emerging evidence supports the review in high-income countries of infant feeding recommendations for mothers who are HIV positive and under medical care and wish to breastfeed (Flynn et al 2018; Gross et al 2019; Moseholm and Weis 2020; Tuthill et al 2019; Waitt et al 2018; Weinberg and Nachman 2021; Yussuf et al 2022)

In the UK, updated 2020 guidelines from the British HIV Association (BHIVA) continue to recommend *'that women living with HIV feed their babies with formula milk'*, but include *'new data on breastfeeding and the emotional impact of not breastfeeding on women'* as follows:

> *9.4.2 Abstaining from breastfeeding can have financial and psychological repercussions for women, requiring support from the HIV MDT.*
>
> *9.4.4 Women who are virologically suppressed on cART with good adherence and who choose to breastfeed should be supported to do so but should be informed about the low risk of transmission of HIV through breastfeeding in this situation and the requirement for extra maternal and infant clinical monitoring.* (BHIVA, 2020).

HIV prevalence in Australia

Australia continues to have a low prevalence of HIV in the general population (0.14% in 2018) and in women, where in 2020 77 new notifications of HIV were female. Long term rates of HIV continue to decline. Highest risk groups for late diagnosis are women born overseas. Australia has high rates of

surveillance and testing and HIV testing of pregnant women is part of routine antenatal care. Pregnant women who tested positive for HIV have access to publicly funded care and treatment. For 2013-17, the rate of mother-to-child transmission (MCT) was 1%, with less than 4 infants per year who tested positive to HIV following perinatal exposure. (Kirby Institute 2018, 2020). In Australia, the total number of infants born per year is approximately 300,000.

- We note that during COVID-19, surveillance of HIV in 2020 was likely to be affected by 'changes to sexual behaviour, healthcare access and testing practices, and travel.' (Kirby Institute 2021).

HIV policy in Australia

There was no change to Australian Government policy at the national level for HIV and breastfeeding, which advises HIV-positive mothers to avoid breastfeeding.

1. The National Breastfeeding Strategy 2019 does not include breastfeeding by HIV-positive women (Action Area 3.2: 'Breastfeeding support for priority groups' – p.52) (COAG Health Council, 2019).
2. The NHMRC Infant Feeding Guidelines (2012) are under review. The current guidelines state:

   > *'At present, breastfeeding is contraindicated when a mother is known to be HIV positive (specialist advice is needed for each individual case).' (National Health and Medical Research Council, 2013)*

   This policy is upheld by the Australian Federation of AIDS Organisations (AFAO, 2022). However, in 2021 Australian NGOs developed guidelines for HIV positive mothers to breastfeed.

3. The National Association of People with HIV Australia (NAPWHA) and Positive Women Victoria developed guidance for women who are living with HIV and want to understand the issues around breastfeeding or formula feeding:

   > *'Although medical and health experts agree that formula feeding is still the safest option, breastfeeding is increasingly being recognised as an option that may be open to some women living with HIV in Australia' (NAPWHA 2021).*

   Recently, some Departments of Health at the State/Territory level have provided an option for women with HIV to breastfeed. For example, Queensland Health clinical guidelines state:

   > *'Formula feeding is recommended for all infants born to women with HIV infection.*
   > *In particular circumstances, where a woman is adherent to her ARV regimen and has maintained a suppressed viral load during pregnancy (or at least during the third trimester of pregnancy), and is fully engaged in her own care, consideration can be given (after consultation with Paediatric Infection Specialist) to supporting breast feeding for a maximum period of 6 months. Additional monthly testing of both mother and infant during breast feeding will be required. (Queensland Health, 2021).*

   Lack of global investment into research to determine whether *Undetectable equals Untransmitable* (U=U) for breastfeeding as it does for sexual intercourse continues to make country level policy development and decision making challenging and reflects an undervaluing of breastfeeding in high income countries.

Criteria for Assessment[24]	√ Check that apply	
8.1) The country has an updated policy on Infant feeding and HIV, which is in line with the international guidelines on infant and young child feeding and HIV[25].	YES 2	NO ✔ 0
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation.	YES 1	NO ✔ 0
8.3) Health staff and community workers of HIV programme have received training on HIV and infant feeding counselling in the past 5 years.	YES	NO ✔ 0
8.4) HIV Testing and Counselling (HTC)/ Provider- Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	YES ✔ 1	NO 0
8.5) Breastfeeding mothers living with HIV are provided ARVs in line with the national recommendations.	YES ✔ 1	NO 0
8.6) Infant feeding counselling is provided to all mothers living with HIV appropriate to national circumstances.	YES (1)	NO ✔ 0
8.7) Mothers are supported and followed up in carrying out the recommended national infant feeding	YES ✔ 1	NO 0
8.8) Country is making efforts to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	YES ✔ 1	NO 0
8.9) Research on Infant feeding and HIV is carried out to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	YES	NO ✔ 0
Total Score:	**4/10**	

24. Some of the questions may need discussion among the core group, and based on information sources the Core group may decide about the strengths.

25. Updated guidance on this issue is available from WHO as of 2016. Countries who may be using the earlier guidance and are on way to use the new guidance if not completely may be included here.

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Conclusions:

There is no change to report on this Indicator. Australia's national infant feeding policy and NHMRC Infant Feeding Guidelines still provides no options to breastfeed for mothers who are HIV positive and under medical supervision, and this policy is unchanged since 2018,

However, the score for Indicator 8 increased over 2018-22 from 3.5 to 4.0 because of the development of guidance developed by NAPWHA and Queensland Health.

Gaps:

1. NHMRC Infant Feeding Guidelines have not been updated to reflect current evidence-based knowledge and international guidelines on preventing mother to child transmission of HIV/AIDS and infant feeding.
2. The NHMRC Infant Feeding Guidelines on HIV/AIDS do not uphold women's rights to make informed choices about childbirth and infant feeding.
3. National policy lacks evaluation of the long term maternal and child health and other outcomes of current policy interventions and related management practices.
4. National infant feeding policy does not address threats to breastfeeding from other infectious diseases (COVID-19 and HTLV) and their management (see below).

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 woman'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 breastfeed in line with current treatment recommendations.
4. Policies and practices should ensure consideration 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.
5. 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.
6. 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.
7. An evaluation of the long term maternal and child health and other outcomes of current policy and practice interventions should be conducted.

Other threats to breastfeeding from infectious disease (COVID-19 and HTLV) in Australia

HIV is just one example of the vulnerability of breastfeeding to unproven assumptions or inaccurate perceptions about the safety and expendability of breastfeeding. Emerging infectious diseases continue to challenge these assumptions and perceptions, and weaken the capacity of health systems to protect and

support women and children's breastfeeding rights. When breastfeeding is not recognized as essential to a population's food security and resilience to infection, mothers and infants are abandoned in responses to pandemics and natural disasters, and programs to address long-term social inequities.

In Australia, two viral diseases, COVID-19 and HTLV, illustrate the fragility of breastfeeding and the ease with which breastfeeding education and support is disrupted in health systems and the community.

COVID-19

The COVID-19 pandemic is an example of the vulnerability of breastfeeding to emerging infectious diseases and the collapse of health systems in a pandemic.

The effects of COVID policy on breastfeeding include:

1. Advice on the safety of breastfeeding.
2. Advice on the safety of COVID vaccination and breastfeeding.
3. Maternal-infant separation.
4. Health professional contact during in-hospital and post-natal visits.
5. Social isolation and access to breastfeeding support and culture from partners and peers.
6. Advice on the safety of expressed breastmilk handling and donation, for example to human milk banks.

Effects of health system strain/collapse on breastfeeding include:

7. Lack of progress on ANBS implementation and budgeting.
8. Staff shortages for maternity care, including breastfeeding support.
9. Provision of breastfeeding training of volunteers and health professionals
    a. No spare time or capacity to train because of the burden on women as workers, mothers and health professionals and volunteers.
10. Inappropriate access of mothers to skilled breastfeeding support from health professionals:
    a. Telehealth replaced face-to-face consultations provided by GPs, lactation consultants and ABA about breastfeeding issues.
11. During the COVD-19 pandemic, a survey of Australian Breastfeeding Association counsellors answering calls on the National Breastfeeding Helpline described the COVID-19 related concerns of 339 mothers seeking breastfeeding support in March-May 2020 (Hull et al 2020):
    a. Mothers were commonly stressed, isolated and needing reassurance.
    b. One hundred and thirty-six mothers (64%) sought support to protect their infants by continuing breastfeeding, increasing milk supply, or restarting breastfeeding.
    c. Thirty-four (10%) raised concerns about COVID-19 and breastfeeding safety.
    d. One hundred and twenty-nine (61%) informed survey respondents (ABA volunteers) they were unable to access face-to-face health services because of fear or unavailability.
    e. Mothers were worried that stress had reduced milk supply, that milk supply concerns were exacerbated by the inability to weigh infants and that seeking medical treatment was delayed.
    f. COVID-19 NICU hospital policies commonly restricted access of infants to their mothers (and mother to their infants) overlooking the importance of mother-infant proximity for the psychological wellbeing of both and for breastfeeding.

HTLV (Human T-Lymphotropic Virus, types I and II)

HTLV has the potential to be transmitted via breastfeeding but is very rare in the general population and not included in routine antenatal screening (Department of Health 2018).

However, in some Central Australian Indigenous communities, high rates of HTLV have resulted in mixed infant feeding recommendations, from no change to breastfeeding practices (Australian Government Department of Health 2018, Department of Health 2018), to advice that women infected with HTLV-1 avoid or restrict breastfeeding (SA Health 2018, Northern Territory Government 2019) or use frozen expressed breastmilk (SA Health 2020).

For some Indigenous communities in low resource or remote settings, HTLV policy recommendations to bottle feed infant formula or expressed milk are associated with high levels of health risk for infants and mothers and food insecurity from dependence on costly infant formula. In 2018 the Australian Government Department of Health responded to these risks and consulted with Central Australian Indigenous communities and health services to protect breastfeeding (Department of Health 2018). This position is consistent with advice that 'serologic screening in pregnant women is not required as a public health policy even in endemic countries such as Brazil. But if it is identified by chance, formula feeding may be the safer option if the conditions required for its safe use can be met' (Binns and Lee, 2019).

