



Australian Health Ministers' Conference

A photograph of a woman breastfeeding a baby, overlaid with a teal tint. The woman is lying down, and the baby is positioned at her breast. The image is the background for the lower half of the cover.

Australian National Breastfeeding Strategy 2010 - 2015



Australian Health Ministers' Conference

Australian National Breastfeeding Strategy 2010 - 2015

ISBN: 978-1-74241-114-9

Online ISBN: 978-1-74241-115-6

Publications Approval Number- P3-6238

Paper-based publications

© Commonwealth of Australia 2009 on behalf of the Australian Health Ministers' Conference (2009)

This Australian National Breastfeeding Strategy was prepared under the auspices of the Australian Health Ministers' Conference.

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

Internet sites

© Commonwealth of Australia 2009

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

Australian Health Ministers' Conference 2009, *The Australian National Breastfeeding Strategy 2010-2015*. Australian Government Department of Health and Ageing, Canberra.

Foreword

This is the first Australian National Breastfeeding Strategy endorsed by the Australian Health Ministers' Conference. The Strategy recognises the biological, health, social, cultural, environmental and economic importance of breastfeeding. It provides a framework for priorities and action for Australian governments at all levels working in partnership with the community to protect, promote, support and monitor breastfeeding throughout Australia.

In the process of developing the Strategy it was confirmed that considerable work is already occurring around Australia to protect, promote, support and monitor breastfeeding, through each level of government and in non-government organisations. It is envisaged that the implementation and governance arrangements established under this Strategy will provide further opportunities to coordinate, share and learn from these valuable efforts at the local, state/territory and national levels.

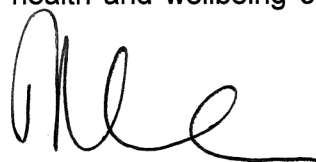
A multifaceted approach is needed to foster an environment that supports and enables mothers to breastfeed, involving not only governments but also health professionals; community, family and peer leaders; non-government organisations; employers and workplaces; child care services; as well as the manufacturers, importers and retailers of infant formula. Many of these stakeholders were consulted during the development of the Strategy. Although the Strategy does not provide immediate resolution to all of the specific issues raised by stakeholders, the Strategy provides a governance mechanism and the mandate to progress these issues. Issues such as the promotion and marketing of infant formula, the regulatory framework for human milk banks and monitoring and reporting will be addressed in greater detail as implementation work progresses. Stakeholders will continue to be involved and consulted.

The launch of this Strategy comes at a time of significant health reform for Australia. Breastfeeding policies and programs are related to many aspects of the health and community services systems where changes are occurring or being considered. This provides both opportunities and challenges for implementing the Australian National Breastfeeding Strategy as it complements and informs these related policies.

The implementation of the Australian National Breastfeeding Strategy will be progressed by governments both independently and nationally under the Australian Health Ministers' Advisory Council, and with ongoing leadership from the Australian Government. With the continued commitment of other sectors, we can create a more enabling environment and culture for breastfeeding. The Australian National Breastfeeding Strategy has been developed through an extensive national process of consultation and the time, effort and advice of the many people who contributed is acknowledged and appreciated. We encourage all Australians to embrace and take forward this Australian National Breastfeeding Strategy and its vision, objectives, principles and strategic goals towards improving the health and wellbeing of infants, young children and mothers.



John Hill
Chair,
Australian Health Ministers' Conference



Nicola Roxon
Minister for Health and Ageing

13 November 2009



Contents

<i>Executive summary</i>	1
<hr/>	
Chapter 1	
<i>Background</i>	3
1.1 Introduction	3
1.2 Background to development	3
1.3 Defining breastfeeding and protection, promotion and support	4
1.4 The breastfeeding continuum	6
<hr/>	
Chapter 2	
<i>Breastfeeding in Australia</i>	9
2.1 Australian breastfeeding rates	9
2.2 Global comparisons	10
2.3 Factors affecting breastfeeding	12
<hr/>	
Chapter 3	
<i>Breastfeeding in Context</i>	17
3.1 International policy and practice	17
3.2 Australian Dietary Guidelines	19
3.3 The National Breastfeeding Strategy (1996–2001)	19
3.4 Jurisdictional and non-government organisational strategies	20
3.5 National inquiries, reviews and health reform	21
3.6 The legislative and regulatory environment	24
3.7 Other complex issues	24
<hr/>	
Chapter 4	
<i>Breastfeeding Practice and Evidence</i>	27
4.1 Jurisdictional stocktake	27
4.2 What works best?	29
<hr/>	
Chapter 5	
<i>The National Breastfeeding Strategy</i>	33
5.1 Introduction	33
5.2 Strategic framework - vision, objectives and principles	34
5.3 Strategic goals	35
5.4 Monitoring	38
5.5 Research and evaluation	39
5.6 Governance framework	40
5.7 Implementation plan	41
<hr/>	
References	43
Appendix A	49
<i>Barriers to breastfeeding</i>	49



Executive summary

In March 2009, Australian Health Ministers agreed to collaborate on developing and implementing an Australian National Breastfeeding Strategy to be led by the Australian Government. The Department of Health and Ageing commissioned the Allen Consulting Group Pty Ltd to facilitate the development of the Australian National Breastfeeding Strategy and a consultation process targeted to key stakeholders during July and August 2009. A jurisdictional stocktake and service/activity mapping exercise was also conducted during this period.

The Australian National Breastfeeding Strategy provides a framework for priorities and action for all governments to address the protection, promotion, support and monitoring of breastfeeding throughout Australia. An implementation plan to accompany the Strategy will be developed during 2010.

The framework for the Australian National Breastfeeding Strategy includes the following vision, objective, and underlying principles:

Vision

Australia is a nation in which breastfeeding is protected, promoted, supported and valued by the whole of society.

Breastfeeding is viewed as the biological and social norm for infant and young child feeding.

Mothers, families, health professionals and other caregivers are fully informed about the value of breastfeeding.

Objective

To increase the percentage of babies who are fully breastfed from birth to six months of age, with continued breastfeeding and complementary foods to twelve months and beyond.

Principles

1. ***Mother and Child*** – The mother and child relationship is the heart and focal point of all breastfeeding related activities.
2. ***Ecological Context*** – Breastfeeding is influenced by a range of family, social, cultural and environmental factors that inform promotion and support activity across the breastfeeding continuum.
3. ***Access*** – All members of a community have universal access to appropriate information and affordable services that protect, promote and support breastfeeding.
4. ***Diversity*** – The diversity of Australian families is recognised through breastfeeding promotion and support activities that are sensitive and responsive to individual circumstances.
5. ***Collaborative Care*** – Services and health professionals work in collaborative partnership to provide holistic care to breastfeeding women and their families that strengthens and maintains existing support services.

6. *Continuity of Care* – Continuity of support at key transition points between birthing and community services and into the broader community is seamless from the perspective of mothers and their families.
7. *Evidence Based* – Protection, promotion and support activities are consistently informed by the best available evidence, the percentage of babies breastfed is regularly monitored, and activities are evaluated.
8. *Effective Governance* – There is a clear accountability for breastfeeding protection, promotion, support and monitoring activities at state/territory and national levels, and appropriate consultation and collaboration with the community sector.

Chapter 1

Background

1.1 Introduction

The aim of the Australian National Breastfeeding Strategy is to contribute to improving the health, nutrition and wellbeing of infants and young children, and the health and wellbeing of mothers, by protecting, promoting, supporting and monitoring breastfeeding.

The Australian and state and territory governments are committed to promoting the value of breastfeeding and improving breastfeeding rates in Australia. States and territories play a large role in delivering breastfeeding support and other services to new mothers, and in promoting the value of breastfeeding more widely.

A large body of Australian and international evidence shows that breastfeeding provides significant value to infants, mothers and society:

- *babies*: breastfed babies are less likely to suffer from a range of serious illnesses and conditions such as gastroenteritis, respiratory illness and otitis media (AIHW 2009, NHMRC 2003);
- *mothers*: breastfeeding promotes faster maternal recovery from childbirth and women who have breastfed have reduced risks of breast and ovarian cancers in later life (AIHW 2009, NHMRC 2003); and
- *society*: protective effects of breastfeeding in infancy may extend to later life, with reduced risks of obesity and chronic disease (Horta et al. 2007). Breastfeeding may assist the bonding and attachment between mothers and babies. The Productivity Commission (2009) noted that several Australian and overseas studies estimated substantial hospitalisation costs associated with premature weaning because of the association with infant illness.

Breast milk is an environmentally friendly product and there are health risks and financial costs associated with not breastfeeding. This applies to developing countries and developed countries such as Australia. It is important to protect, promote and support breastfeeding at a population level and for those members of the community who are vulnerable to social and health disadvantage. Despite these considerations, about half of Australian babies are not receiving any breast milk by the time they reach six months of age (Baxter 2008).

1.2 Background to development

The Australian Health Ministers' Conference agreed in March 2009 to collaborate on developing and implementing an Australian National Breastfeeding Strategy, led by the Australian Government, to provide a framework for priorities and action for all governments to address the protection, promotion, support and monitoring of breastfeeding in the community. The commitment to develop the Australian National Breastfeeding Strategy was a key element of the Australian Government's response to *The Best Start: Report on the inquiry into the health benefits of breastfeeding* from the House of Representatives Standing Committee on Health and Ageing (HoR 2007, Australian Government 2008).

The development of the Australian National Breastfeeding Strategy was coordinated by the Australian Government Department of Health and Ageing with the Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee acting as the Reference Group for strategic direction. The Department of Health and Ageing commissioned the Allen Consulting Group Pty Ltd to facilitate the development of the Strategy including a review of the Australian and international context and evidence for the effectiveness of interventions designed to increase breastfeeding rates with a particular focus on priority population groups, and a consultation process that targeted key stakeholders during July and August 2009. A jurisdictional stocktake and service/ activity mapping exercise was also conducted during this period to inform the Australian National Breastfeeding Strategy.

The Australian Population Health Development Principal Committee, Australian Health Ministers' Advisory Committee and the Australian Health Ministers' Conference have been involved in endorsing the Australian National Breastfeeding Strategy.

1.3 Defining breastfeeding and protection, promotion and support

There are internationally recommended terms defining breastfeeding practices which are used to guide breastfeeding data collection and reporting (WHO 2008). These can be summarised as:

- *Exclusive breastfeeding* requires that the infant receive only breast milk (including expressed milk) and medicines (including oral rehydration solutions, vitamins and minerals) but no infant formula or non-human milk.
- *Predominant or 'full' breastfeeding* has a slightly less stringent definition as in addition to breast milk and medicines the infant may receive water, or water-based drinks, tea or fruit juice (which are not recommended for babies) but no non-human milk or formula.
- *Complementary feeding or partial breastfeeding* requires that the infant receive solid or semi-solid food in addition to breast milk, including expressed milk. This may include any food or liquid, including non-human milk and formula.
- *Breastfeeding* or *'any' breastfeeding* includes all of the above definitions.
- *Ever breastfed* means that the infant has been breastfed or received expressed breast milk or colostrum, at least once.

Protection

Breastfeeding protection is about enabling mothers to breastfeed their babies and young children anywhere a mother and child have a right to be, with confidence and without harassment. Breastfeeding protection includes legislative and regulatory environments, leave and employment entitlements, and the creation of baby and breastfeeding friendly environments in the health system and broader community. There is some overlap between the concepts of breastfeeding protection and promotion.

Promotion

Breastfeeding promotion includes but is not limited to education and social marketing. Overlap can occur with breastfeeding protection and support. The Australian National Breastfeeding Strategy recognises the many facets of health promotion and defines breastfeeding promotion in this context:

A combination of educational, organisational, economic and political actions designed with consumer participation, to enable individuals, groups and whole communities to increase control over, and to improve their health through attitudinal, behavioural, social and environmental changes (Howat et al. 2003).

In keeping with the spirit of the Ottawa Charter for Health Promotion (WHO 1986) the Australian National Breastfeeding Strategy is designed to create an enabling culture for change by strengthening community action, reorienting health services, building healthy public policy, creating supportive environments, and developing personal skills.

Support

Support is defined within the Australian National Breastfeeding Strategy as support provided to mothers at the antenatal and postnatal stages, for both breastfeeding initiation and maintenance. This support may take the form of verbal advice, physical assistance (e.g., to help the mother and baby establish good positioning and attachment) or infrastructure, such as publicly available breastfeeding rooms or workplace facilities.

Breastfeeding support encompasses training provided to breastfeeding support staff, including doctors, midwives, pharmacists, nurses and International Board Certified Lactation Consultants, as well as voluntary counsellors, Aboriginal Health Workers and support workers. Support activities target a range of groups such as first-time mothers, mothers with other children, workplaces, health facilities, partners, grandparents, extended family, and peers. It should target Aboriginal and Torres Strait Islander, young, culturally and linguistically diverse, and low socio economic status women, their partners or families.

Support can be provided from a range of different sources, including health professionals, trained peer counsellors, family members, friends, Aboriginal matriarchs and community leaders and Elders. The Australian National Breastfeeding Strategy differentiates between peer and lay support:

- *peer support* is provided by people who usually have had some experience in breastfeeding, and have received a level of specific training to assist in their support role (Shealy et al. 2005). A good example of peer support is the counselling and assistance provided through the Australian Breastfeeding Association national 24 hour toll-free Breastfeeding Helpline available on 1800 MUM 2 MUM (1800 686 2 686).
- *lay support* is provided by other mothers, family members or friends who may have some experience in breastfeeding but have not received any formal training.

