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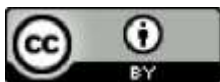
**Department of Health**

# Australian National Breastfeeding Strategy: 2018 and Beyond -- Report on public consultation

*October 2018*



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## EXECUTIVE SUMMARY

### Background

The Department of Health conducted online public consultation on the draft **Australian National Breastfeeding Strategy** from 22 May to 18 June 2018. Two hundred ninety four respondents across Australia provided their views on the Strategy. This report summarises key themes from the consultation, which will inform the Final Strategy.

### Consultation Feedback

Most respondents agreed the **Structure** of the Strategy is appropriate. Some respondents suggested including an Executive Summary and more visual information, restructuring the document, rewording some of the language, summarising the achievements and learnings from the previous Strategy and strengthening the evidence.

There were mixed responses to Part 2, which covered the **challenges** of breastfeeding. While most agreed that the section was comprehensive, the Strategy needs to acknowledge:

- incorrect breastfeeding advice from health professionals and its negative effects;
- lack of resources for maternity and postnatal support services, which are critical to establishing breastfeeding; and
- the limitations of the Manufacturing in Australia of Infant Formula (MAIF) Agreement in restricting the inappropriate marketing of infant formula.

Respondents suggested actions to address these, including adopting in full the World Health Organization (WHO) Code on the marketing of breast milk substitutes and providing more affordable and practical support in the postnatal period, including through midwives, Lactation Consultants and Maternal, Child and Family Health Nurses (MCAFHNs).

Most respondents agreed with the proposed **Vision, Objectives and Principles**. A number of comments raised the inconsistency between the National Health and Medical Research Council (NHMRC) Infant Feeding Guidelines and the WHO recommendations. It was proposed that the Strategy align with the WHO recommendations for continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

Most respondents agreed with the **Initiatives**, however, respondents sought more specific information, including implementation timeframes and accountability. Most of the comments were about:

- **restricting the advertising of infant formula** -- that Australia should fully implement the WHO Code.
- **health professional education and training** -- should include *practice* and be targeted at all health professionals who come in contact with women of childbearing age, children and families. There should be a core curriculum, skills matrix and national competency standards and health professionals need to maintain this level of competency.

Despite an incomplete **Monitoring and Evaluation Framework**, most respondents agreed that the proposed headings and content were appropriate and comprehensive. The **Strategy Logic** was also viewed as meaningful and feasible by most respondents. The Department held a monitoring and evaluation workshop in June 2018 with some members of the Breastfeeding Jurisdictional Officers Group (BJOG) and the Expert Reference Group (ERG). The report on the workshop's outcomes at **Attachment A** will inform the final Monitoring and Evaluation Framework.

## BACKGROUND

The Department of Health sought broader stakeholder and community feedback on the draft ***Australian National Breastfeeding Strategy: 2018 and Beyond*** through its [Consultation Hub](#).

Interested parties were invited to provide comment on the draft Strategy through an online survey; however, the survey was open to anyone. The public consultation was open for four weeks from 22 May 2018 to 18 June 2018.

The online survey asked respondents for comments on the structure of the draft Strategy, the proposed Vision, Principles, Objectives, Initiatives, and Monitoring and Evaluation Framework.

Responses to the consultation have been collated and analysed by the Department of Health and are presented in this report.

The results of the consultation were also provided to the ***Breastfeeding Jurisdictional Officers Group*** (BJOG) and the ***Expert Reference Group*** (ERG), given their role in advising on the Final Strategy.

The Department of Health will rework the draft Strategy to ensure it covers the key issues raised in the public consultation and the workshop on monitoring and evaluation. The Final Strategy will be presented to the BJOG and ERG by the end of 2018.

The Final Strategy will be presented for endorsement to the Health Services Principal Committee, the Australian Health Ministers' Advisory Committee (AHMAC) and the COAG Health Council (CHC) in early 2019.