The ANBS 2019 does not refer to HTLV or address concern about HTLV transmission via human milk as a potential threat to perceptions of the safety of breastfeeding relative to other feeding options in some of Australia's most vulnerable populations.

Commentary on gender in infectious disease policy

The management of infectious diseases can perpetuate gender inequity. Policies to prevent potential transmission of infectious diseases that prohibit or interfere with breastfeeding may unfairly disadvantage women. This form of gender discrimination results from institutions avoiding the risks of disease rather than managing these risks in ways that recognize the importance of breastfeeding to public health and women's and children's rights, health and wellbeing. These disease policies exacerbate discrimination against women of low socioeconomic status, in particular population groups, or locations, and will intensify with emerging risks and social disruption from climate change. In many cases, adequate research, policy, resourcing and education can develop strategies to protect breastfeeding and manage disease risks to a level acceptable to the mother and her health care providers. These strategies should be tailored for individuals and populations. Health budgets should provide funding, and staff educated in breastfeeding and infectious disease, to ensure that mothers can make fully informed decisions about the relative risks and benefits of infant feeding options, which may include cross-feeding and donor milk as a recognised option, where appropriate. Recommendations against breastfeeding and/or maternal-infant proximity should not be made unless and until there is compelling evidence it is necessary.

Recommendations

1. National policy addresses the risks of infectious diseases to breastfeeding and maternity care that can arise through inaccurate medical advice.
2. Emergency and pandemic preparedness plans should include strategies to protect, promote and support breastfeeding in the community, health facilities and media.

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Indicator 9: Infant and Young Child Feeding during Emergencies

Background

Infants and young children are among the most vulnerable groups in emergencies, and their caregivers need particular support. Women have the right to support that enables them to breastfeed, especially in emergencies. Absence of, or inadequate, breastfeeding and inappropriate complementary feeding increase the risks of undernutrition, illness and mortality. Supporting breastfeeding in emergencies is important because artificial feeding places both mothers and children at risk. In emergency and humanitarian relief situations the emergency-affected host country and responding agencies share the responsibility for protecting, promoting and supporting recommended infant and young child feeding practices and minimising harmful practices for all women and children affected by emergencies. Women's ability to breastfeed is commonly undermined in emergencies by the indiscriminate distribution of breast-milk substitutes and the absence of breastfeeding support. Concise Operational guidance on how to ensure appropriate feeding in emergency situations and comply with international emergency standards has been developed by an interagency Infant Feeding in Emergencies Core Group and was adopted at WHA 63.23 in 2010 (Infant and Young Child Feeding in Emergencies. Operational Guidance for emergency and relief staff and program managers, version 2.1, 2007, IFE Core group **http://www.ennonline.net/resources/6**). In 2018 the World Health Assembly Resolution called for all governments to ensure IYCF-E is part of their policy and plans and that their staff have the capacity needed to protect, promote and support IYCF practices during emergencies. Practical details on how to implement the guidance summarized in the Operational Guidance are included in companion training materials, also developed through interagency collaboration as well as part of the UN Nutrition Cluster capacity building materials. All these resources are available at **www.ennonline.net/IFE**

What has happened in Australia since the last WBTi Australia Report (2018)?

Australia has seen some small but positive movements towards implementing appropriate breastfeeding support in emergencies. **Recommendation 3 of the 2018 WBTi Australia Report was that, '*Indicators***

related to IYCF-E to be included in the National Breastfeeding Strategy.' In 2019, the Australian National Breastfeeding Strategy was launched by the Commonwealth of Australian Governments (COAG). It includes as an '*action for priority groups*' to '*Provide breastfeeding and lactation support and maternal health care to families in exceptionally difficult circumstances…[and] Ensure skilled breastfeeding and lactation support is available to mothers, infants and young children … during emergencies and disasters.*' It also includes as an action to *'Develop a national policy on infant and young child feeding in emergencies.'*

Recommendation 4 of the 2018 WBTi Australia Report, was that the *'Australian Institute for Disaster Resilience [AIDR] 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).'* AIDR has not been commissioned to produce a handbook on IYCF-E. However, the Disaster Health Handbook was revised in 2019 and the renamed Health and Disaster Management Handbook contains two paragraphs on IYCF-E. These paragraphs note that the World Health Assembly, the WHO/UNICEF Global Strategy for Infant and Young Child Feeding, and the Australian National Breastfeeding Strategy underline the need for development of policies and strategies to support appropriate IYCF-E.

It also stated that, *'In order to protect the health and wellbeing of infants, emergency planning must protect, promote and support breastfeeding and provide for the needs of formula-fed infants. Support for formula feeding must include consideration of access to infant formula, feeding and preparation implements, water, washing facilities and health care. It must be ensured that interventions to support formula fed infants do not undermine breastfeeding.'*

The AIDR Evacuation Handbook is currently under review and will also contain content on the feeding needs of infants and young children.

Since the 2018 WBTi Australia Report was published, Australia faced the Black Summer Bushfires. The Black Summer Bushfires of July 2019- March 2020 were a natural disaster of unprecedented scale and extent. Bushfires occurred in every state and territory and 80% of the population of Australia was directly impacted by fire or by the smoke from bushfire. Millions of people prepared to evacuate or were evacuated because of the bushfires and more than 3000 homes were destroyed. Failures in the emergency response to infants and young children were evident. For example, the Royal Australian Navy evacuated the fire ravaged town of Mallacoota by ship. There was no provision for infants and young children to get on board first, which resulted in the very young children remaining behind in the choking smoke. They and their families were the last to be evacuated from Mallacoota, several days later.

A multitude of problems in the IYCF-E response were also reported:

1. Mothers having breastfeeding difficulties were not able to get support and some shifted to formula feeding
2. Donations of infant formula were made and distributed inappropriately to breastfeeding women
3. Formula feeding parents and caregivers did not have access to resources to use infant formula with an adequate level of safety
4. Evacuation centres had no facilities for preparing infant formula or washing feeding bottles and unsafe formula feeding practices occurred

After the Black Summer Bushfires, WBTi coordinated a Call for Action, asking the Australian government to ensure that the needs of infants and young children were better supported in emergencies. This Call for Action echoed to a large extent the recommendations of the 2018 WBTi Report and was signed by more than 40 health, women's, children's and emergency organisations (**https://wbtiaus.com/2020/11/12/infant-and-young-child-feeding-in-emergencies-call-for-action/**)

Since the last WBTi report, Australia has also experienced the COVID-19 pandemic. Lack of planning for the needs of mothers and infants and young children was also evident in this emergency. Health services such as those provided by family and child health nurses to new mothers and families were severely impacted. Australia was fortunate that the Australian Breastfeeding Association existed, that the Association's model of support was suited to provision of remote support and continued almost unaffected throughout the pandemic. However, ABA was not a part of any pandemic planning. Australia's State and Territory guidance for maternity units and the care of newborns of mothers with COVID-19 largely reflected that of the WHO and supported mother-infant proximity and breastfeeding. However, NICU and nursery policies as well as general hospital ward policy commonly constructed mothers and infants as 'visitors' to one another which had an adverse impact on breastfeeding through promotion of separation. Major flooding in eastern Australia in 2022 has also highlighted the lack of policy and planning on IYCF-E, and gaps in support for women and caregivers of young children in emergencies.

Australia's low WBTi scores for Indicator 9 are largely a function of an absence of comprehensive national policy, planning or guidance on IYCF-E. The development of national policy and planning is hampered by the absence of an evidence base for adapting the Operational Guidance for Infants and Young Children in Emergencies for Australian conditions. It is also hampered by the lack of priority given to collecting regional and sub-regional data on infant and young child feeding practices. However, the Australian government has recently taken a significant step towards enabling this planning. This step is in the form of funding for the Community Protection for Infants and Young Children in Bushfire Emergencies Project. This Project involves research to consider the experiences of families with infants and young children during the Black Summer fires, documentation of best practice internationally, and will implement research findings to pilot emergency planning and preparedness tools in one bushfire-prone local government area. Hopefully by the next WBTi assessment there will be national IYCF-E planning and guidance in place.

Criteria for assessment	√ Check the one that applies	
9.1) The country has a comprehensive Policy/Strategy/ Guidance on infant and young child feeding during emergencies as per the global recommendations with measurable indicators.	YES 2	NO ✔ 0
9.2) Person(s) tasked to coordinate and implement the above policy/ strategy/guidance have been appointed at the national and sub national levels	YES 2	NO ✔ 0
The health and nutrition emergency preparedness and response plan based on the global recommendation includes: Basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately skill trained counsellors, and support for relactation and wet-nursing.	YES ☐ 0.5	NO ✔ 0
b. Measures to protect, promote and support appropriate and complementary feeding practices	YES 0.5	NO ✔ 0
c. Measures to protect and support non, breast-fed infants	YES 0.5	NO ✔ 0
d. Space for IYCF counselling support services.	YES 0.5	NO ✔ 0
e. Measures to minimize the risks of artificial feeding, including an endorsed Joint statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and minimize the risk of formula feeding, procurement management and use of any infant formula and BMS, in accordance with the global recommendations on emergencies	YES 0.5	NO ✔ 0
f. Indicators, and recording and reporting tools exist to closely monitor and evaluate the emergency response in the context of feeding of infants and young children.	YES 0.5	NO ✔ 0
9.4) Adequate financial and human resources have been allocated for implementation of the emergency preparedness and response plan on IYCF	YES 2	NO ✔ 0
9.5) Appropriate orientation and training material on 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.	YES 0.5	NO ✔ 0

Criteria for assessment	√ Check the one that applies	
9.6) Orientation and training is taking place as per the national plan on emergency preparedness and response is aligned with the global recommendations (at the national and sub-national levels)	YES 0.5	NO ✔ 0
Total Score:	**0/10**	

Information Sources Used

COMDISPLAN- Australian Government Disaster Response Plan (2020).
https://www.homeaffairs.gov.au/emergency/files/plan-disaster-response.pdf

National Strategy for Disaster Resilience (2011).
https://www.homeaffairs.gov.au/emergency/files/national-strategy-disaster-resilience.pdf

Australian Disaster Resilience Handbook Collection **https://knowledge.aidr.org.au/collections/handbook-collection/**

Royal Commission into National Natural Disaster Arrangements Report (2020) **https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report**

Australian National Breastfeeding Strategy (2019) **https://www.health.gov.au/sites/default/files/documents/2022/03/australian-national-breastfeeding-strategy-2019-and-beyond.pdf**

Infant feeding Guidelines for Health Workers 2012
https://www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n56_infant_feeding_guidelines.pdf

Gribble KD, Palmquist AEL. 'We make a mistake with shoes [that's no problem] but… not with baby milk': Facilitators of good and poor practice in distribution of infant formula in the 2014–2016 refugee crisis in Europe. *Maternal & Child Nutrition* (2021) n/a(n/a):e13282. doi: **https://doi.org/10.1111/mcn.13282**

Gribble KD, Peterson M, Brown D. Emergency preparedness for infant and young child feeding in emergencies (IYCF-E): an Australian audit of emergency plans and guidance. *BMC Public Health* (2019) 19(1):1278. doi: 10.1186/s12889-019-7528-0.