Monitoring

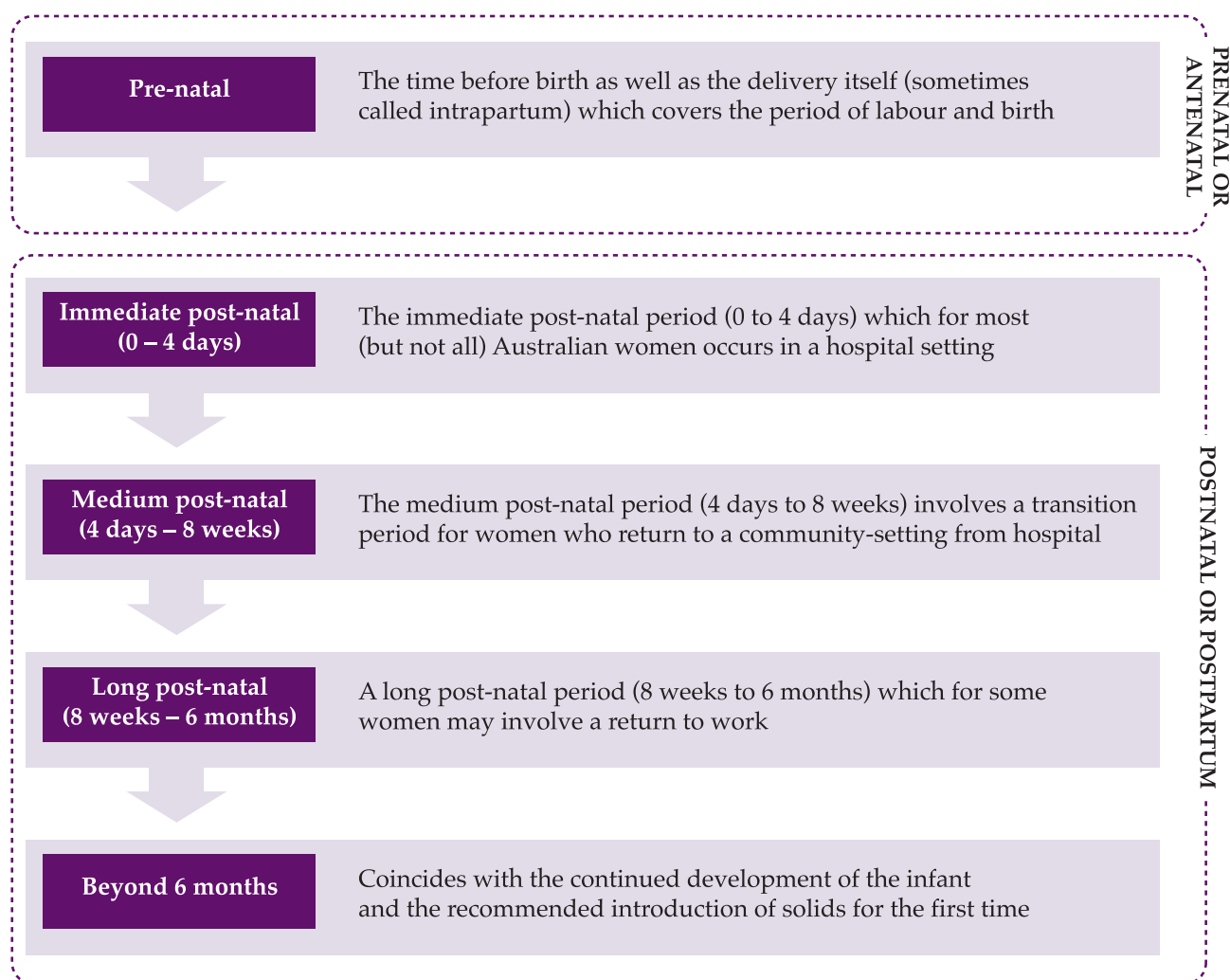
Monitoring encompasses data collection on breastfeeding rates and duration. It also relates to monitoring and evaluation of specific programs or interventions.

1.4 The breastfeeding continuum

The Australian National Breastfeeding Strategy recognises breastfeeding as occurring on a continuum or natal cycle that starts well before the birth of a baby and then progresses through several stages, including birth and the weeks and months after birth. While the concept of the continuum is widely used and accepted, there is no uniformly agreed definition. The Australian National Breastfeeding Strategy draws upon the continuum in Figure 1.1 that is based on Thornley et al. (2007).

Figure 1.1

BREASTFEEDING CONTINUUM



Source: Based on Thornley et al. (2007)

The needs of parents, mothers and infants will change between the stages and settings of the breastfeeding continuum. It is important that the activities and interventions that are provided to protect, promote, and support breastfeeding are evidence based and suited to the different stages of the continuum. The evidence indicates that multifaceted approaches are the most effective. The Australian National Breastfeeding Strategy sets out Australia's breastfeeding goals and objectives for each stage of the breastfeeding continuum.

Antenatal Stage

This is the preparatory stage for breastfeeding and includes developing knowledge, commitment and support networks. The development of a commitment to breastfeeding includes viewing breastfeeding as the biological and social norm for infant and young child feeding. Attitudes are formed from childhood and can change through to parenthood. Antenatal promotion and education play a large role in informing mothers and families about breastfeeding. The extent to which a mother commits to breastfeed at this point can impact on the duration of breastfeeding (Shealy et al. 2005). The goal is to enable mothers to understand the value of breastfeeding and to breastfeed successfully by equipping them with knowledge and establishing or consolidating their support networks.

Immediate postnatal (birth to four days)

This is when mothers begin breastfeeding. Approximately 92 per cent of Australian babies are breastfed at birth (AIFS 2008). Mother and baby's experiences in birthing services, and the feeding practices encouraged there affect the establishment of breastfeeding. Medications and procedures administered during labour can affect the baby's behaviour at the time of birth, which can impact on the ability to breastfeed. Placing babies in skin to skin contact with their mothers immediately following birth and encouraging mothers to recognise when their babies are ready to breastfeed helps to establish the breastfeeding relationship (WHO 2009). Mothers who room-in with their babies have more opportunities to practice breastfeeding because of the infant's proximity (Shealy et al. 2005).

Medium postnatal (four days to eight weeks)

By one week of age, the rate of full breastfeeding drops to 80 per cent. At one month only 71 per cent are fully breastfed, another 11 per cent receive a combination of breast milk and infant formula, 18 per cent receive formula only (AIFS 2008). Many mothers are reliant on their social networks after returning home from birthing services. These social networks can be highly influential in many of the decision making processes associated with raising a baby. Lay advice and support can either act as a barrier to or provide encouragement for breastfeeding (McLorg and Bryant 1995). New mothers' preferred resource for concerns about child rearing is often other mothers (Shields 2004).

Long postnatal (eight weeks to six months and beyond)

At four months, approximately 46 per cent of Australian infants are fully breastfed, noting that at five months, this rate has dropped to 28 per cent. By six months, around the time when the Australian Dietary Guidelines recommend introducing solid foods, a total of 56 per cent are still receiving at least some breast milk and 14 per cent are fully breastfeeding (NHMRC 2003, AIFS 2008, Baxter 2008). Efforts to extend breastfeeding during the long postnatal stage include the continuation of health professional and peer support, and the creation of enabling breastfeeding friendly environments in a range of settings including workplaces, child care and public spaces, and the broader community.



Chapter 2

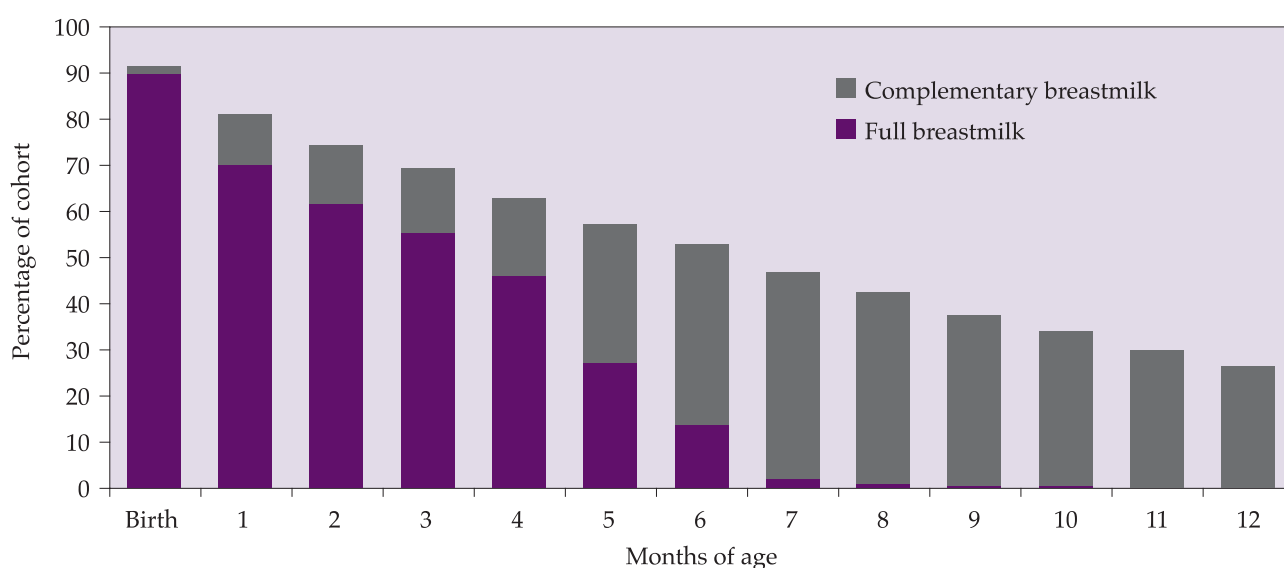
Breastfeeding in Australia

2.1 Australian breastfeeding rates

The Longitudinal Study of Australian Children, funded by the Australian Government, provides the most recent and extensive national data on breastfeeding in Australia. Amongst the infant cohort in 2004, from a 92 per cent breastfeeding initiation rate, there was a sharp decline in both full and any breastfeeding with each month post birth. By one month old, 71 per cent of infants were fully breastfed. Only 56 per cent of infants were fully breastfed at three months, 46 per cent at four months and 14 per cent at six months (AIFS 2008). The rates of any breastfeeding (including both full breastfeeding and complementary feeding) were 83 per cent at one month, 73 per cent at three months, 63 per cent at four months, 56 per cent at six months, 30 per cent at 12 months and five per cent at 24 months (AIFS 2008, Baxter 2008, Baxter personal communication 2009). Figure 2.1 presents these data, reproduced from AIFS 2008.

Figure 2.1

BREASTFEEDING: THE FIRST TWELVE MONTHS



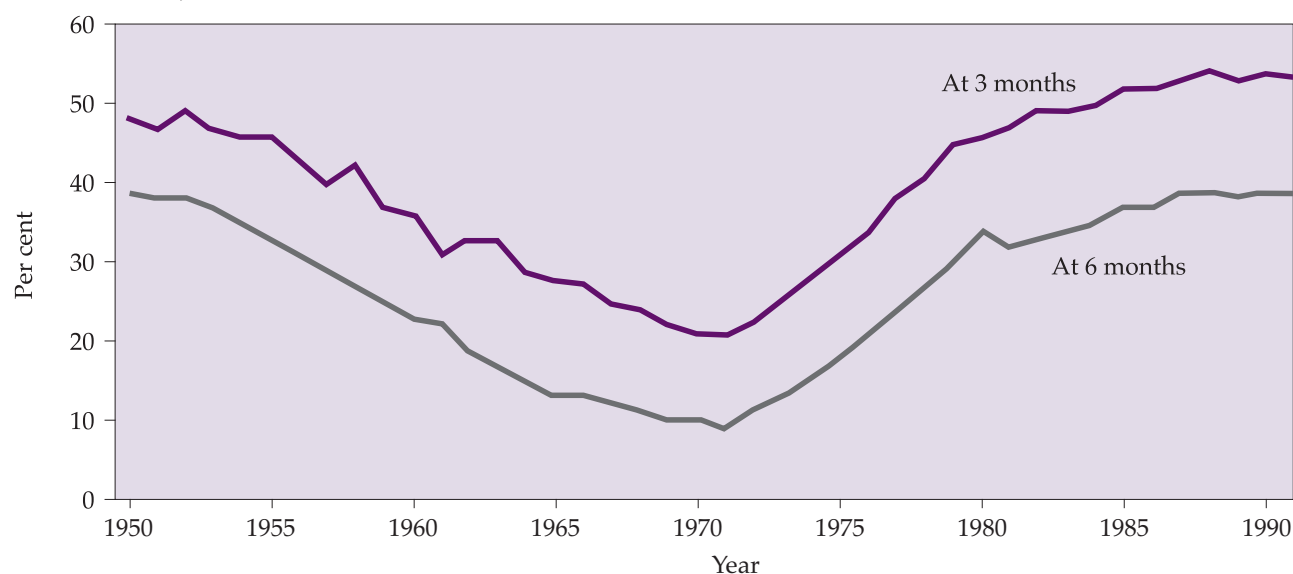
Source: Growing up in Australia, Wave 1 and 2 (AIFS 2008)

Reliable national level time trend data and even comparisons between jurisdictions for Australian breastfeeding rates are not available due to the inconsistent use of definitions and methodological differences between surveys (AIHW 2009). Breastfeeding experts consider that breastfeeding rates have remained fairly static over the last ten years. Of concern are recent findings that breastfeeding rates can vary substantially between local government areas. For example full breastfeeding at three months ranged between less than 35 per cent to greater than 70 per cent between different local government areas in Victoria (ABS and DEECD 2009). Regional variations in breastfeeding rates have also been noted in New South Wales (Garden 2007) and it is likely that similar variations would be found in other jurisdictions.

Victoria has more comprehensive records on breastfeeding rates over time. Figure 2.2 shows that full breastfeeding at three months declined from 48 per cent in 1950 to 21 per cent in 1970. Breastfeeding rates began to recover during the 1970s and full breastfeeding at three months reached 54 per cent in 1987-88 (AIHW & Lester 1994). These data from Victoria are likely to be indicative of long term time trends for breastfeeding rates for Australia at the national level.