Conclusions

Policy and planning for protecting appropriate infant and young child feeding in emergencies and disasters remains weak and under-resourced in Australia, despite growing awareness and experience of the problem, and some progress. 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 the response and recovery for any emergency within their borders. The Federal Government has the role of providing leadership and financial and non-financial assistance to the states with planning expertise, response guidance and physical support (including via the Australian Defense Force). 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 absent from emergency preparedness and response plans in Australia. Legislation and policies relating to milk banking, wet nursing, and donor human milk sharing (recognised options that can support women in appropriate infant and young child feeding during emergencies) are lacking. There also remains a lack of legislative and regulatory clarity, and health worker training on protecting and supporting breastfeeding practices in these situations.

The 2023 WBTi assessment for IYCF-E resulted in a score of 0, a decline from the 2018 assessment of 0.5. However, this scoring decline was a function of changes to the scoring tool rather than as a result of any change in Australian policy.

Nonetheless, the inclusion of a recommendation for breastfeeding support in emergencies in the ANBS and the funding of the Community Protection for Infants and Young Children in Bushfire Emergencies Project by the Australian government that suggest that the 2018 WBTi Report has been attended to and is preparing for the development and implementation of proper planning in the future. .

Gaps

1. No Federal government agency has taken responsibility for supporting the states and territories on IYCF-E.
2. There is no national emergency management policy on IYCF-E and very little 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. The WHO International Code is not legislated and donations and distributions of infant formula and other breastmilk substitutes undermines women's ability to breastfeed in emergencies.
5. Training on IYCF-E exists but is not readily available to emergency workers or managers, and there is a need to build capacity to ensure that skilled breastfeeding and lactation support is available during emergencies and disasters
6. Wet nursing, donor human milk sharing and milk banking occurs in emergencies and disasters yet there is no suitable guidance available to families or emergency workers or managers to support practice.

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 governments, academe, emergency and health related non-government organisations, and excluding commercial interests, to adapt international IYCF-E guidance to the Australian context and develop national planning principles for IYCF-E.
3. Australian Institute for Disaster Resilience to produce a Disaster Resilience Handbook on Children including IYCF-E and integrate cross-cutting IYCF-E issues into other Handbooks (e.g., Planning for Spontaneous Volunteers, Evacuation Planning).
4. Include detailed advice for health workers on how to support mothers and other caregivers of infants in emergency preparedness, and in the feeding and care of infants and young children during emergencies in the updated National Health and Medical Research Council's Infant Feeding Guidelines for Health Workers
5. Orientation and training on IYCF-E to be required for Defense personnel involved in emergency management and response.
6. Existing Australian education and training on IYCF-E (e.g., ABA and NCCTC) to be made available to all relevant health and emergency workers.
7. Communicate guidance to families as well as health and emergency workers on IYCF-E.

Indicator 10: Monitoring and Evaluation

Background:

Monitoring and Evaluation (M & E) components should be built into all infant and young child feeding program activities and collection of data concerning feeding practices should be integrated into national nutritional surveillance and health information systems and surveys. Women's contribution to the food system through breastfeeding needs to be more visible for it to be properly accounted for in policy and programs. Regular collection of relevant data is essential for recognising the unpaid care work of new mothers, and resourcing women and families for optimal infant and young child feeding.

Periodic monitoring and management information system data should be collected systematically, analysed and considered by program managers as part of the planning, management, and implementation process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Unified criteria on the use of internationally agreed-upon indicators and data collection strategies should be considered, to increase availability of comparable data.[26] It is important to devise strategies for results of important evaluations to be incorporated to ensure evidence-based decision making.

Criteria for assessment and scoring

The table shows the five criteria for assessing countries and the score applied. The maximum total score for the indicator is 10.

26. See the WHO Indicators for assessing infant and young child feeding practices for suggestions concerning Infant and Young Child Feeding indicators and data collection strategies.

SCORE 2023

Criteria for assessment	√ Check that apply	
10.1) Monitoring and evaluation of the IYCF programs or activities (national and sub national levels) include IYCF indicators (early breastfeeding within an hour, exclusive breastfeeding 0-6 months, continued breastfeeding, complementary feeding and adequacy of complementary feeding)	YES ☐ 2	NO ✔ 0
10.2) Data/information on progress made in implementing the IYCF programs are used by program managers to guide planning and investment decisions.	YES ☐ 1	NO ✔ 0
10.3) Data on progress made in implementing IYCF program and activities are routinely or periodically collected at the sub national and national levels.	YES ☐ 3	NO ✔ 0
10.4) Data/information related to IYCF program progress are reported to key decision-makers.	YES ☐ 1	NO ✔ 0
10.5) Infant and young child feeding practices data is generated at least annually by the national health and nutrition surveillance system, and/or health information system.	YES ☐ 3	NO ✔ 0
Total Score	**0/10**	

Information Sources Used

1. Australian Bureau of Statistics (ABS). 2018. Children's Risk Factors. **https://www.abs.gov.au/statistics/health/health-conditions-and-risks/childrens-risk-factors/latest-releasehttps://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release**
2. Australian Government. Department of Health. Child and Youth Health. Page accessed, 16 May 2022. **https://www1.health.gov.au/internet/main/publishing.nsf/Content/child-and-youth-health-1**
3. Australian Health Ministers Advisory Council. National Framework for Universal Child and Family Health **https://www1.health.gov.au/internet/main/publishing.nsf/Content/4C6E476B74CC27D1CA257BF0001B0ABD/$File/NFUCFHS_National%20Framework%20for%20Universal%20Child%20and%20Family%20Health%20Services.pdf**
4. Australian Health Ministers' Advisory Council (2016) National Maternity Services Plan 2014-2015 Annual Report **http://www.health.gov.au/internet/main/publishing.nsf/content/8985FF7FE467D0AACA257D330080BCD2/$File/NSMP%20Annual%20Report-FINAL%20ENDORSED%20(D16-524081).PDF https://www1.health.gov.au/internet/main/publishing.nsf/Content/maternity-pubs**
5. Australian Health Ministers Advisory Council. 2015. National Survey of the Availability of Access to a Midwifery Care for Postnatal Carer Outside of the Hospital Setting) **https://www1.health.gov.au/internet/main/publishing.nsf/content/8985FF7FE467D0AACA257D330080BCD2/$File/National%20Survey%20of%20the%20Availability%20of%20Access%20to%20a%20Midwifery%20Carer.pdf**
   Note: There have been no subsequent updates, nor further "Annual Reports"

6. Australian Health Survey: Health Service Usage and Health Related Actions, 2011-12 (2013) **http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/6664B939E49FD9C1CA257B39000F2E4B?opendocument**
Note: There have been no subsequent updates
7. Australian Institute of Health and Welfare (AIHW). 2011. National breastfeeding indicators: Workshop report **https://www.aihw.gov.au/getmedia/8718b74f-db38-4bc9-a122-ca4431cd9eb2/13346.pdf.aspx?inline=true**
8. AIHW. 2021. National Core Maternity Indicators **https://meteor.aihw.gov.au/content/742377**
9. AIHW. 2021. Australia's Mothers and Babies. Page last updated, 15 December 2021. **https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/about**
Note: The data in this report are based on final 2019 data from the National Perinatal Data Collection(NPDC), the National Maternal Mortality Data Collection and the National Perinatal Mortality Data Collection.
For the first time, an early release of preliminary 2020 NPDC data is also being made available within 12 months of the relevant reporting period (these data tables are available under 'Data'). Please note that the preliminary 2020 data include data from 6 of 8 jurisdictions, totals in the preliminary 2020 data are not comparable with the final 2019 data used throughout this report. Final 2020 data and a full update of the Australia's Mothers and Babies web report will be released in mid-2022.
10. Australian National Breastfeeding Strategy (ANBS): 2019 and Beyond **https://www.health.gov.au/sites/default/files/documents/2022/03/australian-national-breastfeeding-strategy-2019-and-beyond.pdf**
Note: There have been no subsequent updates
11. National Action Plan for the Health of Children and Young People 2020-2030. Page last updated, 21 May 2019 **https://www1.health.gov.au/internet/main/publishing.nsf/Content/child-and-youth-action-plan**
12. National Health and Medical Research Council (NHMRC). 2012. Infant feeding guidelines information for health workers. **https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers**
13. National Maternity Services Plan 2010-2015 (2011) **http://www.health.gov.au/internet/main/publishing.nsf/content/8AF951CE492C799FCA257BF0001C1A4E/$File/maternityplan.pdf**
Note: There have been no subsequent updates
14. Public Health Association (PHA). 2018. Food and Nutrition Monitoring and Surveillance in Australia Policy Position Statement. **https://www.phaa.net.au/advocacy-policy/policies-position-statements**
Note: From the PHA:
Breastfeeding Policy Position Statement Key messages:
Infant feeding practices have important implications for public health in Australia. To achieve optimal growth, development, and health, Australian infants should be exclusively breastfed for the first six months of life and continue breastfeeding as part of an increasingly diversified diet into the second year of life and beyond. Available data suggests most infants born in Australia initiate breastfeeding. However, very few are exclusively breastfed to six months, and most have stopped breastfeeding at 12 months. Increasing the duration and prevalence of exclusive and continued breastfeeding would improve public health in Australia. Achieving this will require a commitment to monitoring infant feeding practices and allocating resources to protecting and supporting breastfeeding in health services and the wider community.
Key policy positions:
1. The PHA encourages the Australian Government to increase its support for the work of the Australian Breastfeeding Association and endorses its vision that: "breastfeeding is recognised as important by all Australians and is a valued cultural norm".
2. The PHA welcomes the release of the Australian National Breastfeeding Strategy: 2019 and Beyond, and calls on the Australian Government to allocate sufficient funding to implementation and evaluation of the Strategy

Comments

10.1 Australia has a National Breastfeeding Strategy (ANBS),[10] and Infant Feeding Guidelines for the Health Worker (NHMRC),[12] that include the IYCF indicators listed. Monitoring and evaluation are not mandated nationally, however some monitoring and evaluation occurs, nationally and sub nationally.[1, 2, 4, 5, 7, 11, 14]

Monitoring and evaluation occur without consistent definitions and indicators, or data collection systems, across all Jurisdictions.

10.2 Australia has a National Breastfeeding Strategy[10], that recognizes the need for a standard, national data collection system to inform planning and investment in IYCF, however the ANBS has not been funded or implemented, nor has a national data collection system been implemented.

10.3 There is no national or sub national mandate to collect data on the implementation and progress of IYCF program and activities.

10.4 There is no national mandate to report data/information on IYCF program progress, to key decision makers.

10.5 IYCF practices are explored, and data from time to time is collected by national health and nutrition surveillance bodies.[1, 2, 4, 5, 7, 11, 14]

However, there is no national mandate to generate data about IYCF practices annually by national health and nutrition surveillance systems, and/or health information systems.[14]

Conclusions

Since 2018, very little progress has been made on the monitoring and evaluation (M & E) of infant and young child feeding practices and programs. The last national survey was conducted in 2010. Lack of adequate information on breastfeeding practices in Australia is a significant barrier to policy development and implementation. It means that women's contribution to the food system through breastfeeding is poorly acknowledged and largely unaccounted for in policy and planning. Collecting suitable data on breastfeeding acknowledges the physiological and time demands that it places on women, and highlights the importance of breastfeeding protection, promotion, and support to enable it.

The monitoring and evaluation of IYCF practices and programs in Australia occurs without consistent planning, definitions, indicators, or data collection systems, nationally and sub-nationally.

Since 2018, Australia has published a National Breastfeeding Strategy,[10] that recognizes the need for a standard, national data collection system to inform planning and investment in IYCF. However, the ANBS has not been funded or implemented, nor has there been a national data collection system to update the 2010 National Infant Feeding Survey. The 2010 Survey collected little data on practices beyond the first 6 months, and yet accurate data on duration of breastfeeding is important for evaluating longer term implications for both women's and children's health. Data on the percentage of children who breastfeed for 2 years or longer is important for assessing changes in continued breastfeeding practices, especially in the light of marketing of breastmilk substitutes and baby foods targeting this age group.

The frequency of data collection at a national level is non-existent, 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.[1,3]

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.[1,3]

National monitoring and evaluation systems need to be in place to collect, analyse, and use data to improve infant and young child feeding practices in Australia[10,14] routinely or periodically.

Gaps

1. The survey of infant and young child feeding has not been conducted since 2010 which is a barrier to policy implementation. Information on feeding practices beyond the first six months is very limited.
2. Monitoring and evaluation of IYCF practices and programs are not integrated, with consistent definitions and indicators, into a national nutritional surveillance system.
3. Monitoring and evaluation of IYCF practices and programs occurs without consistent planning, definitions, and indicators, nationally and sub-nationally.
4. 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.
5. There is no national mandate to report data/information on IYCF program progress, to key decision makers.

Recommendations

1. The Australian Government fund and implement the Australian National Breastfeeding Strategy and its monitoring and evaluation component.[10]
2. The Australian Government adopt the WHO Global Data Bank definitions and indicators for IYCF (breastfeeding) and mandate the monitoring of these indicators across all jurisdictions.
3. A National IYCF Advisory Committee be 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 national health surveys.
4. Data acquired is to be made available routinely and in a timely manner to enable effective monitoring and evaluation of IYCF programmes across all jurisdictions to better the integration of programs between hospitals and child and family health services.

Part II – IYCF Practices

In Part II ask for specific numerical data on each infant and young child feeding practice. Those involved in this assessment are advised to use data from a random household survey that is national in scope[27]. The data thus collected is entered into the web- based printed toolkit. The achievement on the particular target indicator is then rated i.e., **Red, Yellow, Blue and Green.** The cut-off points for each of these levels of achievement were selected systematically, based on an analysis of past achievements of these indicators in developing countries. These are incorporated from the WHO's tool.

Definition of various quantitative indicators have been taken from "WHO's Indicators for assessing infant and young child feeding practices - 2008" Available at: **http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/** (Annex 10.1)

Preferably, data should have been collected in the past five years. Most recent data should be used, which is national in scope.

The last time any data was collected nationally was in 2010. Therefore, no statistics have been reported in the following indicators.

The ABS National Health Surveys are not dedicated infant feeding surveys although the data they do collect about breastfeeding can be linked to other health conditions, which has value.

The ABS National Health Surveys provide the least robust data on Australian rates of exclusive breastfeeding to 6 months. The data comes from a very small sample of the population, 1498 children, and definitions and collection time points have changed over time (NHS 2011-12; NHS 2014-15; NHS

27. One source of data that is usually high in quality is the Demographic and Health Survey (DHS) (4) conducted in collaboration with Macro International and national research organizations, with support from USAID. If this source of data is used the data are likely to be comparable across countries. Other sources of data include UNICEF's Multiple Indicator Cluster Surveys (MICS) (5) and the WHO Global Data Bank on Breastfeeding (6). In some countries recent national surveys may have been conducted. It is important to assess the scope and quality of any data sources being considered for use.

2017-18; p147, AIHW 2020), so longitudinal data showing trends over time for exclusive breastfeeding to six months are not available.

Data from NHS 2017-18 found that 29% of babies had been exclusively breastfed to 6 months. This figure is 1.5 to 2 times higher than other Australian infant feeding surveys and unchanged from NHS 2014-15.

Data from the latest NHS 2020-21 survey found 35.4% of babies were exclusively breastfed to 6 months. However, the survey collected data from only 826 children aged 0 to 4 years and was collected many years after the baby/child had stopped breastfeeding. Also, due to the impact of COVID-19, the data was collected via an online, self-completed form rather than an interview by telephone. The NHS states: *The 2020-21 NHS data should be considered a break in time series from previous NHS collections and used for point-in-time national analysis only.*

ABS National Health Survey breastfeeding data is weak, inconsistent with other infant feeding surveys, and not sufficient to make the claim that Australian breastfeeding rates are increasing. The WBTi AUS team do not consider these statistics as valid and therefore do not report on them.

Indicator 11: Initiation of Breastfeeding (within 1 hour)

Definition of the indicator: Proportion of children born in '0-23' months who were put to the breast within one hour of birth.

Background

Many mothers, in the world, deliver their babies at home, particularly in low-income countries and more so in rural areas. Breastfeeding starts late in many of these settings due to cultural or other beliefs. According to the new guidelines for the Baby Friendly Hospital Initiative (BFHI), Step 4 of the *Ten Steps to Successful Breastfeeding* recommends placing all babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encouraging mothers who have chosen to breastfeed to recognize when their babies are ready to breastfeed, offering help if needed.

If the mother has had a cesarean section, the baby should be offered the breast when the mother is able to respond; this happens within few hours even if general anesthesia was used. Mothers who have undergone a cesarean section need extra help with breastfeeding otherwise they may initiate breastfeeding much later. Ideally, the baby should start to breastfeed before any routine procedure (such as bathing, weighing, umbilical cord care, administration of eye medications) is performed. Early breastfeeding contributes to better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases the chances of establishing exclusive breastfeeding early and its success. Evidence shows that early initiation of breastfeeding could reduce neonatal mortality by 22% in low-income countries.[28]

Source of data: Demographic and Health Surveys, MICS surveys, national and sub-national surveys, national health information systems.

28. Edmond KM, Zandoh C, Quigley MA et al. Delayed breastfeeding initiation increases risk of neonatal mortality. Pediatrics 2006; 117: 380-386

Assessment

Indicator 11: Initiation of Breastfeeding (within 1 hour)	Key to rating adapted from WHO tool (see Annex 11.1)	Please enter your country data in %	Colour-rating
	0.1-29%	N/A	Red
	29.1-49%		Yellow
	49.1-89%		Blue
	89.1-100%		Green

Data Source (including year):

There has been no national data relating to this statistic in the past five years.

Indicator 12: Exclusive Breastfeeding under 6 months

Definition of the indicator: Proportion of infants 0–5 months of age who received only breastmilk during the previous 24 hours. (0-*5 months means 5 months and 29 days as per research guidance*)

Technical note: this indicator can be calculated if data are available for the whole population of infants less than 6 months of age or, more often, it can be estimated from a random sample of infants. The sample must be random so that it reflects the distribution of infants by month of age of the whole population. If the sample is not random, it may over- or under-represent an age group, thus over- or under-estimating the rate of exclusive breastfeeding under 6 months.

Background

Exclusive breastfeeding for the first six months is crucial for survival, growth and development of infants and young children. It lowers the risk of illness, particularly diarrheal diseases and acute respiratory infections. It also prolongs lactation amenorrhea in mothers who breastfeed frequently, also at night. WHO commissioned a systematic review of the published scientific literature about the optimal duration of exclusive breastfeeding and in March 2001 the findings were submitted for technical review and scrutiny during an Expert Consultation. This Expert Consultation recommended a change to exclusive breastfeeding for 6 months from the earlier recommendation of 4-6 months. The World Health Assembly (WHA) formally adopted this recommendation in May 2001 through Resolution 54.2/2001. In 2002, the WHA approved Resolution 55.25 that adopted the Global Strategy for Infant and Young Child Feeding. Later on, in September 2002, the UNICEF Executive Board also adopted this Resolution and the Global Strategy for Infant and Young Child Feeding, bringing a unique consensus on this health recommendation. Analyses published in the Lancet in 2003[30]and 2016[31]clearly point to the role of exclusive breastfeeding during first six months for infant survival and development.