Figure 2.2

MOTHERS FULLY BREASTFEEDING AT THREE AND SIX MONTHS, VICTORIA, 1950-1992



Source: AIHW & Lester, 1994

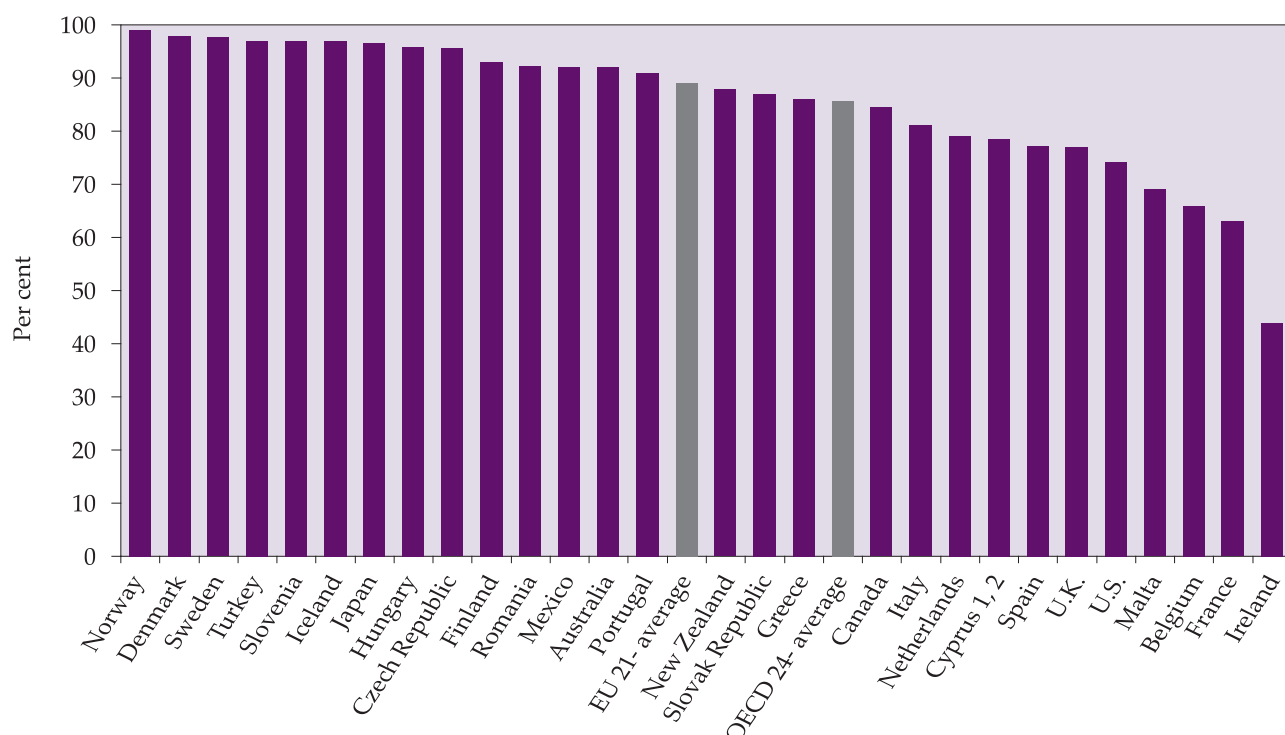
Several studies in Australia have sought to identify why some women do not breastfeed, or do not breastfeed for longer. The 2001 National Health Survey found that the most common self-reported reasons for discontinuing breastfeeding of children aged from birth to three years were: inadequate milk supply (30 per cent), felt it was time to stop (23 per cent), problems with breastfeeding such as cracked nipples (10 per cent) and resumed work (eight per cent) (ABS 2003). A literature review by the Victorian Department of Human Services (2005) found that barriers to breastfeeding included returning to the workforce, difficulties experienced with breastfeeding in public, maternal or infant medical problems and giving infant formula or introducing solids earlier than is optimal. Other reports have cited reasons such as inconsistency of advice, beliefs about infant formula, and the level of community support (e.g., HoR 2007). Reasons can include individual commitment to breastfeeding, the partner's opinion and support, cultural roles and expectations, and responsibilities (NHMRC 2003). For women on a low-income, evidence suggests that male support is crucial in their decision to breastfeed (Schmidt and Sigman Grant 2000).

2.2 Global comparisons

Breastfeeding initiation rates in most member countries of the Organisation for Economic Co-operation and Development (OECD) are high (see Figure 2.3). However, the proportion of children being breastfed declines more or less rapidly with age. On average, almost half of all infants aged three months are being exclusively breastfed in OECD countries. At six months old, less than a quarter are exclusively breastfed (see Figure 2.4).

Figure 2.3

**PROPORTION OF CHILDREN WHO WERE 'EVER BREASTFED'
(DATA COLLECTED BETWEEN 1999-2007)**



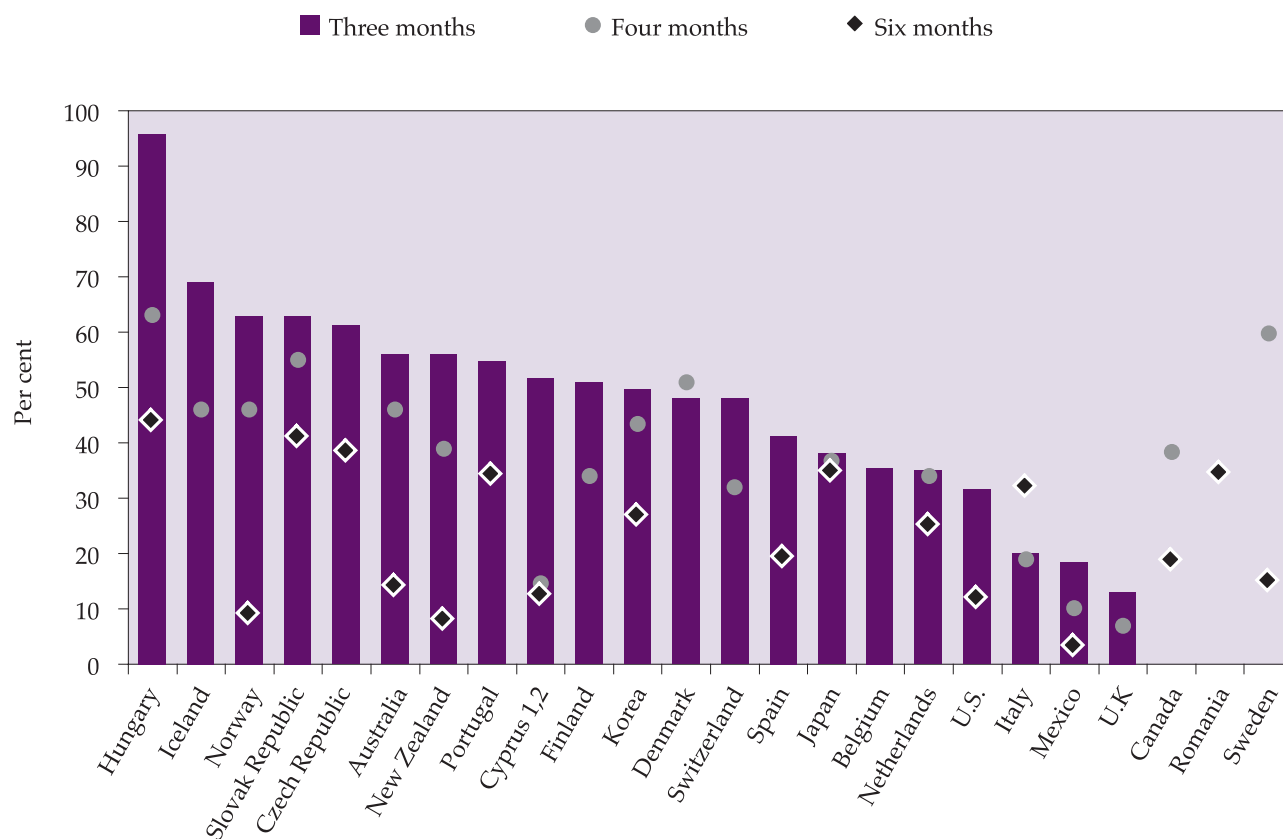
Source: OECD (2009a)

Australia compares reasonably favourably with other OECD countries in regard to breastfeeding initiation and breastfeeding at three months. However, the continuation rate, particularly at six months, appears to lag behind other OECD countries (see Figure 2.4).

These data should be viewed with caution, as the extent to which national survey data obtained by the OECD are directly comparable is unclear. The data were obtained by the OECD from national health institutes or surveys that took place between 1994 and 2007. There are often variations between breastfeeding definitions and survey methodologies. For example, the Australian data included in the OECD comparison are from the Longitudinal Study of Australian Children referred to previously which measured full rather than exclusive breastfeeding. Surveys often measure breast milk and other food intake in the previous 24 hours rather than from birth (Binns et al. 2009). It is also noted that exclusive breastfeeding 'at' six months is not a stable indicator because this is around the time recommended for starting solid foods (DHS 2006).

Figure 2.4

PROPORTION OF CHILDREN WHO WERE EXCLUSIVELY BREASTFED AT THREE, FOUR AND SIX MONTHS (DATA COLLECTED BETWEEN 1994-2007)



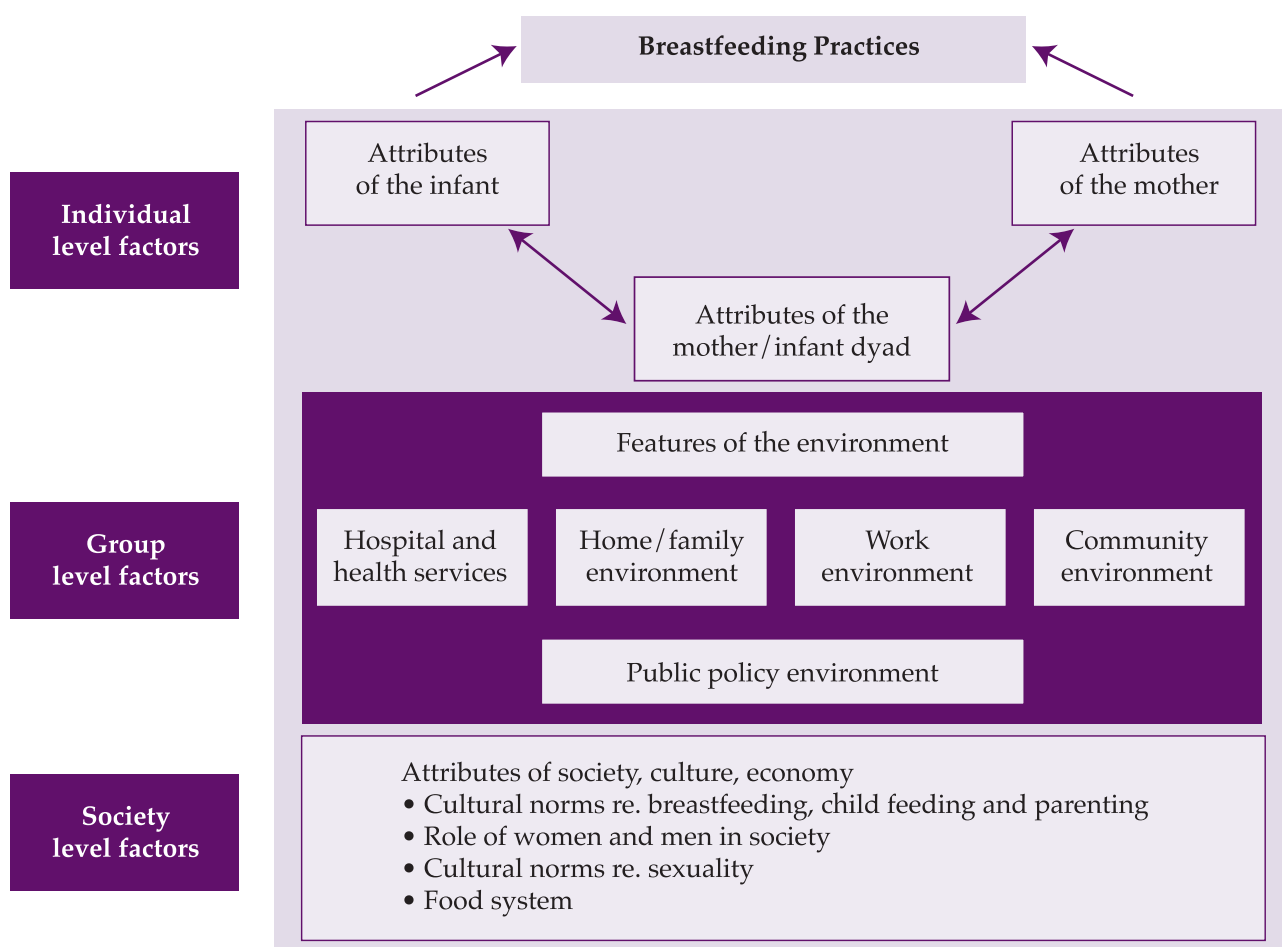
Source: OECD (2009a)

2.3 Factors affecting breastfeeding

There are numerous barriers and enablers to breastfeeding, which operate at a range of different levels, as outlined in Figure 2.5. Importantly, environmental factors and societal considerations have an impact on a mother's commitment to breastfeed and ability to continue.

Figure 2.5

FACTORS AFFECTING BREASTFEEDING PRACTICES



Source: Hector et al. (2005).

The Queensland Health *Optimal Infant Nutrition: Evidence-based Guidelines* (Queensland Health 2003) provide a detailed list of the factors that hinder the initiation and/or the duration of breastfeeding (see Appendix A).

Qualitative research commissioned by the Australian Government Department of Health and Ageing (Woolcott 2009) found that as babies grew older, some mothers gave up breastfeeding because breastfeeding in public was not felt to be the social norm. Breastfeeding mothers reported being confronted by negative comments from strangers. People were unclear about the right to breastfeed in public and whether they could be asked to leave a restaurant or café. Some people incorrectly believed that breastfeeding in public was illegal. A 2009 Newspoll commissioned by the Australian Lactation Consultants' Association found that 26 per cent of respondents considered it was unacceptable to breastfeed a baby in a restaurant or café, 19 per cent thought it was unacceptable to breastfeed in a shopping centre (Newspoll 2009).

The workplace has an important environmental impact on breastfeeding rates. Analysis on the relationship between return to work and breastfeeding for mothers in Australia suggests a complex relationship, with other interplaying factors impacting on the decision to breastfeed, such as maternal and family characteristics (AIFS 2008). Employment flexibility and jobs that are less time intensive make it easier for mothers to continue breastfeeding. Full-time work was not necessarily a barrier as breastfeeding rates were not always lowest among those working full-time hours (AIFS 2008). Data on the percentage of women returning to work in the first year of an infant's life is outlined in Figure 2.6.

Figure 2.6

RETURN TO WORK: AGE OF INFANT

The Longitudinal Study of Australian Children (2006-07) suggests the following trends:

- when children were 3 months old — 11 per cent of mothers had returned to work;
- when children were 6 months old — 21 per cent of mothers had returned to work;
- when children were 9 months old — 31 per cent of mothers had returned to work; and
- when children were 12 months old — 42 per cent had returned to work.

Source: AIFS 2008

The parental leave environment may influence breastfeeding rates. OECD research has found that the return to work is one of the reasons why some mothers never start breastfeeding, or only do so for short durations. The incidence of exclusive breastfeeding and its duration tends to be higher/longer in countries with long periods of parental leave, such as the Scandinavian countries, Hungary and the Czech Republic. However, this relationship does not always hold. For instance, the United Kingdom and Ireland have more generous leave arrangements than Australia, but lower rates of breastfeeding duration (OECD 2009b). Following an inquiry by the Productivity Commission, the Australian Government announced in May 2009 that it will fund a paid parental leave scheme, providing 18 weeks pay on the minimum wage, commencing on 1 January 2011. The Productivity Commission's recommendation to fund the scheme took into consideration a range of factors including the health and wellbeing of children and parents and the need to allow sufficient time away from the workplace to establish breastfeeding.

Research has found that some population priority groups are less likely to breastfeed than others:

- *Aboriginal and Torres Strait Islander mothers:* In 2004–05, approximately 79 per cent of Indigenous infants from non-remote areas aged 0–3 years had been breastfed compared with 88 per cent of non-Indigenous infants. Breastfeeding status varied by remoteness, with a higher proportion of Aboriginal and Torres Strait Islander children aged under six months being breastfed in remote areas (85 per cent) than in non-remote areas (56 per cent). Seventy per cent of Indigenous children aged from birth to three years from households in the lowest Socio-Economic Indexes for Areas (SEIFA) quintile were breastfed compared with 90 per cent in the highest SEIFA quintile (AHMAC 2008, AIHW 2009).

- *Less educated women of low socio-economic status:* In 2001, almost two-thirds (64 per cent) of mothers with a post-school qualification were breastfeeding infants at six months of age, compared with 41 per cent of those with no post-school qualification (ABS 2007). Research also suggests that for each increase in SEIFA quintile, the odds of breastfeeding at six months increased by 26 per cent, with evidence suggesting this gap is widening over time (Amir and Donath 2008).
- *Young mothers:* The 2001 National Health Survey found that for mothers aged 30 years or over, 54 per cent were still breastfeeding their baby at six months of age, compared with 38 per cent for mothers aged 18–29 years. Mothers aged 30 years or over were also twice as likely to be breastfeeding their babies at 12 months of age (28 per cent) compared with mothers aged 18–29 years (14 per cent) (ABS 2003).

Evidence is mixed as to whether breastfeeding rates in culturally and linguistically diverse communities are comparable to the general Australian population rates. For instance, a study of breastfeeding rates of Chinese women in Northern Sydney at discharge from hospital and at three months, found considerably lower rates than both the local population and state average (Stephens, 2001). In contrast, a more recent study has indicated that compared to non-Asian women, Asian women were no less likely to exclusively breastfeed upon discharge from hospital (Dahlen and Homer 2009).

It has been reported that breastfeeding practices vary between different cultural groups in Australia. Some communities where breastfeeding is the cultural norm experience strong support from extended families and few difficulties with breastfeeding. In other cultures there is a tradition of providing rice milk or formula before the first breastfeed and weaning or introducing supplementary foods early. The Woolcott report found that some recent African arrivals had been given incorrect information that it was illegal to breastfeed in public in Australia (2009).



Chapter 3

Breastfeeding in Context

3.1 International policy and practice

This Australian National Breastfeeding Strategy reflects Australia's support for international organisations and frameworks as well as domestic efforts to protect, promote, support, and monitor breastfeeding. Australia provides assistance to United Nations agencies that play a key role in improving child and maternal health and increasing rates of breastfeeding. These include the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund.

As a member state of the WHO, and through the World Health Assembly (WHA), Australia supports resolutions and strategies that encourage breastfeeding, recognising its importance to infant and young child nutrition, and in reducing infant mortality. Several resolutions have been passed relating to infant and young child nutrition and appropriate feeding practices: *International Code of Marketing of Breast-milk Substitutes* (1981); *WHO/UNICEF Global Strategy for Infant and Young Child Feeding* (2003); and the 1990 and 2005 Innocenti Declarations. The most recent WHA resolutions have focussed on strengthening implementation, seeking assistance for member states that are lagging behind, and on monitoring progress in implementation of measures such as the *International Code of Marketing of Breast-milk Substitutes*.

The *Baby-Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding* (see Figure 3.1) launched by the WHO/UNICEF in 1991 after the 1990 *Innocenti Declaration*, and recently updated in 2009, is an example of effective practical guidance to assist countries in increasing breastfeeding rates. Child and maternal health is also a key priority area for Australia's aid program. Australia supports the United Nations *Millennium Development Goals* (MDG) to reduce child mortality and improve maternal health. Australia's aid program contributes to infant and young child nutrition programs, particularly in the Asia Pacific region.

Figure 3.1

BABY-FRIENDLY INITIATIVE: TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing care for 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 staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.^a
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 breast milk, unless medically indicated.
7. Practise rooming-in - that is, 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.

Source: WHO (2009, 1989)

^a This step is now interpreted as: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed and offer help if needed.

Australia is a party to the *United Nations Convention on the Rights of the Child* which entered into force in Australia in 1991. Article 24 of this international treaty recognises that the child has the right to the enjoyment of the highest attainable standard of health. Parties are responsible for pursuing the full implementation of this right and, in particular, taking appropriate measures to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, *the advantages of breastfeeding*, hygiene and environmental sanitation and the prevention of accidents (DFAT 1991) (emphasis added).

Australia also participates in the work of the Codex Alimentarius Commission (Codex) the international food standards setting body. Codex is the reference point for international food trade standards, including an international food standard for infant formula.

Australia's support for these global frameworks includes international engagement, federal, state/territory and local government policies and initiatives, and health, community sector, and food industry efforts. The Australian National Breastfeeding Strategy draws upon key principles from these global frameworks, as well as strategies and practices from other countries and regions, such as New Zealand, Norway, the United States, the European Union, and Australia's own states and territories.

3.2 Australian Dietary Guidelines

The Australian Government supports the Australian Dietary Guidelines which aim to encourage, support, and promote exclusive breastfeeding for the first six months of an infant's life. The need to encourage and support breastfeeding is highlighted in both the *Dietary Guidelines for Australian Adults* and the *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*, which advise:

For Australia, it is recommended that as many infants as possible be exclusively breastfed until six months of age. It is further recommended that mothers then continue breastfeeding until 12 months of age—and beyond if both mother and infant wish. Although the greatest benefits from breastfeeding are to be gained in the early months, especially from exclusive breastfeeding for at least six months, there is no doubt that breastfeeding provides benefits that continue beyond this time. After six months, continued breastfeeding along with complementary foods for at least 12 months will bring continuing benefits (NHMRC 2003).

Despite this recommendation and the high level of government and non-government activity that promotes and supports breastfeeding, only 28 per cent of infants are fully breastfed at five months while around half are receiving at least some breast milk at six months (AIFS 2008, Baxter 2008).

3.3 The National Breastfeeding Strategy (1996–2001)

The previous National Breastfeeding Strategy (1996–2001) was a \$2 million program funded by the Australian Government that resulted in the creation of a range of breastfeeding promotion resources that targeted families and community groups, health professionals, hospitals, partners, employers and a range of priority groups (DHAC 2001). Specific activities included:

- audit of training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and health professionals providing care to Indigenous women. This was accompanied by a *Review of current interventions and identification of best practice currently used by community based Aboriginal and Torres Strait Islander health service providers in promoting and supporting breastfeeding and appropriate infant nutrition* (OATSIH 1998);
- production of a fact sheet kit, *Naturally: the facts about breastfeeding* sent to health professionals and general practitioners in community-based settings to improve their understanding of breastfeeding issues and ability to provide consistent, practical advice;
- production and distribution of a continuing education kit to over 25,000 general practitioners, pharmacists, child health nurses and paediatricians. This kit included continuing education modules for pharmacists, pharmacy assistants and child health nurses, a health professionals guide for managing common breastfeeding problems and a guide to further breastfeeding information and resources;
- development of national accreditation standards for maternal and child health services;
- the production and distribution of resources outlining the benefits of breastfeeding, with a focus on families. These resources included tip cards, posters, a comic booklet for young parents, a booklet for those with low literacy and tip cards translated into five languages. The cards are still in use by the Australian Breastfeeding Association;
- a four page newsletter insert distributed to approximately 3,000 employers and a booklet, poster and flyers in five languages called *Balancing Breastfeeding and Work* distributed to approximately 50,000 employers; and

- an antenatal breastfeeding education package *Breastfeeding and you*, including an educators manual with lesson plans and strategies for use with people from culturally and linguistically diverse backgrounds, a video and poster sent to 3,500 antenatal educators and obstetricians.

Despite these important achievements, the 1996-2001 strategy was primarily an Australian Government initiative and in the absence of a nationally agreed framework, the policy environment for breastfeeding in Australia has been at best ad hoc.

3.4 Jurisdictional and non-government organisational strategies

South Australia, New South Wales, Queensland and the Australian Breastfeeding Association have all developed breastfeeding strategies or guidelines. Tasmania has included breastfeeding as a key focus area in the Tasmanian Food and Nutrition Policy. These strategies have clear objectives and targets, which are broadly consistent with the WHO/UNICEF *Global Strategy for Infant and Young Child Feeding* (2003) and the Australian Dietary Guidelines (NHMRC 2003) (see Figure 3.2).

Figure 3.2

EXAMPLES OF STATE-SPECIFIC AND NON-GOVERNMENT ORGANISATION STRATEGIES: AUSTRALIA: OBJECTIVES AND TARGETS

South Australia Breastfeeding Program Strategic and Action Plan 2007-2012

Objectives:

- To increase the capacity of hospitals, health services, health professionals and volunteer organisations to provide best practice breastfeeding services.
- To increase community acceptance of breastfeeding as the cultural norm.

This strategy has the goal, to increase the percentage of South Australian babies who are fully breastfed at every age of birth to six months, and then to twelve months of age, in line with the Australian Dietary Guidelines.

Breastfeeding in New South Wales: Promotion, Protection and Support (2006-2012)

Goals:

- To at least maintain the current proportion of infants who are 'ever breastfed'.
- To increase the proportion of infants 'exclusively' breastfed to six months.
- To increase the duration of breastfeeding.

Queensland Infant Nutrition Guidelines 2003-2010

Queensland's *Optimal Infant Nutrition: Evidence-Based Guidelines* (2003 - 2010) highlights the importance of priority groups within an overall aim to increase breastfeeding awareness, promotion and support. They aim to ensure that pregnant women, mothers, fathers, carers, health care workers and the wider community are aware of the health benefits of optimal infant nutrition (QLD Health 2003).

Australian Breastfeeding Association

The vision of the Australian Breastfeeding Association's Strategic Directions Plan for 2009-2012 is: As the normal way to feed and nurture infants, for babies to breastfeed exclusively for six months, with continuing breastfeeding for two years and beyond.

Sources: Children, Youth and Women's Health Service (2007), NSW Government (2006), QLD Health (2003), ABA (2009)

3.5 National inquiries, reviews and health reform

The Best Start — Report on the Inquiry into the Health Benefits of Breastfeeding

The Best Start inquiry was a significant catalyst for the Australian National Breastfeeding Strategy. This 2007 House of Representatives Standing Committee on Health and Ageing inquiry examined how the Australian Government could take a lead role in improving the health of the Australian population through support for breastfeeding (HoR 2007). The inquiry noted that there is significant government and non-government support for breastfeeding, but little coordination and limited evidence about what works in practice. Twenty two recommendations were made in the inquiry report. The development of an Australian National Breastfeeding Strategy was a key element of the Australian Government's response to the inquiry (2008).

The Report of the Maternity Services Review

Improving Maternity Services in Australia: The Report of the Maternity Services Review (2009) highlighted the complex nature of maternity services, which involve a mix of federal, state and territory and private arrangements. The maternity services review made a number of recommendations that focused on the need to improve the maternal and perinatal outcomes for Indigenous and rural Australians, improve choices available to pregnant women, increase access to high quality maternity services, and provide support for the maternity services workforce.

In relation to breastfeeding, the review recommended:

That in order to lengthen the duration of breastfeeding, further evaluation be undertaken to identify the health care or community settings in which breastfeeding information and support are most effectively received, with a particular priority on consulting and supporting women from diverse cultural and socioeconomic backgrounds (DoHA 2009).

The Australian Government has responded to the report with a \$120.5 million maternity services reform package to provide access for midwives to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, and a Government supported professional indemnity insurance scheme for eligible midwives. These arrangements will be available to appropriately qualified and experienced midwives working in collaboration with obstetricians and health facilities. New national guidance for health professionals to support collaborative models of maternity care will be developed.

The Australian Government is committed to building on the maternity services reform package by working with the states and territories and key stakeholders to develop a National Maternity Services Plan to ensure co-ordination of maternity services across Australia.

The Paid Parental Leave: Support for Parents with Newborn Children Inquiry

This inquiry was undertaken to assess the economic, productivity, and social costs and benefits of providing paid maternity, paternity and parental leave. The Productivity Commission's analysis suggested that 18 weeks of parental leave in conjunction with other complementary policies would encourage employed women to breastfeed exclusively for longer. The report outlined the health benefits to mothers and children when parental leave from work is available to support the care of young children. It included a detailed examination of the evidence for the health benefits of breastfeeding, the effectiveness of interventions to promote and support breastfeeding, and the impact on breastfeeding of returning to paid work (PC 2009).

The Productivity Commission's report did not make an official recommendation about breastfeeding support, on the basis that work on the Australian National Breastfeeding Strategy was already underway. However, the report did note that further research on breastfeeding support in the first month after birth and beyond, as well as supportive environments such as breastfeeding friendly workplaces, would be worthwhile. It also noted that the Australian National Breastfeeding Strategy and the National Maternity Services Plan could address the need to improve coordination and continuity of care between antenatal, birthing and postnatal support services to encourage breastfeeding continuation rates (PC 2009).

Following the completion of the Productivity Commission inquiry, the Australian Government announced in May 2009 that it will fund a paid parental leave scheme, providing 18 weeks pay on the minimum wage, commencing on 1 January 2011.

Council of Australian Governments early childhood initiatives

Early childhood is a high priority for Australian governments. A number of recent Council of Australian Governments (COAG) initiatives seek to improve the health and wellbeing of Australia's children.