29. 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 except for drops or syrups consisting of vitamins, mineral supplements, or medicines (2)

30. Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year? Lancet 2003; 361:2226-34

31. Victora CG, Bahl R, Barros AJD et al. Breastfeeding in the 21st century: epidemiology, mechanisms and lifelongeffect. Lancet 2016; 387:475-90 31

Source of data: Demographic and Health Surveys[32], MICS surveys, national and sub-national surveys, national health information systems.

Assessment

Indicator 12: Exclusive Breastfeeding under 6 months	Key to rating adapted from WHO tool (see Annex 11.1)	Please enter your country data in %	Colour-rating
	0.1-11%	N/A	**Red**
	11.1-49%		**Yellow**
	49.1-89%		**Blue**
	89.1-100%		**Green**

Data Source (including year):

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

32. Exclusive breastfeeding rate (EBR) calculator may be used, if required, to calculate data for exclusive breastfeeding for babies <6 months. The calculator may be seen at: WHO (2003). Infant and Young Child Feeding - A tool for assessing national practices, policies, and programmes. Available at http://whqlibdoc.who.int/publications/2003/9241562544.pdf

Indicator 13: Median Duration of Breastfeeding

Background

The *"Innocenti Declaration"* and the Global Strategy for Infant and Young Child Feeding recommends that babies continue to be breastfed for two years of age or beyond along with adequate and appropriate complementary foods starting after six months of age. Breastmilk continues to be an important source of nutrition and fluids and immunological protection for the infant and the young child. The continued closeness between mother and child provided by breastfeeding helps in optimal development of the infant and young child.

Source of data: Demographic and Health Surveys, MICS survey, national and sub-national survey, national health information systems.

Assessment

Indicator 13: Median Duration of Breastfeeding	**Key to rating adapted from WHO tool (see Annex 11.1)**	**Please enter your country data in months**	**Colour-rating**
	0.1-18 **Months**	N/A	**Red**
	18.1-20 "		**Yellow**
	20.1-22 "		**Blue**
	22.1-24 or beyond "		**Green**

Data Source (including year):

There has been no national data relating to this statistic in the past five years.

Indicator 14: Bottle-feeding

Definition of the indicator: *Proportion of children 0–12 months of age who are fed with a bottle*

Background

Babies should be breastfed exclusively for the first six months of age and they need not be given any other fluids, fresh or tinned milk formula as this would cause more harm to babies and replace precious breastmilk. Similarly, after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from his/her mother's breast, s/he should be fed with a cup (if unable to swallow, breastmilk can be given by means of an infant feeding tube). Bottle feeding means the proportion of children 0–12 months of age who are fed with a bottle having nipple/teat. Information on bottle feeding is useful because of the potential interference of bottle feeding with optimal breastfeeding practices and the association between bottle feeding and increased diarrhoeal disease morbidity and mortality. Bottles with a nipple are particularly prone to contamination.

Source of data: Demographic and Health Surveys[33], MICS survey, national and sub-national survey, national health information systems

33. Bottle feeding rate (BOT) calculator may be used, if required, to calculate data for bottle feeding for babies 0-<12 months. The calculator may be seen at: WHO (2003). Infant and Young Child Feeding - A tool for assessing national practices, policies, and programmes. Available at **http://whqlibdoc.who.int/publications/2003/9241562544.pdf**

Assessment

Indicator 14: Bottle-feeding (0-12 months)	Key to rating adapted from WHO tool (see Annex 11.1)	Please enter your country data in %	Colour-rating
	29.1-100%	N/A	Red
	4.1-29%		Yellow
	2.1-4%		Blue
	0.1-2%		Green

Data Source (including year):

There has been no national data relating to this statistic in the past five years.

Indicator 15: Complementary Feeding (6-8 months)

Definition of the indicator: *Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods*

Background

As babies need additional nutrients, along with continued breastfeeding, after 6 months of age, complementary feeding should begin with locally available foods that are affordable and sustainable, in addition to safe and nutritious. Infants should be offered a variety of soft or mashed foods in small quantities, 3-5 times a day. Complementary feeding should gradually increase in amount and frequency as the baby grows. Breastfeeding, on demand, should continue for 2 years or beyond. Complementary feeding is also important from the care point of view, the caregiver should continuously interact with the baby and take care of hygiene to keep it safe.

The proposed indicator measures only whether complementary foods are added in a timely manner, after 6 months of age along with breastfeeding.

Source of data: Demographic and Health Surveys, MICS surveys, national and sub-national surveys, national health information systems

Assessment

Indicator 15: Complementary Feeding (6-8 months)	Key to rating adapted from WHO tool (see Annex 11.1)	Please enter your country data in %	Colour-rating
	0.1-59%	N/A	Red
	59.1-79%		Yellow
	79.1-94%		Blue
	94.1-100%		Green

Data Source (including year):

There has been no national data relating to this statistic in the past five years.

Summary Part I: IYCF Policies and Programmes

Targets:	Score (Out of 10)
1. National Policy, Governance and Funding	1.5
2. Baby Friendly Hospital Initiative / Ten Steps to Successful Breastfeeding	6
3. Implementation of the International Code of Marketing of Breastmilk Substitutes	5
4. Maternity Protection	6
5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF)	2.5
6. Counselling Services for Pregnant and Breastfeeding Mothers	6
7. Accurate and Unbiased Information Support	2
8. Infant Feeding and HIV	4
9. Infant and Young Child Feeding during Emergencies	0
10. Monitoring and Evaluation	0
Total Country Score	**33**

Guidelines for WBT*i*

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

Scores	Total Country Score	Colour-coding
0 – 30.9		**Red**
31 – 60.9	33	**Yellow**
61 – 90.9		**Blue**
91 – 100		**Green**

34. 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 a team of stakeholders. Find out reasons and draw a list of recommendations for your health and nutrition managers and policy makers.

Summary Part II: Infant and young child feeding (IYCF) practices

IYCF Practice	Result	Colour-coding
Indicator 11: Initiation of Breastfeeding (within 1 hour)	_____ %	**Red**
Indicator 12: Exclusive Breastfeeding under 6 months	_____%	**Red**
Indicator 13: Median Duration of Breastfeeding	_____ months	**Red**
Indicator 14: Bottle-feeding (0-12 months)	_____%	**Red**
Indicator 15: Complementary Feeding (6-8 months)	_____%	**Red**

NOTE - There has been no nationally consistent data collected nationally in the past five years. Some breastfeeding and infant feeding statistics have been included in the National Health Surveys (NHS) collected by the Australian Bureau of Statistics (ABS).

Conclusions

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 almost 60 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 work of ABA is brought into stark relief in several WBT*i* 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, but instead has the Australian National Breastfeeding Strategy 2019, and is also without 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. BFHI 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. 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 of 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 wellbeing. 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.

Except for 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.

Australia has seen some small but positive movements towards implementing appropriate breastfeeding support in emergencies. Planning bodies dedicated to the management of emergency situations continue to be fragmented by state boundaries with significant variation in commitments and priorities. Strategic planning for breastfeeding in emergency situations is more of a priority in 2022, but there is much to be done in the aftermath of the Black Summer bushfires, the COVID-19 pandemic, and severe flooding that has ravaged much of the country in the past two years.

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 WBT*i* assessment tool has revealed several 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 WBT*i* 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.

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ANNEXES

Annex-1

Policy issues[10]

[10] Summarized and adapted from the *WHO Global Strategy for Infant and Young Child Feeding* (*1*), pages 13–15

In the light of the crucial gaps identified above, the following targeted actions for Australian governments will improve the implementation of comprehensive policies on infant and young child feeding:

- Promote infant and young child feeding practices consistent with WHO recommendations for 6 months of exclusive breastfeeding and continued breastfeeding with safe and adequate complementary foods to 2 years and beyond.
- Ensure functioning of a strong and independent Australian National Breastfeeding Strategy Action Coalition (ANBSAC) and coordinator.
- Monitor breastfeeding trends through an appropriately designed infant and young child feeding survey and report and evaluate implementation of all ANBS priority action areas in relation to improvements in infant and young child feeding practices and other indicators in the ANBS Monitoring and Evaluation plan.
- Provide technically sound and consistent messages through appropriate media and educational channels.
- Negotiate arrangements for and fund the national implementation of the Baby-friendly Health Initiative (BFHI)[2] within all public hospitals, and fully integrate the Ten Steps and BFHI accreditation into mandatory requirements for public and private hospital accreditation by Australian Council on Healthcare Standards (ACHS)[3] as a condition of eligibility for public funding of maternity care services in such facilities or insurance cover. This should include BFHI accreditation of community health services.
- Strengthen pre-service education on the importance of breastfeeding and breastfeeding management, including in emergency situations and other exceptionally difficult circumstances for health workers as recommended by the ANBS.
- Ensure all health workers receive ongoing education on the above, and are made aware of and accountable to their professional bodies for, **their responsibilities under the *International Code of Marketing of Breast-milk Substitutes***, through the revision of the NHMRC Infant Feeding Guidelines, and regular updated communication of WHO guidance in this area.
- To help ensure infants and young children are fed as recommended by the WHO. Hospitals and other maternity care models should ensure all mothers have continuity of care from hospitals to the community and these services should work together, so that health services support and refer all mothers to community-based breastfeeding services and mother-to-mother-breastfeeding support networks (predominantly the ABA, a national organization that the Federal Government provides some financial support to provide the **National Breastfeeding Helpline.**)

In line with the WBT*i*AUS position statement of November 2020, the federal government can further develop, lead, and coordinate the formulation of suitable plans for ensuring appropriate

- feeding for infants and young children in emergency situations and other exceptionally difficult circumstances.