- *Investing in the Early Years - A National Early Childhood Development Strategy* - aims to improve the health, safety, early learning and wellbeing of all children and better support disadvantaged children to reduce inequalities. Its vision is that all children have the best start in life to create a better future for themselves and the nation (COAG 2009). The framework recognises that the Australian National Breastfeeding Strategy can contribute to this vision.
- *The National Partnership Agreement on Preventive Health* provides \$325.5 million over four years, commencing in 2011-12, for the Healthy Children initiative to deliver programs that promote physical activity and healthy eating in a range of settings. This initiative recognises the need for breastfeeding support interventions (COAG 2008).
- COAG aims to halve the gap in mortality rates between Indigenous and non-Indigenous children under the age of five within a decade. The *Indigenous Early Childhood Development National Partnership* will contribute to meeting this target. The partnership agreement comprises \$564 million of joint funding over six years (2009-2014) to address the needs of Indigenous children in their early years. This National Partnership has three priority areas:

- integration of early childhood services through the establishment of thirty five Children and Family Centres;
- increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health; and
- increased access to, and use of, maternal and child health services by Indigenous families.

Support under this National Partnership will enable Mothers and Babies Services, under the *New Directions Program*, to provide Aboriginal and Torres Strait Islander children and their mothers with better access to antenatal and postnatal care; standard information about baby care including practical advice and assistance with breastfeeding, nutrition and parenting skills; and monitoring of the child's developmental milestones, immunisation and health status and referral for specialist treatment if needed.

Social Inclusion

The Government's social inclusion agenda seeks to ensure that all Australians have the resources, opportunities and capabilities they need to learn, work, engage with their community and have a voice to influence decisions that affect them. Social inclusion principles give high priority to early intervention and sustainability, development of tailored services and using an evidence-based approach. The Australian National Breastfeeding Strategy is consistent with the social inclusion agenda and focuses on targeting disadvantaged groups, community approaches and generating long-term health gains through improved breastfeeding rates.

Health Reform

The broader health reform agenda is relevant to the Australian National Breastfeeding Strategy. This agenda is being informed by the following key documents and accompanied by an extensive consultation with the state and territory governments and the Australian community:

- *Building a 21st Century Primary Health Care System – A Draft of Australia's First National Primary Health Care Strategy* (2009) is aimed at addressing the delivery of care to ensure that families can get the health care they need, in an appropriate place and at the right time. It has a focus on priority direction for change including improving access and reducing inequity, better management of chronic conditions, increased focus on prevention and improving the quality, safety, performance and accountability of services.
- *Australia: The Healthiest Country by 2020 - National Preventative Health Strategy - the roadmap for action* (2009) from the Preventative Health Taskforce provides a blueprint for tackling the burden of chronic disease and includes as an action item: support the development and implementation of a National Breastfeeding Strategy in collaboration with the state and territory governments.
- *A Healthier Future for all Australians*, the final report of the National Health and Hospitals Reform Commission (NHHRC) tackles performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address the challenges of access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies, and the escalating costs of new health technologies. The NHHRC has provided a long term, comprehensive view and options about health care reform. This report also recognises the importance of breastfeeding in the context of disease prevention with a particular focus on providing a healthy start to life for priority groups.

The work involved in the development of the Australian National Breastfeeding Strategy ensured alignment with the health reform agenda and the development of the National Maternity Services Plan.

3.6 The legislative and regulatory environment

An important contextual issue influencing breastfeeding in Australia is the legislative and regulatory environment, particularly with respect to the protection of breastfeeding. Breastfeeding protection is about enabling mothers to breastfeed their babies and young children with confidence and without harassment and includes legislative and regulatory environments, employment entitlements, such as parental leave, and restrictions on the marketing of infant formula.

The legislative environment plays an important role in reducing discrimination against breastfeeding mothers. It is legal to breastfeed in public in every state and territory of Australia. Most jurisdictions also have specific legislation making it unlawful to discriminate against breastfeeding mothers.

In some cases of family separation, parents may need to consider parenting arrangements that facilitate the breastfeeding of children. The *Family Law Act 1975* provides that in proceedings for a parenting order in relation to a child, family law courts must regard the best interests of the child as the paramount consideration. In determining what is in the child's best interests, the court must consider relevant facts and circumstances which may include the benefits of maintaining breastfeeding. The *Best Start* inquiry identified concerns about some legal professionals perceiving the desire to breastfeed as a strategy to limit fathers' access to children without giving consideration to the importance of breastfeeding to the child's health (HoR 2007). Recent reports about babies removed by child protection services being unable to continue breastfeeding and concerns about support within the correctional system for mothers to breastfeed have also been raised. The highest priority for child protection should be the health, safety, and wellbeing of the child and maintaining and promoting breastfeeding must be considered in that context.

Australia supports the WHO's *International Code of Marketing of Breast-milk Substitutes* and has implemented key elements of the WHO Code through regulatory and quasi-regulatory mechanisms rather than legislation. Australia's response to the WHO Code is discussed in more detail below.

3.7 Other complex issues

Numerous other complex issues are associated with the breastfeeding environment in Australia. These issues, all of which were examined in The *Best Start* inquiry, include human milk banks, growth charts, and the marketing of infant formula (HoR 2007). These issues remain on the Australian National Breastfeeding Strategy agenda but do not lend themselves to immediate solutions. The governance structure for the Australian National Breastfeeding Strategy, outlined in Chapter 5, identifies the need for these issues to be thoroughly addressed in the implementation plan.

Human milk banks and associated regulatory issues

A human milk bank is a service that collects, screens, processes, and distributes donated human milk, primarily for sick and premature babies who cannot be breastfed (HoR 2007).

Human breast milk sharing both informally and on a more organised basis was a known practice in Australian maternity wards since the 1940s. In the 1980s, concern about the spread of HIV led to the discontinuation of milk banks in Australia. Human milk banking re-emerged in Australia in 2006. Facilities currently exist at King Edward Memorial Hospital in Western Australia and on the Gold Coast in Queensland. It is understood that milk banks are under consideration in other jurisdictions.

It is important that milk banks are well managed, with good risk management and quality control. Existing Australian milk banks are known to have done significant work on establishing quality management processes. However, there is no specific Australian regulatory framework for human milk banks. At the Australian Government level human breast milk is regarded as a food rather than a therapeutic good. However variations between state and territory legislation such as food laws and human tissue acts create regulatory uncertainty.

As part of its response to *The Best Start* inquiry, the Australian Government acknowledged the need for risk management and quality control for human milk banks and, in the context of developing an Australian National Breastfeeding Strategy, undertook to work with states and territories to consider the evidence, quality assurance and regulatory issues, including the existing best practice guidelines developed by the PREM Bank at King Edward Memorial Hospital in Perth. This work will be progressed under the implementation plan and governance arrangements for the Australian National Breastfeeding Strategy.

Growth charts

Growth charts are widely used as a clinical and research tool to assess nutritional status and the general health and wellbeing of infants, children, and adolescents (HoR 2007). There is concern from breastfeeding advocates about the current growth charts being used in Australia. Often exclusively breastfed infants do not put on weight at the same rate or level as formula fed infants and they may appear to be 'underweight' when in fact the growth rate is healthy for an exclusively breastfed baby.

Debate exists over the best growth charts to use. Some states and territories use the 2000 US Centre for Disease Control growth charts recommended by the NHMRC 2003 *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*. Some advocates have recommended that Australia adopt WHO standards developed in 2006 based on the breastfed child as the biological norm for growth and development. There is concern amongst some experts that the WHO growth charts represent an optimal growth pattern, and a heavier weight than the current charts, which could lead to unnecessary supplementation of some infants.

The Best Start inquiry recommended that Australian Health Ministers decide on a standard infant growth chart to be used in all states and territories (HoR 2007). In the Australian Government's response to the inquiry, it was agreed in principle that infant growth charts will be considered as part of the Australian Government's review of the *Dietary Guidelines for Children and Adolescents in Australia* incorporating the *Infant Feeding Guidelines for Health Workers*; and that the Australian

Government will subsequently consult with state and territory governments about the merits of adopting a single, evidence based population level reference for use as a growth monitoring tool, and the need for appropriate education and explanatory materials to ensure growth charts are interpreted appropriately.

The merits of adopting a single, evidence-based population level reference for use as a growth monitoring tool will require significant state and territory and stakeholder consultation. This work will be included in the implementation plan for the Australian National Breastfeeding Strategy.

The marketing of infant formula in Australia

Australia currently has several measures in place to implement the WHO Code:

- The *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement* (MAIF Agreement), a voluntary, self-regulatory code of conduct between manufacturers and importers of infant formula in Australia. All major manufacturers and importers of infant formula are parties to the MAIF Agreement. Compliance with the agreement is monitored by the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), a non-statutory panel appointed by the Australian Government.
- Mandatory labelling and composition provisions for infant formula, consistent with Article 9 of the WHO Code, contained in the *Australia New Zealand Food Standards Code* (FSANZ).
- The NHMRC *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers* include guidance for health workers on interpreting the WHO Code in Australia.

With respect to these measures, it is important to note that:

- The Australian Competition and Consumer Commission's authorisation of the MAIF Agreement will expire on 31 December 2015 (ACCC 2007). This will allow scope for a review of the MAIF Agreement prior to any re-authorisation which may be sought at that time.
- Following a recent public consultation process, a draft policy guideline for the regulation of infant formula products will be considered by the Food Regulation Standing Committee and is expected to be considered by the Australia and New Zealand Food Regulation Ministerial Council in the first half of 2010.
- The Australian Dietary Guidelines, including the *Infant Feeding Guidelines for Health Workers*, are currently under review with release expected in 2011.

The Best Start inquiry recommended the Australian Government adopt in full the WHO's *International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions (HoR 2007). The Australian Government's response to the inquiry noted the recommendation and stated that the Australian Government would consider Australia's response to the WHO Code in the context of developing an Australian National Breastfeeding Strategy. This will be progressed under the implementation plan and governance arrangements for the Australian National Breastfeeding Strategy and with respect to the development of the infant formula policy guidelines and revision of the *Infant Feeding Guidelines for Health Workers*.

Chapter 4

Breastfeeding Practice and Evidence

4.1 Jurisdictional Stocktake

The Australian and state and territory governments have a range of breastfeeding activities in place. Breastfeeding policy and programs are spread across a number of areas within the health system such as nutrition, health promotion, infant/child and maternal health, health surveys and statistics, and community health and hospital settings. Responsibilities are shared between various levels of government, non-government organisations and the private health sector. The Australian National Breastfeeding Strategy seeks to achieve greater coordination and integration of breastfeeding efforts across Australia.

An important component of the developmental work for the Australian National Breastfeeding Strategy was identifying areas of excellence, and gaps and opportunities for improvement by completing a stocktake and mapping exercise of breastfeeding related activities. This included the exploration and analysis of information about existing policies, programs, and initiatives, and evaluation findings from past and present programs.

Key findings from the jurisdictional stocktake include:

- Some jurisdictions, such as New South Wales, South Australia and Queensland, have a more comprehensive approach and are guided by an overarching policy or framework. Others include breastfeeding as a focus within broader public health policy such as *Tasmania's Food and Nutrition Policy*. Some jurisdictions have a less formal or coordinated approach, and still others, such as Victoria are exploring the possibility of developing an action plan pursuant to the Australian National Breastfeeding Strategy.
- Several states and territories such as Tasmania, Western Australia and New South Wales have appointed bodies that coordinate breastfeeding policies and programs and facilitate collaboration between government and non-government organisations.
- All states and territories offer educational and promotional material that captures antenatal and post birth information, with the majority directed towards pregnant women.
- South Australia and Queensland have current experience with mass media breastfeeding social marketing campaigns.
- Support programs appear to account for a large proportion of state and territory assistance to breastfeeding mothers at the postnatal stage. Support is offered in different ways across the country. Support to mothers in the community appears to be a focus.
- There are three Aboriginal and Torres Strait Islander specific programs funded by the Australian Government Department of Health and Ageing with a focus on improving maternal and child health:
 - *Healthy for Life Program* provides the necessary funding for primary health care services to increase capacity by employing additional staff, developing better infrastructure and improving data collection in the areas of child and maternal health services, men's health and chronic disease care. The program also has a focus on increasing participation in the Indigenous health workforce.

- *New Directions Mothers and Babies Services* provides Aboriginal and Torres Strait Islander children and their mothers with increased access to antenatal care, standard information about baby care, practical advice and assistance with parenting, nutrition and breastfeeding; monitoring of developmental milestones, immunisation status and infections, and health checks and treatment for Indigenous children before starting school.
- *Australian Nurse Family Partnership Program (ANFPP)* provides regular nurse home-visiting services to mothers pregnant with an Aboriginal or Torres Strait Islander child. The services include step-by-step life course guidance and education, rather than clinical services. This program is highly dependent on referring patients to existing programs in the community (e.g., smoking cessation programs, antenatal programs and clinics, substance abuse treatment programs, early learning centres, and playgroups). The program directly integrates and is complementary to the services provided under the *Healthy for Life* and *New Directions Mothers and Babies* programs.
- A 2004 evaluation of the *New South Wales Aboriginal Maternal Infant Health Strategy (AMIHS)* found that the service provision model was associated with improved breastfeeding rates, particularly in locations where there was high intensity contact with women in the antenatal and postnatal period with home visits and support.
- The stocktake did not provide significant information on activities specifically targeting other priority groups. This may have been because some of these activities are very small, and are funded or delivered by non-government organisations, with or without government funding. Alternatively, this may be because few exist.
- The Australian, state and territory governments work closely with non-government organisations, in particular the Australian Breastfeeding Association. The Australian Breastfeeding Association provides a range of programs across the country. A key feature of this activity is the National Breastfeeding Helpline (1800 MUM 2 MUM), which provides toll-free 24 hour breastfeeding information and peer support. The Breastfeeding Helpline, funded by the Australian Government, received in excess of 58,000 calls between October 2008 and July 2009. More than 200 trained peer support volunteer breastfeeding counsellors staffed the helpline in that time. Survey results indicate that most callers (96.1 per cent) are mothers, almost half are between the ages of 30-34 years, and most have only one child. Seventy seven percent of respondents identified themselves as being born in Australia and almost 80 per cent of callers were from metropolitan areas. Work is underway to expand the promotion and marketing of the helpline.
- The *Get Up & Grow: Healthy Eating and Physical Activity for Early Childhood* (2009) guidelines promote breastfeeding after returning to work and provide guidance on supporting breastfeeding in childcare settings.
- Different members of the workforce are trained in different ways to varying extents and there is no consistency across states and territories. The Australian Government is funding the Australian Breastfeeding Association to enhance training and education opportunities for breastfeeding counsellors and health professionals across Australia. A number of jurisdictions provide electronic learning modules or subsidised training opportunities for health service staff. There are also some relevant university courses and offerings from private commercial providers.

- Very few breastfeeding programs appear to be evaluated.
- Monitoring of breastfeeding rates is conducted by all jurisdictions to varying extents. However, it is not well coordinated across the country.

4.2 What works best?

There is a myriad of government and non-government activity in protecting, promoting and supporting breastfeeding. While most of the evidence about what works best is from overseas, there are nevertheless important findings relevant to the implementation of the Australian National Breastfeeding Strategy. The evidence used in developing the Australian National Breastfeeding Strategy was sourced from a variety of references, including systematic reviews from the Cochrane Collaboration and the United States Centre for Disease Control and Prevention, peer reviewed journals and documented expert opinion in sources such as *The Best Start Inquiry*.

Key findings from the review of evidence include:

- The timing of breastfeeding interventions is crucial for effectiveness. Interventions can occur at different stages within the breastfeeding continuum (see Figure 1.1). Some may occur during the antenatal phase in a hospital or community setting, while others occur during or soon after the birth, and again others may target the medium and longer-term postnatal stages at home or in a community setting. Some interventions may also be employed at multiple stages (e.g., breastfeeding education).
- Combinations of interventions addressing both the antenatal and postnatal stages were considered more effective in improving initiation rates and prolonging the duration of breastfeeding (Chung et al. 2008, Protheroe et al. 2003, Su et al. 2007). Multifaceted or combination interventions were generally more effective than standalone interventions, noting that promotion and education initiatives are often combined (Aniansson et al. 1994).
- Continuity of care enables women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period. There is strong level one evidence which demonstrates that continuity of midwifery care across these periods (Hodnett 2001) is as safe as traditional models of care, and can achieve beneficial effects (Hodnett 2001; Waldenstrom and Turnbull 1998; Waldenstrom et al. 2001).

Figure 4.1 summarises the findings of Chung et al. (2008), a systematic review of evidence of the effectiveness of primary care initiated interventions to promote and support breastfeeding.

Figure 4.1

COMPARING BREASTFEEDING INTERVENTIONS TO ROUTINE CARE

Effectiveness of antenatal and postnatal interventions:

- Antenatal breastfeeding interventions increased the rate of any short-term breastfeeding, with postnatal interventions also effective in increasing short-term exclusive breastfeeding.
- A combination of antenatal and postnatal breastfeeding interventions was more effective in increasing the rates of both intermediate and long-term 'any breastfeeding'.

Effectiveness of different types of activities and interventions:

- Structured breastfeeding education with or without other components increased the rate of 'any breastfeeding' initiation.
- Individual level professional support with or without other components significantly increased the rate of any intermediate duration breastfeeding.
- Peer support with or without other components increased the rate of short- and long-term 'any breastfeeding' and the rate of short-term exclusive breastfeeding duration.
- The *Baby Friendly Hospital Initiative* increased the exclusive breastfeeding rates at three months by 43.3 per cent compared to 6.4 per cent through usual care, and at six months by 7.9 per cent compared to 0.6 per cent for usual care.

Source: Chung et al. (2008)

Note: The report by Chung et al. (2008) used the following categories of breastfeeding durations: breastfeeding initiation is any breastfeeding at discharge or before two weeks post delivery, short-term is one to three months of breastfeeding, intermediate-term is four to five months, long-term is six to eight months, and prolonged is nine months or more.

- There is evidence from overseas suggesting that hospitals that have adherence to the *Baby Friendly Health Initiative* can have an impact on breastfeeding initiation and duration rates (see Figure 3.1) (Fairbank et al. 2000, Chung et al. 2008). This can be achieved either through encouraging implementation of the *Ten Steps to Successful Breastfeeding* or undertaking a more formal accreditation program to have the birthing service recognised as baby friendly (Fallon et al. 2005).
- There is also evidence to suggest that the *Baby Friendly Health Initiative* may be effective for people from priority groups, particularly for groups that would otherwise have low rates of breastfeeding initiation, and that the tenth step, which covers the transition from hospital to the community, is critically important (Bechara Coutinho et al. 2005, Chung et al. 2008).
- Evidence is available on the effectiveness of trained peer support (Shealy et al. 2005, Sikorski et al. 2003).
- There is some evidence that social marketing media campaigns can have an impact on breastfeeding initiation and duration rates (Foster et al. 2006, Protheroe et al. 2003, Shealy et al. 2005).
- Evidence supports the understanding that breastfeeding education efforts are more successful at prolonging full breastfeeding to six months if they involve partners and significant caregivers (Protheroe et al. 2003, Olayemi 1996, Chung et al. 2008).

- Providing printed breastfeeding information as a standalone intervention (e.g., pamphlets, books, posters) tended to be ineffective at improving breastfeeding rates (Guise et al. 2003).
- A US study of low-income American women found that rooming-in of mother and baby during the hospital stay was particularly effective when combined with formal breastfeeding education, employment of a breastfeeding counsellor and training of hospital staff (Protheroe et al. 2003).
- For Aboriginal and Torres Strait Islander people the available evidence suggests one-on-one or small group structured education sessions are more likely to be effective, with peer support particularly important. A recurring theme is the importance of outreach services, and the importance of support occurring in a 'familiar' home or community environment. It is important that other influential family and support network members such as grandmothers and aunts, have access to appropriate information and health professionals are trained about valuing and supporting breastfeeding. Health professionals' cultural awareness and listening skills are critical and Aboriginal and Torres Strait Islander health workers have a valuable role in increasing the uptake of support services and improving outcomes (OATSIH 1998).
- There has been limited research into the effectiveness of workplace initiatives designed to encourage breastfeeding, although some studies, mainly from the US, showed encouraging results (Cohen et al. 1994, Bar Yam 1997).

Chapter 5

The National Breastfeeding Strategy

5.1 Introduction

The aim of this Australian National Breastfeeding Strategy is to contribute to improving the health, nutrition and wellbeing of infants and young children, and the health and wellbeing of mothers, by protecting, promoting, supporting and monitoring breastfeeding. It provides a framework for priorities and action for Australian governments at all levels to address the protection, promotion, monitoring and support of breastfeeding in the community.

The Australian and state and territory governments have a range of breastfeeding activities in place. Responsibilities are shared between various levels of government, non-government organisations and the private health sector. This Australian National Breastfeeding Strategy now seeks to achieve greater coordination and integration of breastfeeding efforts across Australia.

The Australian National Breastfeeding Strategy complements the Australian Dietary Guidelines and reflects Australia's support for international organisations and frameworks. It is important to protect, promote and support breastfeeding at a population level and for those members of the community who are vulnerable to social and health disadvantage. Despite these considerations, about half of Australian babies are not receiving any breast milk by the time they reach six months of age.

A large body of Australian and international evidence shows that breastfeeding provides significant value to infants, mothers and society. The House of Representatives Standing Committee on Health and Ageing inquiry into the health benefits of breastfeeding was a significant catalyst for the Australian National Breastfeeding Strategy. The evidence informing the Australian National Breastfeeding Strategy was drawn from a range of sources including systematic reviews, peer reviewed journals and documented expert opinion from sources such as *The Best Start* report. The high level themes emerging from the review of evidence included the need for continuity of care, the importance of combination or multifaceted approaches and providing promotion and support at multiple stages before and after birth.

A number of complex issues remain on the Australian National Breastfeeding Strategy agenda but do not lend themselves to immediate solutions. These issues will be thoroughly addressed as the implementation plan is developed and enacted under the recommended governance structure.

The Australian National Breastfeeding Strategy was developed in an environment of national health reform and it complements the health reform agenda and will inform the development of the National Maternity Services Plan.

5.2 Strategic framework - vision, objectives and principles

Vision

Australia is a nation in which breastfeeding is protected, promoted, supported and valued by the whole of society.

Breastfeeding is viewed as the biological and social norm for infant and young child feeding.

Mothers, families, health professionals and other caregivers are fully informed about the value of breastfeeding.

Objective

To increase the percentage of babies who are fully breastfed from birth to six months of age, with continued breastfeeding and complementary foods to twelve months and beyond.

Principles

1. ***Mother and Child*** – The mother and child relationship is the heart and focal point of all breastfeeding related activities.
2. ***Ecological Context*** – Breastfeeding is influenced by a range of family, social, cultural and environmental factors that inform promotion and support activity across the breastfeeding continuum.
3. ***Access*** – All members of a community have universal access to appropriate information and affordable services that protect, promote and support breastfeeding.
4. ***Diversity*** – The diversity of Australian families is recognised through breastfeeding promotion and support activities that are sensitive and responsive to individual circumstances.
5. ***Collaborative Care*** – Services and health professionals work in collaborative partnership to provide holistic care to breastfeeding women and their families that strengthens and maintains existing support services.
6. ***Continuity of Care*** – Continuity of support at key transition points between birthing and community services and into the broader community is seamless from the perspective of mothers and their families.
7. ***Evidence Based*** – Protection, promotion and support activities are consistently informed by the best available evidence, the percentage of babies breastfed is regularly monitored and activities are evaluated.
8. ***Effective Governance*** – There is a clear accountability for breastfeeding protection, promotion, support and monitoring activities at state/territory and national levels, and appropriate consultation and collaboration with the community sector.

5.3 Strategic Goals

BREASTFEEDING CONTINUUM	OBJECTIVES	EVIDENCE-BASE WHAT WORKS BEST?	GOALS
ALL STAGES <i>Settings</i> <i>Birth services (hospital and community)</i> <i>Homes</i> <i>Health and community services</i> <i>Public spaces</i> <i>Broader community</i> <i>Workplaces</i> <i>Child care</i> <i>Child protection services</i>	<p>Encourage protection, promotion and support for breastfeeding as the biological and social norm for infant and young child feeding.</p> <p>Encourage breastfeeding friendly workplaces, services and environments.</p> <p>Protect breastfeeding from commercial pressures and misleading information.</p> <p>Provide appropriate information and instruction to carers of formula fed infants.</p> <p>In difficult circumstances, ensure breastfeeding relationships are maintained, as appropriate, with priority given to the safety and wellbeing of the child.</p>	<p>Partner, family, caregivers and support networks value, protect and support breastfeeding.</p> <p>Support from health professionals and trained peer counsellors.</p> <p>Targeted information, education and social marketing.</p> <p>Paid parental leave.</p> <p>Environments that empower mothers to continue breastfeeding.</p> <p>Breastfeeding friendly environments.</p> <p>Priority Groups</p> <p><i>Partners, family members, caregivers, health professionals, support networks and community leaders value, protect and support breastfeeding.</i></p>	<p>Increase community acceptance of breastfeeding as a cultural and social norm.</p> <p>Mothers feel comfortable and supported in their breastfeeding relationship.</p> <p>Breastfeeding friendly communities, public spaces, workplaces and child care environments empower mothers to continue breastfeeding.</p> <p>Community leaders and role models value and enable breastfeeding and are supported to breastfeed.</p>
ANTENATAL <i>Settings</i> <i>Birth services (hospital and community)</i> <i>Health and community services</i> <i>Workplaces</i> <i>Broader community</i>	<p>Provide opportunities for pregnant women and their families to learn about the value of breastfeeding.</p> <p>Encourage and enable pregnant women to make informed decisions about breastfeeding.</p> <p>Encourage families and support networks to appreciate the value of breastfeeding.</p>	<p>Accessible antenatal education that covers breastfeeding and information on support services.</p> <p>Involvement of partners or key support people in antenatal education.</p> <p>Priority Groups</p> <p><i>One-on-one interaction and small, culturally appropriate group settings.</i></p> <p><i>Provision of antenatal education in home-like or community environments.</i></p>	<p>Improve the availability and access to antenatal education with information on the value of breastfeeding.</p> <p>Pregnant women establish breastfeeding support networks and are linked to support groups in the community.</p>

BREASTFEEDING CONTINUUM	OBJECTIVES	EVIDENCE-BASE WHAT WORKS BEST?	GOALS
IMMEDIATE POSTNATAL (Birth to four days) <i>Settings</i> <i>Birth services (hospital and community, including early discharge services)</i> <i>Health and community services</i> <i>Homes</i> <i>Broader community</i>	<p>Provide consistent evidence-based advice to support initiation and facilitate successful breastfeeding practice.</p> <p>Ensure health professionals are appropriately trained to provide breastfeeding support and advice.</p> <p>Ensure continuity of care for mothers between birthing and community services, and breastfeeding support services and networks.</p>	<p>Support for mothers to initiate breastfeeding by placing babies in skin-to-skin contact with their mothers immediately following birth and assisting if needed.</p> <p>Timely community service interventions following early discharge from birthing services.</p> <p>Birthing services have a written breastfeeding policy that is actively promoted among staff and includes breastfeeding friendly strategies.</p> <p>All care staff are trained and appreciate the value and support of breastfeeding.</p> <p>Priority Groups</p> <p><i>Culturally appropriate one-on-one, or small group interaction.</i></p> <p><i>Rooming-in of mother, baby (and partner) during hospital stay.</i></p> <p><i>Health professional training in interacting with priority groups.</i></p> <p><i>Special attention to helping mothers of low birth weight and preterm babies to establish lactation and breastfeeding or provide breast milk.</i></p>	<p>Improve breastfeeding initiation rates.</p> <p>Improve the consistency of breastfeeding advice provided by health professionals.</p> <p>Increase the number of birthing services with documented breastfeeding policies and workplace supports.</p> <p>Improved breastfeeding training for health professionals.</p>

BREASTFEEDING CONTINUUM	OBJECTIVES	EVIDENCE-BASE WHAT WORKS BEST?	GOALS
MEDIUM POSTNATAL (Four days to eight weeks) <i>Settings</i> <i>Birth services (hospital and community)</i> <i>Health and community services</i> <i>Homes</i> <i>Broader community</i>	<p>Ensure continuity of care for mothers between birthing and community services, and breastfeeding support services and networks.</p> <p>Provide consistent evidence-based advice and support to mothers and their families to encourage the continuation of breastfeeding.</p> <p>Increase availability of breastfeeding training for health professionals.</p> <p>Improve the consistency of breastfeeding advice provided by health professionals.</p>	<p>Supported and timely referral from birthing services to health and community services.</p> <p>Community services facilitate introduction to local peer support groups with trained breastfeeding counsellors.</p> <p>Advice and support from health professionals trained in the management of breastfeeding.</p> <p>Priority Groups</p> <p><i>Priority referral to culturally sensitive health and community services.</i></p> <p><i>One-on-one, small group, and culturally appropriate peer support.</i></p> <p><i>Health professional training in meeting the needs of priority groups.</i></p>	<p>Improve continuity of care between birthing and health and community services, and breastfeeding support services and networks. Ensure mothers and their families know what breastfeeding support services are available and how to access them.</p> <p>Ensure mothers receive appropriate breastfeeding support and referrals, including access to trained peer breastfeeding counsellors.</p>
LONG POSTNATAL (eight weeks to six months and beyond) <i>Settings</i> <i>Homes</i> <i>Health and community services</i> <i>Public spaces</i> <i>Broader community</i> <i>Workplaces</i> <i>Child care</i>	<p>Ensure mothers and their families are supported to continue breastfeeding to six months and beyond.</p> <p>Enable more parents to stay at home to care for their baby full time during the early months.</p> <p>Encourage breastfeeding friendly workplaces, services and environments.</p>	<p>Increased parental leave.</p> <p>Breastfeeding friendly environments.</p> <p>Continuity of care and facilitated access to peer support.</p> <p>Priority Groups</p> <p><i>Breastfeeding policies that recognise the needs of priority groups.</i></p> <p><i>Peer and community leaders and support for role models.</i></p> <p><i>One-on-one, small group, and culturally appropriate peer support.</i></p> <p><i>Health professional training in meeting the needs of priority groups.</i></p>	<p>Increase the percentage of babies who are fully breastfeed from birth to six months and continue breastfeeding with complementary foods to 12 months and beyond.</p> <p>Increase the access to parental leave.</p> <p>Increase the number of model breastfeeding friendly workplaces, services and environments.</p>

5.4 Monitoring

Monitoring, research and evaluation are important to provide further insight into breastfeeding initiation and duration rates, as well as a better understanding of ways in which breastfeeding can be protected, promoted and supported. Research, monitoring and evaluation are required at all stages of the breastfeeding continuum.