- Fully implement and enforce the *International Code of Marketing on Breast-milk Substitutes* and subsequent World Health Assembly Resolutions. including retailing and all products within the scope of the Code implementation in Australia. It should also expand federal and state food and consumer laws prohibiting health and nutrition claims on all infant formula products and breastmilk substitutes for infants and young children (0-36 months). The federal government should take responsibility for WHO Code baseline and ongoing monitoring, enforcement on the level of compliance achieved, and improvements using the **WHO/UNICEF Net Code protocols**, and the federal health minister should be mandated to report annually to parliament on behalf of all Australian health ministers.
- Provide publicly funded paid maternity leave at two thirds of women's average earnings for duration of at least 6 months (i.e., the ILO standard)[4], and ensure that any additional parental leave, is additional to paid maternity leave at this standard.[5]
- Adopt safeguards against conflicts of interest and industry interference in the implementation of the ANBS including public registries of all contacts, in particular corporate lobbying activities, universities, and institutes; mandatory and timely public disclosure by senior public officials of meetings with lobbyists and receipt of gifts or other inducements.[6]

Policies on infant and young child feeding should be:

- Officially adopted/approved and implemented by all Australian governments.
- Routinely distributed and communicated to those managing and implementing relevant programmes.
- Integrated into other relevant national and national policies (nutrition, family planning, integrated child health policies, labour, disaster, HIV, information etc.).

2. BFHI in Australia includes hospitals and community health facilities
3. ACHS is the Australian Council on Healthcare Standards Australian Council on Healthcare Standards encompassing National Safety and Quality Health Service (NSQH)
4. Refer to ABA work on maternity leave
5. Refer to IBFAN document on maternity leave and paternity leave additional
6. Refer to NHMRC declaration on all contacts /transparency

Annex-2.1

Nine key responsibilities of a national BFHI programme

- Establish or strengthen a national breastfeeding coordination body.
- Integrate the Ten Steps into relevant national policy documents and professional standards of care.
- Ensure the competency of health professionals and managers in implementation of the Ten Steps.
- Utilize external assessment systems to regularly evaluate adherence to the Ten Steps.
- Develop and implement incentives for compliance and/or sanctions for non-compliance with the Ten Steps.
- Provide technical assistance to facilities that are making changes to adopt the Ten Steps.
- Monitor implementation of the initiative.
- Advocate for the BFHI to relevant audiences.
- Identify and allocate sufficient resources to ensure the ongoing funding of the initiative.

Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Annex-2.2

Ten Steps to Successful Breastfeeding in lay terms

	Hospitals support mothers to breastfeed by…	Because…
a. Hospital policies	• Not promoting infant formula, bottles or teats • Making breastfeeding care standard practice • Keeping track of support for breastfeeding	Hospital policies help make sure that all mothers and babies receive the best care
b. Staff competency	• Training staff on supporting mothers to breastfeed • Assessing health workers' knowledge and skills	Well-trained health workers provide the best support for breastfeeding
c. Antenatal care	• Discussing the importance of breastfeeding for babies and mothers • Preparing women in how to feed their baby	Most women are able to breastfeed with the right support
d. Care right after birth	• Encouraging skin-to-skin contact between mother and baby soon after birth • Helping mothers to put their baby to the breast right away	Snuggling skin-to-skin helps breastfeeding get started
e. Support mothers with breastfeeding	• Checking positioning, attachment and suckling • Giving practical breastfeeding support • Helping mothers with common breastfeeding problems	Breastfeeding is natural, but most mothers need help first
f. Supplementing	• Giving only breast milk unless there are medical reasons • Prioritizing donor human milk when a supplement is needed • Helping mothers who want to formula feed to do so safely	Giving babies formula in the hospital makes it hard to get breastfeeding going
g. Rooming-in	• Letting mothers and babies stay together day and night • Making sure that mothers of sick babies can stay near their baby	Mothers need to be near their babies to notice and respond to feeding cues
h. Responsive feeding	• Helping mothers know when their baby is hungry • Not limiting breastfeeding times	Breastfeeding babies whenever they are ready helps everybody

	Hospitals support mothers to breastfeed by…	Because…
i. Bottles, teats, and pacifiers	• Counselling mothers about the use and risks of feeding bottles and pacifiers	Everything that goes in the baby's mouth needs to be clean
j. Discharge	• Referring mothers to community resources for breastfeeding support • Working with communities to improve breastfeeding support services	Learning to breastfeed takes time

Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Annex-2.3

Ten Steps to Successful Breastfeeding – revised 2018 version: comparison to the original Ten Steps and the new 2017 WHO guideline

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, Promoting and Supporting Breast-feeding: The special sole of Maternity Services (1989)
Critical management procedures		
1a. The International Code of Marketing of Breast-milk Substitutes (25–27): Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.	N/A	N/A (incorporated in the hospital self- appraisal and monitoring guidelines and the external assessment)
1b. Infant feeding policy: Have a written infant feeding policy that is routinely communicated to staff and parents.	Recommendation 12: Facilities providing maternity and newborn services should have a clearly written breastfeeding policy that is routinely communicated to staff and parents.	Step 1: Have a written breastfeeding policy that is routinely communicated to all health-care staff.
1c. Monitoring and data-management systems: Establish ongoing monitoring and data-management systems.	N/A	N/A
2. Staff competency: Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.	Recommendation 13: Health facility staff who provide infant feeding services, including breastfeeding support, should have sufficient knowledge, competence and skills to support women to breastfeed.	Step 2: Train all health-care staff in the skills necessary to implement this policy.

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, Promoting and Supporting Breast-feeding: The special sole of Maternity Services (1989)
Key clinical practices		
3. Antenatal information: Discuss the importance and management of breastfeeding with pregnant women and their families.	**Recommendation 14:** Where facilities provide antenatal care, pregnant women and their families should be counselled about the benefits and management of breastfeeding.	**Step 3:** Inform all pregnant women about the benefits and management of breastfeeding.
4. Immediate postnatal care: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.	**Recommendation 1:** Early and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth. **Recommendation 2:** All mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour after delivery.	**Step 4:** Help mothers initiate breastfeeding within a half-hour of birth.
5. Support with breastfeeding: Support mothers to initiate and maintain breastfeeding and manage common difficulties.	**Recommendation 3:** Mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties. **Recommendation 4:** Mothers should be coached on how to express breast milk as a means of maintaining lactation in the event of their being separated temporarily from their infants.	**Step 5:** Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, Promoting and Supporting Breast-feeding: The special sole of Maternity Services (1989)
6. Supplementation: Do not provide breast-fed newborns with any food or fluids other than breast milk, unless medically indicated.	**Recommendation 7:** Mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated.	**Step 6:** Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Rooming-in: Enable mothers and their infants to remain together and to practise rooming-in throughout the day and night.	**Recommendation 5:** Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practise rooming-in throughout the day and night. This may not apply in circumstances when infants need to be moved for specialized medical care.	**Step 7:** Practise rooming in – allow mothers and infants to remain together – 24 hours a day.
8. Responsive feeding: Support mothers to recognize and respond to their infants' cues for feeding.	**Recommendation 6:** Mothers should be supported to practise responsive feeding as part of nurturing care. **Recommendation 8:** Mothers should be supported to recognize their infants' cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options, during their stay at the facility providing maternity and newborn services.	**Step 8:** Encourage breastfeeding on demand.

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, Promoting and Supporting Breast-feeding: The special sole of Maternity Services (1989)
Feeding bottles, teats and pacifiers: Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.	**Recommendation 9:** For preterm infants who are unable to breastfeed directly, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established. **Recommendation 10:** If expressed breast milk or other feeds are medically indicated for term infants, feeding methods such as cups, spoons or feeding bottles and teats may be used during their stay at the facility. **Recommendation 11:** If expressed breast milk or other feeds are medically indicated for preterm infants, feeding methods such as cups or spoons are preferable to feeding bottles and teats.	**Step 9:** Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. **Care at discharge:** Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	**Recommendation 15:** As part of protecting, promoting and supporting breastfeeding, discharge from facilities providing maternity and newborn services should be planned for and coordinated, so that parents and their infants have access to ongoing support and appropriate care.	**Step 10:** Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Annex 2.4

Protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018: Implementation guidance Link: https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/

(Please see the web link for the complete document) and Appendix: Indicators for monitoring

https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf?ua=1

Authors:

World Health Organization, UNICEF

Annex 2.6

WHO UNICEF Breastfeeding Promotion and Support in A Baby-friendly Hospital (20 hours course for maternity staff)

https://www.unicef.org/nutrition/files/BFHI_2009_s3.1and2.pdf

Annex 2.7

WHO Guidelines on counselling of women to improve breastfeeding practices (2018)

https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf-practices/en/

Annex 3.1

International Code of Marketing of Breast-milk Substitutes

See complete document at:**http://whqlibdoc.who.int/publications/9241541601.pdf**

Annex 3.2

ICDC – IBFAN State of the Code by Country

Complete document may be procured from:

https://www.ibfan-icdc.org/product/state-of-the-code-by- country-2016-blue-soc-poster/

https://www.ibfan-icdc.org/product/state-of-the-code-by-country-2018-chart-hardcopy/

Marketing of Breast-milk Substitutes: National Implementation of the International Code-Status Report 2018

https://apps.who.int/iris/bitstream/handle/10665/272649/9789241565592-eng.pdf?ua=1

Marketing of Breast-milk Substitutes: National Implementation of the International Code-Status Report 2016

https://apps.who.int/iris/bitstream/handle/10665/206008/9789241565325_eng.pdf?sequence=1

Annex 4.1

Human Rights Related to Breastfeeding

Infants have the right to …

- Enjoyment of the highest attainable standard of health (Art. 24(1) CRC, Art. 12(1) ICESCR)
- Adequate nutritious food (Art.24 (2)(c) CRC, Art. 11(1) ICESCR)
- Primary health care (Art. 24(2)(b) CRC)
- A standard of living adequate for the child's physical, mental, spiritual, moral and social development (Art. 27(1) CRC)
- *Mothers have the right to…*
- Health care services and appropriate post-natal care (CEDAW 12.2, CRC 24)
- Education and support in the use of basic knowledge of child health and nutrition, the advantages of Breastfeeding (CRC 24.2(e))
- Appropriate assistance in their child-rearing responsibilities (CRC 18)
- Adequate nutrition during pregnancy and lactation (CEDAW 12.2)
- Paid maternity leave or other equivalent, including job protection (ICESCR 10, CEDAW 11.2(b))
- Safeguarding of the function of reproduction in working conditions (CEDAW 11.1(f))
- Decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights (CEDAW 16.1(e))

States Parties are obliged to…

- Ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff, as well as competent supervision (Art. 3(3) CRC)
- Ensure to the maximum extent possible the survival and development of the child (Art. 6(2) CRC)
- Take appropriate measures to diminish infant and child mortality (Art.24 (2)(a) CRC)
- Ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (Art. 24(2)(b) CRC)
- Combat disease and malnutrition, including within the framework of primary health care (Art. 24(2)
- (c) CRC)
- Take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children (Art. 24(3) CRC)
- Take [in accordance with national conditions and within their means] appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programs, particularly with regard to nutrition. (Art.27 (3) CRC)