Most states and territories monitor breastfeeding rates and duration. However, there is a lack of consistency on what data are collected and what indicators are reported. Several states use Computer Assisted Telephone Interviewing (CATI) to collate data on breastfeeding, including Queensland, Victoria, Western and South Australia. South Australia also uses CATI to ask questions about community perceptions of breastfeeding and evaluate social marketing campaigns.

At a national level, breastfeeding data have been collected through the National Health Surveys and the National Aboriginal and Torres Strait Islander Health Surveys. The most recent national data are from the Longitudinal Study of Australian Children.

The measurement of breastfeeding is a complex matter. In 2001, as part of a broader food and nutrition monitoring and surveillance project, Webb et al. proposed a set of breastfeeding indicators for Australia. Considerations included the need to ensure they were relevant to the Australian policy environment, consistency with WHO indicators, feasibility with a nationally representative sample and relevance for priority groups. The recommendations in the 2001 Webb report have not been implemented.

In 2006, 19 Headline Indicators for priority areas for children's health, development and wellbeing were endorsed by the Australian Health Ministers' Conference, the Community and Disability Services Ministers' Conference, and the Australian Education Systems Officials Committee. These Headline Indicators are designed to focus government policy attention on identified priorities for children's health, development, and wellbeing (DHS 2006). One of the indicators is the proportion of infants exclusively breastfed at four months of age. This indicator is for four, rather than six, months because exclusive breastfeeding at six months is not a stable indicator as solid foods are often introduced at this time.

The Australian Institute of Health and Welfare report, *A Picture of Australia's Children 2009* presents data on those National Children's Headline Indicators for which data are currently available. The report includes a summary of the available national and state/territory breastfeeding data. However, no data are currently available on the indicator of exclusive breastfeeding at four months, either at national or state and territory levels (AIHW 2009).

The Child Health and Wellbeing Subcommittee is responsible for overseeing the Headline Indicators work program which includes two streams of work: data development and data reporting. This work program will facilitate comparison of state and territory data, and data from sub populations of children, including Aboriginal and Torres Strait Islander children, children living in remote and disadvantaged areas, and children from culturally and linguistically diverse backgrounds.

In 2007, the Core Maternity Indicators Project recommended a set of ten core maternity indicators for benchmarking the quality and safety of maternity care. One of the recommendations from

the report concerns the achievement and maintenance of Baby Friendly Hospital Initiative accreditation or the number of WHO *Ten Steps to Successful Breastfeeding* (see Figure 3.1) that have been implemented in each facility (WHA 2007). The core maternity indicators are under consideration by the Maternity Services Inter-Jurisdictional Committee.

Further work on breastfeeding indicators was commissioned by the Australian Government Department of Health and Ageing and conducted by Hector in 2008. A key finding was the need for stakeholders to collaborate and agree on a specific way forward for breastfeeding indicators.

The Department of Health and Ageing is currently working with the Australian Institute of Health and Welfare to progress this breastfeeding indicators work in the context of developing a National Infant Feeding Survey. It is noted that breastfeeding practices performance indicators contained within the Aboriginal and Torres Strait Islander Health Performance Framework are relevant to the Indigenous Early Childhood Development National Partnership Agreement (COAG 2009).

Monitoring breastfeeding amongst other priority groups such as young mothers, mothers from a low socio-economic status and mothers from culturally and linguistically diverse backgrounds is not undertaken in Australia in a standardised or regular manner. In general, research and data collection for each of these priority groups is the subject of individual research projects and survey methodologies rather than a consistent national agenda. This is a deficiency of the current monitoring system that could be addressed through a monitoring framework to support the Australian National Breastfeeding Strategy.

5.5 Research and Evaluation

The development of the Australian National Breastfeeding Strategy has raised the need for a national approach to monitoring and coordinating research into breastfeeding in Australia, both at the population level and through clinical studies. Currently research activities are funded and conducted in a piecemeal way, which increases the risk of duplication of effort across research agencies or jurisdictions, and limits the capacity of researchers to undertake collaborative projects, particularly on a national level. The lack of national leadership for monitoring and coordinating breastfeeding research makes it harder to raise awareness of current data gaps and the need for ongoing research funding for developing or evaluating activities to promote breastfeeding.

The release of this Australian National Breastfeeding Strategy in the current environment of national health reform presents an opportunity to create new linkages between breastfeeding promotion and research, and other preventive health promotion and research activities. The implementation plan for the National Breastfeeding Strategy should map these opportunities to ensure it acts as a framework for further monitoring, research and evaluation activities.

Very few breastfeeding activities and programs are formally evaluated in Australia. Several states have plans to evaluate some programs going forward. For example the Australian Capital Territory is planning to pilot and evaluate a newly developed training package for staff working in childcare centres. A New South Wales Aboriginal Breastfeeding Project has also been established with the objective of conducting qualitative research that will be used to inform the development of appropriate interventions for the promotion and support of breastfeeding in Aboriginal and Torres Strait Islander communities.

The Australian National Breastfeeding Strategy will provide a context for measuring success of breastfeeding programs against stated goals and objectives. New governance arrangements will provide opportunities for the outcomes of evaluations to be shared between jurisdictions to inform future policy and program development.

5.6 Governance framework

Consistent with the *WHO Global Strategy for Infant and Young Child Feeding* the Australian National Breastfeeding Strategy provides a framework for the overarching governance of breastfeeding policies and interventions in Australia. This governance framework has three components: stewardship, leadership and consultation and collaboration with stakeholders.

Stewardship

The Australian National Breastfeeding Strategy is endorsed by all Health Ministers through the Australian Health Ministers' Conference, which has asked the Australian Population Health Development Principal Committee of the Australian Health Ministers' Advisory Council to develop an implementation plan in consultation with key stakeholders in 2010.

Leadership

The Australian Government will be responsible for providing national leadership and coordination and play a significant role in monitoring, research and evaluation frameworks. States and territories will continue to be responsible for implementation activities with a view to achieving the objectives and goals set out in the Australian National Breastfeeding Strategy and consulting and liaising with stakeholders (non-government organisations, community services and consumers) at a local level. Opportunities will be created for information sharing between all governments and stakeholders to discuss and measure achievements with respect to the Australian National Breastfeeding Strategy.

Stakeholder collaboration and consultation

While national leadership, stewardship and government action are important, achieving the vision of the Australian National Breastfeeding Strategy also relies on the efforts and goodwill of other sectors and stakeholders. These include health professionals, community, family and peer leaders, non-government organisations, employers and workplaces, child care services, shopping centres, pharmacies, the hospitality industry, as well as the importers, manufacturers and retailers of infant formula.

States and territories will continue to be responsible for consulting and liaising with stakeholders at a local level. Some jurisdictions have breastfeeding stakeholder engagement arrangements already in place. States and territories will also remain responsible for implementing and evaluating breastfeeding interventions, as is the case currently, but with a view to achieving the objectives and goals set out in the Australian National Breastfeeding Strategy.

Information sharing events and strategic workshops involving government and community representatives at national and state/territory levels could be arranged from time to time to assess achievements under the Australian National Breastfeeding Strategy and consider monitoring and evaluation outcomes.

5.7 Implementation plan

The Australian National Breastfeeding Strategy provides a high level policy context for improving the health and nutrition of infants and young children. A detailed implementation plan with defined roles and responsibilities for governments is required to achieve the outcome. The implementation plan will ensure an integrated and complementary approach with other government funded health promotion programs for mothers and babies.

The information obtained in the mapping exercise conducted to inform the development of the Australian National Breastfeeding Strategy will provide an opportunity for all jurisdictions to learn, and aid in the preparation of the implementation plan. Examples of existing local programs which could be considered for evaluation and suitability to adapt for possible wider distribution might include social marketing campaigns and programs for culturally and linguistically diverse audiences, refugee families and young mothers.

The Australian Health Ministers' Conference will delegate authority to the Australian Population Health Development Principal Committee, as the appropriate Principal Committee of the Australian Health Ministers' Advisory Council, to develop the implementation plan in consultation with key stakeholders. The Australian Government Department of Health and Ageing will take on a coordinating role and, where necessary, will take the lead on progressing particular issues.

Importantly, the implementation plan will devise a way forward for the complex issues identified in the Australian National Breastfeeding Strategy, including milk banks, growth charts and the WHO Code. All this will be done in the context of broader health reform, including the development and implementation of the Maternity Services Plan, and consideration of the recommendations of the Hospital and Health Reform Commission Report, the National Preventative Health Strategy and the draft National Primary Care Strategy.

References

Amir L & Donath S 2008, 'Socioeconomic status and rates of breastfeeding in Australia: evidence from three recent national health surveys', *Medical Journal of Australia* vol. 189 no. 5 pp. 254-256. <http://www.mja.com.au/public/issues/189_05_010908/ami11480_fm.html>

Aniansson, J, Alm B and Anderson B 1994, 'A prospective cohort study on breastfeeding and otitis media in Swedish infants', in: *Pediatric Infectious Disease Journal*: 13-8.

Australian Breastfeeding Association. *Strategic Directions: Our Plan for 2009-2012*. <<http://www.breastfeeding.asn.au/aboutaba/index.html>>

Australian Bureau of Statistics (ABS) 2007, *Australian social trends 2007*, Canberra.

Australian Bureau of Statistics (ABS) and Victorian Government Department of Education and Early Childhood Development (DEECD) 2009 *Best Start Atlas: Children aged 0-8 years in Victoria*, 2nd ed. Data Outcomes and Evaluation Division, Victorian Government Department of Education and Early Childhood Development, Melbourne.

Australian Bureau of Statistics 2003, '4810.0.55.001 Breastfeeding in Australia', <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4810.0.55.001Main+Features12001?OpenDocument>>.

Australian Competition and Consumer Commission (ACCC) 2007. Determination: Application for Minor Variation of Authorisations A90539 and A90540 Lodged by Nestlé Australia Ltd in respect of Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement, Date 30 August 2007. Public Register no. C2007/1426. <<http://www.accc.gov.au/content/index.phtml/itemId/791666/fromItemId/401858/display/acccDecision>>

Australian Government Department of Health and Ageing (DoHA) 2009 *Building a 21st Century Primary Health Care System – A Draft of Australia's First National Primary Health Care Strategy*, Commonwealth of Australia, Canberra. <www.yourhealth.gov.au>

Australian Government Department of Health and Ageing (DoHA) 2009 *Get Up and Grow: Healthy Eating and Physical Activity Guidelines for Early Childhood*. Commonwealth of Australia, Canberra. <<http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-early-childhood-nutrition-resources>>

Australian Government Department of Health and Ageing (DoHA) 2009 *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, Commonwealth of Australia, Canberra. <www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-report>

Australian Government National Health and Hospitals Reform Commission 2009. *A Healthier Future for all Australians - Final Report of the National Health and Hospitals Reform Commission* – June 2009, Commonwealth of Australia, Canberra. <www.yourhealth.gov.au>

Australian Government Preventative Health Taskforce 2009. *Australia: The Healthiest Country by 2020 - National Preventative Health Strategy - the roadmap for action*. Commonwealth of Australia, Canberra. <www.yourhealth.gov.au>

Australian Government, 2008, *Australian Government Response to the Report on the inquiry into the health benefits of breastfeeding*, December 2008, <<http://www.aph.gov.au/house/committee/haa/breastfeeding/bfgovresp.pdf>>

Australian Health Ministers' Advisory Council 2008. *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, AHMAC, Canberra.

Australian Institute of Family Studies (AIFS) 2008, *Growing Up In Australia: The Longitudinal Study of Australian Children, Annual Report 2006-07*, <<http://www.aifs.gov.au/growingup/pubs/ar/ar200607/breastfeeding.html>>

Australian Institute of Health and Welfare & Lester, IH 1994, *Australia's Food & Nutrition*, Commonwealth of Australia. <<http://www.aihw.gov.au/publications/index.cfm/title/3800>>

Australian Institute of Health and Welfare (AIHW) 2009, *A picture of Australia's children 2009*, Cat. no. PHE 112, Canberra. <<http://www.aihw.gov.au/publications/index.cfm/title/10704>>

Australian Institute of Health and Welfare 2008 Aboriginal and Torres Strait Islander Health Performance Framework 2008 Report: Detailed analyses, Cat no. IHW 22. Canberra: AIHW. <<http://www.aihw.gov.au/publications/index.cfm/title/10664>>

Bar-Yam NB, Nursing mothers at work: an analysis of corporate and maternal strategies to support lactation in the workplace [dissertation]. Waltham, MA: Heller School, Brandeis University, 1997.