Source: *Kaia Engesveen. (2005). Strategies for Realizing Human Rights to Food, Health and Care for Infants and Young Children in Support of the Millennium Development Goals: Role and Capacity Analysis of Responsible Actors in Relation to Breastfeeding in the Maldives.SCN News (United Nations System Standing Committee on Nutrition). 30: 56-66.*

Annex 4.2

Status of Maternity Protection by Countries

http://www.waba.org.my/whatwedo/womenandwork/pdf/mp_chart_2015_updated-Feb%202015.pdf

Annex 5.1

Education checklist Infant and young child feeding topics

Objectives *(to be achieved by all health students and trainees who will care for infants, young children and mothers)*	**Content/skills** *(to achieve objectives)*
1. Identify factors that influence breastfeeding and complementary feeding.	National/local breastfeeding and complementary feeding rates and demographic trends; cultural and psychosocial influences; common barriers and concerns; local influences.
2. Provide care and support during the antenatal period.	Breastfeeding history (previous experience), breast examination, information targeted to mother's needs and support.
3. Provide intra-partum and immediate postpartum care that supports and promotes successful lactation.	The Baby-friendly Hospital Initiative (BFHI), *Ten steps to successful breastfeeding*; supportive practices for mother and baby; potentially negative practices.
4. Assess the diets and nutritional needs of pregnant and lactating women and provide counselling, as necessary.	Nutritional needs of pregnant and lactating women, dietary recommendations (foods and liquids) taking account of local availability and costs; micronutrient supplementation; routine intervention and counselling.
5. Describe the process of milk production and removal.	Breast anatomy; lactation and breastfeeding physiology
6. Inform women about the benefits of optimal infant feeding.	Benefits of breastfeeding for infant, mother, family, and community; benefits of exclusive breastfeeding for 0–6 months; options and risks when unable to breastfeed.
7. Provide mothers with the guidance needed to successfully breastfeed.	Positioning/ attachment; assessing effective milk removal; signs of adequate intake; practise observing and assessing breastfeeding and suggesting improvements.

Objectives *(to be achieved by all health students and trainees who will care for infants, young children and mothers)*	**Content/skills** *(to achieve objectives)*
8. Help mothers prevent and manage common breastfeeding problems. Manage uncomplicated feeding difficulties in the infant and mother.	Normal physical, behavioural and developmental changes in mother and child (prenatal through lactation stages); feeding history; observation of breastfeeding; suckling difficulties; causes and management of common infant feeding difficulties; causes and management of common maternal feeding difficulties.
9. Facilitate breastfeeding for infants with special health needs, including premature infants.	Risk/benefit of breastfeeding/breast milk; needs of premature infants; modifications; counselling mothers.
10. Facilitate successful lactation in the event of maternal medical conditions or treatments.	Risk/benefit; modifications; pharmacological choices; treatment choices.
11. Inform lactating women about contraceptive options.	Advantages and disadvantages of various child spacing methods during lactation; counselling about LAM; cultural considerations for counselling.
12. Prescribe/recommend medications, contraceptives and treatment options compatible with lactation.	Compatibility of drugs with lactation; effects of various contraceptives during lactation.
13. Assist mothers to sustain lactation during separation from their infants, including during hospitalization or illness of mother or child and when returning to work or school.	Milk expression, handling and storage; alternative feeding methods; cup-feeding; cause, prevention and management of common associated difficulties such as low milk supply; coordinating out-of-home activities with breastfeeding; workplace support.

Objectives *(to be achieved by all health students and trainees who will care for infants, young children and mothers)*	**Content/skills** *(to achieve objectives)*
14. Explain the *International Code of Marketing of Breast-milk Substitutes* and World Health Assembly resolutions, current violations, and health worker responsibilities under the *Code*.	Main provisions of the *Code* and WHA resolutions, including responsibilities of health workers and the breast-milk substitute, bottles and teats industries; violations by infant food companies; monitoring and enforcement of the *Code*.
15. Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable to the general population.	Developmental approach to introduce complementary foods; foods appropriate at various ages; available foods and their costs; incomes of local families and how income levels affect their abilities to afford various foods.
16. Ask appropriate questions of mothers and other caregivers to identify sub-optimal feeding practices with young children between 6 and 24 months of age.	Growth patterns of breastfed infants; complementary foods: when, what, how, how much; micronutrient deficiencies/supplements; young child feeding history; typical problems.
17. Provide mothers and other caregivers with information on how to initiate complementary feeding, using the local staple.	Local staples and nutritious recipes for first foods; practise counselling mothers; common difficulties and solutions.
18. Counsel mothers and other caregivers on how to gradually increase consistency, quantity, and frequency of foods, using locally available foods.	Guidelines for feeding young children at various ages and stages of development; potential difficulties and solutions regarding feeding and weaning; Essential Nutrition Actions.
19. Help mothers and other caregivers to continue feeding during illness and assure adequate recuperative feeding after illness.	Energy and nutrient needs; appropriate foods and liquids during and after illness; strategies for encouraging child to eat and drink; local beliefs about feeding during illness; appropriate feeding support during hospitalization; re-lactation.

Objectives *(to be achieved by all health students and trainees who will care for infants, young children and mothers)*	**Content/skills** *(to achieve objectives)*
20. Help mothers of malnourished children to increase appropriate food intake to regain correct weight and growth pattern.	Feeding recommendations for malnourished children; micronutrient supplements for malnourished children.
21. Inform mothers of the micronutrient needs of infants and young children and how to meet them through food and, when necessary, supplementation.	Micronutrient needs of infants and young children (iron, vitamin A, iodine, others); meeting these needs with food (breastfeeding and complementary foods); supplementation needs.
22. Demonstrate good interpersonal communication and counselling skills.	Listening and counselling skills, use of simple language, providing praise and support, considering mother's viewpoint, trials of new practices.
23. Facilitate group education sessions related to infant and young child nutrition and maternal nutrition.	Adult education methods; strategies for preparing and facilitating competency-based, participatory sessions.
24. Counsel mothers about prevention and reduction of mother-to-child-transmission of HIV/AIDS; options and risks of various feeding methods to consider when HIV-positive.	Modes of mother-to-child-transmission of HIV and how to prevent or reduce it; counselling confirmed HIV-positive mothers about feeding options and risks.
25. Provide guidance on feeding infants and young children in emergencies and appropriate protection, promotion and support in these circumstances.	Policies and guidelines on feeding in emergencies; appropriate promotion and support; compliance with the *International Code of Marketing of Breast-milk Substitutes* and WHA resolutions.

Annex 5.2

Criteria for mother-friendly care[19]

A woman in labour, regardless of birth setting, should have:

- Access to care is sensitive and responsive to the specific beliefs, values, and customs of the mother's culture, ethnicity and religion.
- Access to birth companions of her choice who provide emotional and physical support throughout labour and delivery.
- Freedom to walk, move about, and assume the positions of her choice during labour and birth (unless restriction is specifically required to correct a complication). The use of the lithotomy position (flat on back with legs elevated) is discouraged.
- Care that minimizes routine practices and procedures that are not supported by scientific evidence (e.g., withholding nourishment; early rupture of membranes; IVs (intravenous drip); routine electronic fetal monitoring; enemas; shaving).
- Care that minimizes invasive procedures (such as rupture of membranes or episiotomies) and involves no unnecessary acceleration or induction of labour, and no medically unnecessary caesarean sections or instrumental deliveries.
- Care by staff trained in non-drug methods of pain relief and who do not promote the use of analgesic or anaesthetic drugs unless required by a medical condition.

A health facility that provides delivery services should have:

- Supportive policies that encourage mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
- Clearly-defined policies and procedures for collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary; and linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow up and breastfeeding support.
- A policy on mother-baby-friendly services (as outlined above) and staff who are trained to understand that the health and well-being of the mother, her fetus, her newborn, and the successful initiation of breastfeeding, are all part of a continuum of care.

[19]WHO's "Infant and Young Child Feeding-A tool for assessing national practices, policies and programmes". Available at **http://whqlibdoc.who.int/publications/2003/9241562544.pdf**

Annex 6.1

WHO's Guideline Counselling of Women to Improve Breastfeeding Practices (2018) lend credible support to organise counselling services in order to enhance early and exclusive breastfeeding rates through protecting, promoting and supporting breastfeeding through the health systems.

https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf- practices/en/?fbclid=IwAR1aWsQZgpgWq5wx6w54atT94S-_PcTbGS7Mxa-BELgEH1X3ariC3tZ7D64

Annex 7.1

World Breastfeeding Week Action Folder (WABA)

See complete document at: **http://worldbreastfeedingweek.org**/

Annex 7.2

WHO and FAO Guidelines on safe preparation, storage and handling of powdered infant formula

See full document at: **http://www.who.int/foodsafety/document_centre/pif_guidelines.pdf?ua=1**

Annex 7.3

Eight World Health Assembly Resolutions have called for Conflict-of-Interest Safeguards in infant and young child feeding since 1996.