Baxter J, 2008, Breastfeeding, employment and leave: An analysis of mothers in Growing Up in Australia. *Family Matters* No. 80. Australian Institute of Family Studies.

Bechara Coutinho S, Cabrai de Lira PI, de Carvalho Lima M, and Ashworth A 2005, 'Comparison of the effect of two systems for the promotion of exclusive breastfeeding', in: *Lancet* 2005, Vol. 366, No. 9491, pp. 1094-1100.

Children, Youth and Women's Health Service 2007, *SA Breastfeeding Program, Strategic and Action Plan 2007-2012*, South Australian Department of Health, Adelaide.

Chung M, Ip S, Yu W, Raman G, Trikalinos T, DeVine D and Lau J 2008, *Interventions in Primary Care to Promote Breastfeeding: A Systematic Review*, report prepared for the Agency for Healthcare Research and Quality by the Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022, Agency for Healthcare Research and Quality AHRQ Publication No. 08-05125-EF-1, Rockville, Maryland, October 2008.

Cohen R, Mrtek MB The impact of two corporate lactation programs on the incidence and duration of breastfeeding by employed mothers. *American Journal of Health Promotion* 1994;8(6):436-41.

Commonwealth Department of Health and Aged Care (DHAC) 2001, National Breastfeeding Strategy Summary Report <<http://www.health.gov.au/internet/main/Publishing.nsf/Content/health-pubhlth-publicat-document-brfeed-stratfeed-cnt.htm>>

Council Of Australian Governments (COAG) 2008, *National Partnership Agreement on Preventative Health*, <http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.pdf>

Council Of Australian Governments (COAG) 2009, *Investing in the Early Years - A National Early Childhood Development Strategy*, Commonwealth of Australia, <http://www.deewr.gov.au/EarlyChildhood/Policy_Agenda/Pages/EarlyChildhoodDevelopmentStrategy.aspx>

Council Of Australian Governments (COAG) 2009, *National Partnership Agreement Between the Commonwealth of Australia and the State and Territory Governments regarding Indigenous Early Childhood Development*, <http://www.coag.gov.au/coag_meeting_outcomes/2008-10-02/docs/indigenous_early_childhood_NPA.pdf>

Dahlen HG and Homer CSE 2009 'Infant feeding in the first 12 weeks following birth: A comparison of patterns seen in Asian and non-Asian women in Australia' *Women and Birth*, published electronically 13 May 2009.

Department of Foreign Affairs and Trade (DFAT) 1991 *United Nations Convention on the Rights of the Child* Australian Treaty Series 1991 no. 4, Canberra
<<http://www.austlii.edu.au/au/other/dfat/treaties/1991/4.html>>

Department of Human Services (DHS), 2006, *Headline indicators for children's health, development and wellbeing*, Prepared by the Victorian Government Department of Human Services on behalf of the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference; Victoria

Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Snowden AJ, Lister-Sharp D A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technology Assessment* 2000;4(25):1-171.

Fallon T, Crepinsek M, Hegney D and O'Brien M 2005, 'The Baby-Friendly Hospital Initiative and breastfeeding duration: Relating the evidence to the Australian context', in: *Birth Issues* 2005;14 (3):90-95.

Food Standards Australia New Zealand (FSANZ) *Standard 2.9.1 Infant Formula Products*, <http://www.foodstandards.gov.au/_srcfiles/Standard_2_9_1_Infant_Formula_Products_v105.pdf>

Foster D, McLachlan H and Lumley J 2006, 'Factors associated with breastfeeding at six months postpartum in a group of Australian women', *International Breastfeeding Journal*, vol. 1, p.18.

Garden F, Hector D, Eyeson-Annan M & Webb K 2007, *Breastfeeding in New South Wales: Population Health Survey 2003-2004*, NSW Centre for Public Health Nutrition, University of Sydney, and Population Health Division, NSW Department of Health, Sydney. <http://www.cphn.mmb.usyd.edu.au/resources_cphn/centre.php#breastfeeding>

Guisse JM, Palda V, Westhoff C, et al. The effectiveness of primary care-based interventions to promote breastfeeding: systematic evidence review and meta-analysis for the U.S. Preventive Services Task Force. *Annals of Family Medicine* 2003;1(2):70-8.

Hector D, 2008 *Review and Update of the Breastfeeding Indicators Contained in the Report 'Towards a National System for Monitoring Breastfeeding in Australia: Recommendations for Population Indicators, Definitions and Next Steps' by Webb et al 2001*. Final report provided to the Australian Government Department of Health and Ageing (unpublished).

Hector D, King L, and Webb K 2005, 'Factors affecting breastfeeding practices applying a conceptual framework', in: NSW Public Health Bulletin, Vol 16, No. 3-4. <<http://www.publish.csiro.au/nid/227/issue/4216.htm>>

Hoddinott P, Lee AJ and Pill R, 'Effectiveness of a breastfeeding peer coaching intervention in rural Scotland', in: *Birth* 2006 Mar;33(1):27-36.

Horta BL, Bahl R, Martines JC & Victora CG 2007, *Evidence on the long-term effects of breastfeeding : systematic review and meta-analyses* Geneva : World Health Organization, <http://whqlibdoc.who.int/publications/2007/9789241595230_eng.pdf>

House of Representatives Standing Committee on Health and Ageing (HoR) 2007, *The Best Start – Report on the inquiry into the health benefits of breastfeeding*, The Parliament of the Commonwealth of Australia, Canberra. <<http://www.aph.gov.au/house/committee/haa/breastfeeding/index.htm>>

Howat P, Cross D, Maycock B 2003, 'Towards a more unified definition of health promotion', *Health Promotion Journal of Australia*, vol. 14 no. 2, pp. 82-4.

Infant Formula Products Working Group (IFPWG) 2009 *Food Regulation Policy Options Consultation Paper for the Regulation of Infant formula Products*. Produced for the Food Regulation Standing Committee. <<http://www.health.gov.au/internet/main/publishing.nsf/Content/foodsecretariat-pgdev>>

Innocenti Declaration 1990, *Innocenti Declaration On the Protection, Promotion and Support of Breastfeeding*, endorsed by 139 governments at the 1990 World Summit for Children, 1 August 1990, Florence, Italy. <<http://www.innocenti15.net/>>

Innocenti Declaration 2005, *Innocenti Declaration On Infant and Young Child Feeding*, adopted by participants at the event "Celebrating Innocenti 1990-2005: Achievements, Challenges and Future Imperatives", 22 November 2005, Florence, Italy. <<http://www.innocenti15.net/>>

McLorg PA, Bryant CA Influence of social network members and health care professionals on infant feeding practices of economically disadvantaged mothers. *Medical Anthropology* 1989;10(4):265-78.

National Health and Medical Research Council (NHMRC) 2003, *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*, <www.nhmrc.gov.au/PUBLICATIONS/synopses/_files/n34.pdf>, viewed June 25, 2009.

National Health and Medical Research Council (NHMRC) 2009, *Review of the Dietary Guidelines*, <http://www.nhmrc.gov.au/your_health/healthy/nutrition/review.htm>

New South Wales Department of Health (NSW Health) 2006, *Breastfeeding in NSW: promotion, protection and support*, <www.health.nsw.gov.au/policies/pd/2006/PD2006_012.html>

Newspoll 2009. *Breastfeeding study*. Prepared for Espresso Communications on behalf of Australian Lactation Consultants' Association.

OECD 2009a, *OECD Family Database: CO3 Breastfeeding rates*, last updated 16/06/2009, available at: <www.oecd.org/els/social/family/database>, viewed 11 August 2009.

OECD 2009b, *OECD Family Database: PF7 Key characteristics of parental leave systems*, last updated 16/06/2009, <www.oecd.org/els/social/family/database>, viewed 11 August 2009.

Office for Aboriginal and Torres Strait Islander Health Services 1997, *Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal or Torres Strait Islander women*, Commonwealth Department of Health and Family Services, Canberra.

Office for Aboriginal and Torres Strait Islander Health Services 1998, *Review of current interventions and identification of best practice currently used by community based Aboriginal and Torres Strait Islander health service providers in promoting and supporting breastfeeding and appropriate infant nutrition*, Commonwealth Department of Health and Family Services, Canberra.

Olayemi G 1996, *Role of fathers in successful breastfeeding*, Staywell Foundation Breastfeeding News, August 1996.

Productivity Commission (PC) 2009, *Paid Parental Leave: Support for Parents with Newborn Children*, Productivity Commission Inquiry Report, No. 47, <<http://www.pc.gov.au/projects/inquiry/parentalsupport/report>>, viewed June 26, 2009.

Protheroe L, Dyson L, Renfrew MJ, Bull J, and Mulvihill C 2003, *The effectiveness of public health interventions to promote the initiation of breastfeeding*, Health Development Agency, London, UK.

Queensland Health 2003, *Optimal infant nutrition: evidence-based guidelines 2003-2008 (now extended to 2010)* available at <www.health.qld.gov.au/health_professionals/childrens_health/docs/Infant_Nutrition.pdf>

Schmidt MM and Sigman-Grant M 2000, 'Perspectives of Low-Income Fathers' Support of Breastfeeding: An Exploratory Study', in: *Journal of Nutrition Education and Behavior*, Volume 32, Issue 1, pp. 31-37, January 2000.

Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM, *The CDC Guide to Breastfeeding Interventions*, Atlanta: U.S. Department of Health and Human Services, Centre for Disease Control and Prevention, 2005. <<http://www.cdc.gov/breastfeeding/resources/guide.htm>>

Shields M, 'Parenting study gives birth to new media strategy: no media'. *Media Daily News*, 2004, July 22.

Sikorski J, Renfrew MJ, Pindoria S, Wade A. Support for breastfeeding mothers (Cochrane review), In: *The Cochrane Library*, Issue 3, 2003. Oxford: Update Software.

Stephens J 2001, *Identifying infant feeding practices from birth to twelve months in Northern Sydney*, March 2001.

Su, LL, Chong YS, Chan YH, Chan YS, Fok D, Tun KT, Ng FSP and Rauff M 2007, *Antenatal education and postnatal support strategies for improving rates of exclusive breast feeding: randomised controlled trial*, *BMJ* 2007; 335; 596, originally published online 1 August 2007.

Tasmanian Government, 2004, *Tasmanian Food and Nutrition Policy 2004* <http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0014/34601/TFNP_final.pdf>

Thornley L, Waa A and Ball J 2007, *Comprehensive plan to inform the design of a national breastfeeding promotion campaign*, report prepared by Quigley and Watts Ltd for the New Zealand Ministry of Health.

Victorian Department of Human Services 2005 *Give Breastfeeding a Boost: Community-based approaches to improving breastfeeding rates. A literature review - February 2005*. Collaborative project undertaken by The Centre for Clinical Effectiveness, Monash Institute of Health Services Research and the Australian Breastfeeding Association, through funding provided by the Victorian Department of Human Services, Public Health Group. <http://www.health.vic.gov.au/nutrition/child_nutrition/resources.htm>

Waldenstrom U & Turnbull D 1998. A systematic review comparing continuity of midwifery care with standard maternity services. *British Journal of Obstetrics and Gynaecology*. 105: 1160-1170

Women's Hospitals Australasia (WHA) 2007 *Supporting Excellence in Maternity Care: The Core Maternity Indicators Project*. Findings from the Core Maternity Indicators Project funded by the Australian Council on Safety and Quality in Health Care and sponsored by the Department of Health, Western Australia. Women's Hospitals Australasia, Turner ACT. <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_InfoStrategy>

Woolcott Research 2009, *Exploratory Research Regarding Infant Feeding Attitudes and Behaviours*, research report prepared for the Department of Health and Ageing, May 2009 (unpublished).

World Health Organization (WHO) 1981 *International Code of Marketing of Breast-milk Substitutes*, WHO Geneva, <http://www.who.int/nutrition/publications/code_english.pdf>

World Health Organization (WHO) and UNICEF (2003), *Global Strategy for Infant and Young Child Feeding*, World Health Organization, Geneva, Switzerland. <http://www.who.int/child_adolescent_health/documents/9241562218/en/index.html>

World Health Organization (WHO) and UNICEF 2009. *Baby-Friendly Hospital Initiative: Revised, updated and expanded for integrated care*, WHO, Geneva. <<http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html>>

World Health Organization (WHO), 1986, *Ottawa Charter for Health Promotion*, First International Conference on Health Promotion, Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1 <http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf, accessed 16 July 2009>

World Health Organization 2008. *Indicators for assessing infant and young child feeding practices: conclusions of a consensus meeting held 6-8 November 2007 in Washington D.C., USA*. <<http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/index.html>>

Appendix A

Barriers to breastfeeding

FACTORS THAT MAY HINDER THE INITIATION AND/OR DURATION OF BREASTFEEDING

Demographic	<ul style="list-style-type: none"> • adolescent/young mothers • limited number of years in full-time education • low-income level/socioeconomic status • mothers from a culturally and linguistically diverse background • Aboriginal and Torres Strait Islander mothers, particularly in urban areas • high parity
Physical	<ul style="list-style-type: none"> • maternal obesity • maternal diabetes • low birth weight, infant prematurity and/or admission to special care nursery • cracked or sore nipples • various congenital malformations, e.g. cleft palate • multiple births • infant medical or physical influences, e.g. rare metabolic disorders such as galactosaemia, swallowing difficulties etc.
Psychological	<ul style="list-style-type: none"> • mother's lack of confidence in breastfeeding • perceived insufficient supply of breast milk • perception of baby demanding too many feeds • maternal depression
Social	<ul style="list-style-type: none"> • mother's attitude towards breast or infant formula feeding • knowledge and attitudes of partner, relatives and the public towards breast or infant formula feeding • maternal smoking • returning to work • media portrayal of breastfeeding and infant formula (bottle) feeding
Clinical	<ul style="list-style-type: none"> • organisation and practices of the health services, e.g.: <ul style="list-style-type: none"> – certain interventions during and after labour – the provision of supplemental feeds – extended separation of mother and baby for non-medical reasons – restricted feeding – free provision and/or promotion of infant formula – knowledge, attitudes, education and beliefs of health workers – unsupported or inadequately supported discharge plans – poor diagnosis and/or management of common breastfeeding problems – inappropriate diagnosis and management of low weight gain and other infant problems
Environmental	<ul style="list-style-type: none"> • lack of facilities to breastfeed in public areas • employment and work environments that lack breastfeeding policies, paid maternity leave, lactation breaks, flexible working arrangements and appropriate places to express and store breast milk

Source: Queensland Health (2003).