(The other resolutions are **https://www.who.int/nutrition/topics/wha_nutrition_iycn/en/**)

The Global Strategy for Infant and Young Child Feeding in 2003 outlines the two clear roles for industry. **https://apps.who.int/iris/bitstream/handle/10665/42590/9241562218.pdf;jsessionid=1F405F7490A5314D7386 274024943269?sequence=1**

Annex 8.1

World Health Organization (2016)

Guidelines: updates on HIV and infant feeding: the duration of breastfeeding, support from health services to improve feeding practices among mothers living with HIV. **http://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1**

Annex 8.2

WHO 2009 (revised 2010). Rapid Advice

Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Recommendations for a public health approach. **http://www.who.int/hiv/pub/mtct/advice/en/**

Annex 9

Infant and young child feeding in emergencies
Criteria for appropriate emergency preparedness policies and programmatic measures at the national level

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**
   Essential items to address in a national policy are included in: *Infant and young child feeding in emergencies: operational guidance for emergency relief staff and programme managers. Interagency Working Group on Infant and Young Child Feeding in Emergencies, version 3, 2017.*
   https://www.ennonline.net/operationalguidance-v3-2017
   Key points from the Operational Guidance (see full text for listed practical steps)
   a. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.
   b. Every agency should endorse or develop a policy on IFE. The policy should be widely disseminated to all staff, agency procedures adapted accordingly and policy implementation enforced (Section 1).
   c. Agencies should ensure the training and orientation of their technical and non-technical staff in IFE, using available training materials (Section 2).
   d. Within the United Nations (UN) Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF is likely the UN agency responsible for co-ordination of IFE in the field. Also, other UN agencies and NGOs have key roles to play in close collaboration with the government (Section 3).
   e. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted (Section 4).
   f. Simple measures should be put in place to ensure the needs of mothers, infants and young children are addressed in the early stages of an emergency.
   g. Support for other caregivers and those with special needs, e.g. orphans and unaccompanied children, must also be established at the outset (Section 5).
   h. Breastfeeding and infant and young child feeding support should be integrated into other sectors and services for mothers, infants and young children (Section 5).
   i. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations (Section 5).
   j. Donated (free) or subsidised supplies of breastmilk substitutes (e.g. infant formula) or commercial complementary foods should be avoided. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency (Section 6).

2. **A person or team responsible for national response and coordination with all relevant partners such as the United Nations, donors, the military and nongovernmental organizations (NGOs)**

on issues related to infant and young child feeding in emergencies has been appointed. Responsibilities will include:

a. Development of a national contingency plan based on the existing national policy and the IFE Operational Guidance.
b. Representation of the national government during an emergency response in the following coordination activities: policy development; inter-sectoral coordination; development of an action plan that identifies agency responsibilities and mechanisms for accountability; dissemination of the policy and action plan to operational and non-operational agencies, including donors; monitoring of the implementation of the action plan
c. Involvement of affected communities in the planning process.

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, that covers….**

a. Identify and sensitise key personnel involved in planning and delivering emergency response regarding IFE.
b. Forecast capacity needs based on emergency scenarios.
c. Identify national capacity development needs on IYCF. Integrate context-specific training content into existing curricula and delivery mechanisms.
d. Orientate and train relevant staff in IYCF support. Include key components of IFE and the Code in pre-service training of health professionals.
e. Map existing capacities for key areas, e.g., skilled breastfeeding support and translators, and develop key contact lists of existing national expertise.
f. Prepare orientation material for use in early emergency response.
g. Update training content based on lessons learned from emergency response.

Coordinate operations

1. Identify government leadership and coordination authority on IFE and support capacity development to strengthen this responsibility as necessary.
2. Where government capacity is constrained, identify options for coordinated IFE response and leadership.
3. Develop terms of reference for IFE coordination in response.
4. Raise public and professional awareness regarding recommended IYCF practices and benefits. Develop an IFE communication strategy and plan for rapid implementation in an emergency. Prepare easily adapted media briefs.
5. Engage development agencies and donors in preparedness planning that includes adaptation of existing programmes to meet emergency needs, negotiating funder flexibility to meet new needs and priming sources of surge funding to accommodate increased demands.
6. Allocate funding to support monitoring, evaluation and learning.
7. Establish links with other sector focal points and coordination mechanisms, especially food security, health and WASH.

Assess and monitor

- Develop a profile on IYCF practices and maternal and child nutrition to inform early decision-making in an emergency.

- Ensure disaggregated data and recent reports are readily accessible.
- Calculate the prevalence of non-breastfed infants less than six months old and at one year and two years old from existing data.
- Prepare key questions to include in early needs assessment.
- Identify existing and/or potential national/sub-national capacity to undertake IYCF assessment and surveys.
- Support government to develop policies and procedures to monitor and act on Code violations. Monitor and report Code violations to relevant authorities.
- Identify what existing monitoring and evaluation tools and systems can be applied in an emergency context and agree any necessary adaptations.

Protect, promote and support optimal infant and young child feeding with integrated multi-sector interventions

a. Actively promote and support recommended IYCF practices in the population.
b. Integrate the Ten Steps to Successful Breastfeeding of the WHO/UNICEF Baby-friendly Hospital Initiative into maternity services.
c. Develop preparedness plans for interventions on breastfeeding support, complementary feeding, artificial feeding and identification and management of particularly vulnerable children.
d. Identify key sector focal points in ministries and agencies to engage in programming.
e. Profile complementary foods and feeding practices, including existing nutrient gaps and culturally-sensitive response options, and mechanisms for scale-up and response in an emergency context.
f. Identify supply chain for an appropriate BMS (if needed) and complementary foods.
g. Work to ensure that local/commercially produced complementary foods meet minimum standards.
h. Examine national legislation related to food and drugs, particularly importation.
i. Anticipate likely need for and mechanisms to provide micronutrient supplementation to PLW and children.
j. Develop plans for response and for transition post-emergency regarding IYCF interventions.
k. Identify existing or potential public health issues of nutrition concern and plan accordingly.

Minimise the risks of artificial feeding

1. Develop plans for prevention and management of donations of BMS, other milk products and feeding equipment in an emergency.
2. Communicate government position on not seeking or accepting donations to key actors, including country embassies, donors, development partners and civil society groups, among others.
3. Use scenarios to forecast potential artificial feeding needs in an emergency-affected population and develop preparedness plans accordingly.
4. Establish systems for management of artificial feeding, including coordination authority (or at least terms of reference), BMS supply chain and monitoring mechanisms.

Note: Programme preparedness actions (as well as response and recovery) are detailed in UNICEF Core Commitments for Children in Humanitarian Action. UNICEF 2010.

5. **Resources have been allocated for implementation of the emergency preparedness and response plan**
   Check if any preparedness activities are/have been carried out (development of policy, identification of coordination person or team, orientation and training) and with what funds; check if any funds have been set aside for an eventual emergency, and if any emergencies have taken place, if any funds/what funds were allocated to infant and young child feeding
6. **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.**

Materials include:

- Policies and guidelines relevant to infant and young child feeding in emergencies.
- Appropriate knowledge and skills to support caregivers in feeding infants and young children in special circumstances of emergencies.

Note: Basic information on infant and young child feeding in emergencies should be provided to all who may be involved in humanitarian assistance work, including policy-makers and decision-makers who will act in an emergency, agency staff (headquarters, regional, desk and field staff) and national breastfeeding specialists.

Useful Resources:

- Media guide on Infant and young child feeding in emergencies. English, French, German, Spanish, Italian, Arabic. **https://www.ennonline.net/iycfmediaguide**
  - The recently updated joint statement can be found here **https://www.ennonline.net/modelifejointstatement**
  - Key messages on IFE - for mothers and caregivers **https://www.ennonline.net//ifekeymessagesmothers**
- World Breastfeeding Week, 2009. 'Breastfeeding, a vital emergency response: are you ready?' **http://www.worldbreastfeedingweek.net/wbw2009/index.htm**
- Save the Children, IYCF E Tool Kit: **https://resourcecentre.savethechildren.net/library/infant-and-young-child-feeding-emergencies-iycf-e-toolkit-rapid-start-emergency-nutrition**

Useful training materials:

For orientation:

Core group in Infant feeding in Emergencies, Module 1, Orientation Package on IFE, v2.1, 2010. English.
https://www.ennonline.net//ourwork/capacitydevelopment/iycfeorientation
https://www.ennonline.net//iycfeorientationpackage

- This is a package of resources to help in orientation on infant and young child feeding in emergencies (IFE). These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies, at national and international level.
- The IFE Orientation Package, an update of Module 1 on IFE (essential orientation), a print content first produced in 2001, uses the Operational Guidance on IFE as a guiding framework to support its implementation. This package supports the content of HTP Module 17 on Infant and Young Child Feeding, v2.0, 2010.
- The IFE orientation package comprises e-learning lessons, training resources, technical notes, key resources, and an evaluation guide.

For technical training:

- Module 2. Infant and young child feeding. For health and nutrition staff, v1.1, 2007. English, French, Bahasa (Indonesia) and Arabic. (working link: **https://www.ennonline.net/ourwork/capacitydevelopment/iycfemodule2**)
- Integration of Infant and Young Child Feeding into Community based Management of Acute Malnutrition. October 2009. English and French **https://www.ennonline.net/ourwork/capacitydevelopment/iycfcmam**
- IASC Nutrition. Harmonized Training Package, Cluster Module 17 on Infant and young child feeding in emergencies. **https://www.ennonline.net/ourwork/capacitydevelopment/htpversion2 http://www.ennonline.net/resources/761**

For other key useful orientation and training materials developed by the IFE core group see

- **http://www.ennonline.net/resources/tag/128**

https://www.ennonline.net//ourwork/capacitydevelopment/iycfeorientation (here you can find all the relevant and available IFE training package)

Annex 10.1

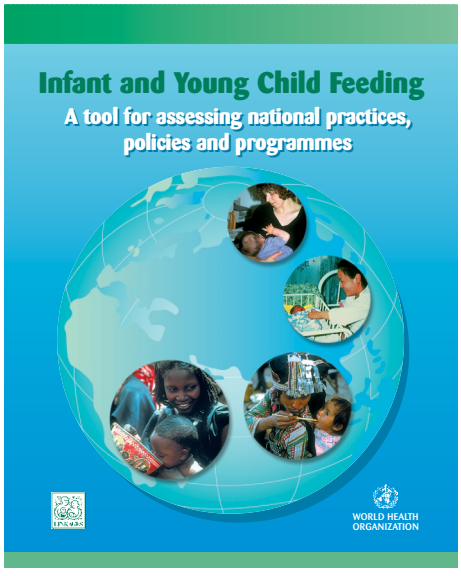
Indicators for assessing infant and young child feeding practices

Available at: **http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/**

WBTi Global Secretariat

Breastfeeding Promotion Network of India (BPNI)
BP-33, Pitampura, Delhi-110034, India
Phone: 91-11-27312705, 42683059
E-mail: **wbtigs@gmail.com**
Website: **www.worldbreastfeedingtrends.org**

Annex 11.1



WHO (2003). Infant and young child feeding - A tool for assessing national practices, policies and programmes. Available at: **http://www.who.int/nutrition/publications/infantfeeding/9241562544/en/**

See page 5-14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