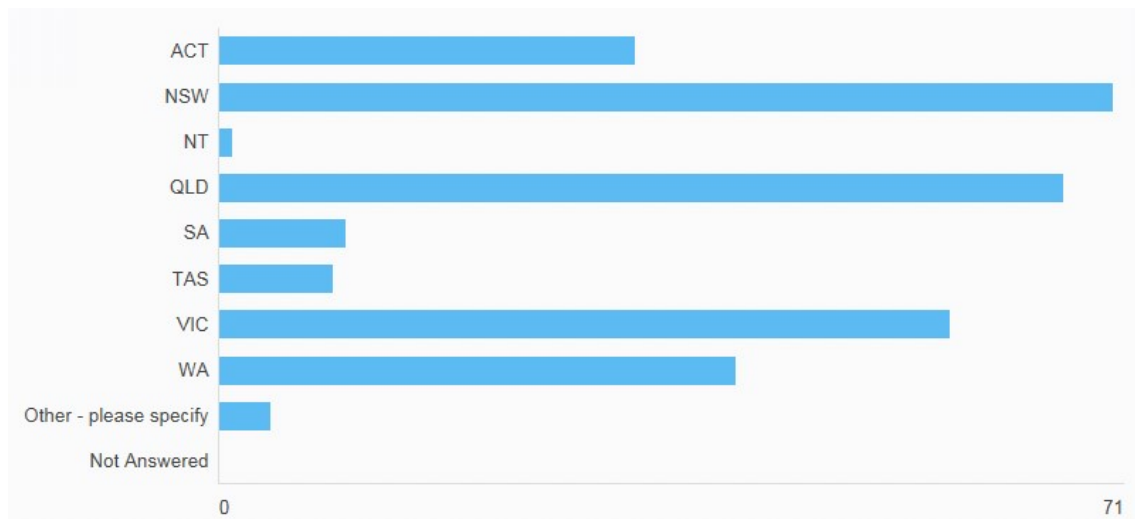
## CONSULTATION FEEDBACK

The Department of Health received 294 submissions. This section provides information on the demographic characteristics of respondents and their responses to the questions about specific sections of the draft Strategy.

### 1. Demographic characteristics

Figure 1 shows that most respondents were from New South Wales (71 or 24%), followed by Queensland (67 or 23%) and Victoria (58 or 20%). Those who responded with 'Other' were representing national organisations.

Figure 1 – Location of respondents



Out of 294 responses, 259 were responding as individuals and 35 responded on behalf of the following organisations:

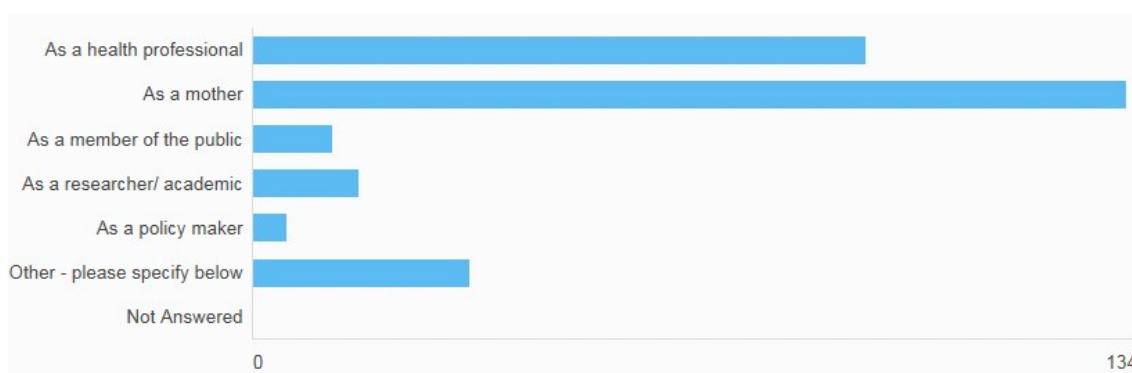
- ACT Health
- Allergy & Anaphylaxis Australia
- Australasian Society of Clinical Immunology and Allergy
- Australian Breastfeeding Association
- Australian Breastfeeding Association - WA Branch
- Australian Breastfeeding Association - Tasmania Branch
- Australian College of Midwives
- Bendigo Health
- Breastfeeding Advocacy Australia Facebook Group
- Breastfeeding Coalition Tasmania
- Child and Family Health Nursing NSW
- Department of Health and Human Services, Tasmania
- Dietitians Association of Australia
- Discipline of Midwifery, Faculty of Health, University of Canberra
- Early Prevention of Obesity in Childhood Centre of Research Excellence
- Infant Nutrition Council
- Institute for Physical Activity and Nutrition, Deakin University
- John Hunter Children's Hospital
- King Edward Memorial Hospital for Women



- Lactation Consultants of Australia and New Zealand
- Launceston General Hospital
- Mater Mothers Hospital, South Brisbane
- Munch & Move - The NSW Office of Preventive Health
- My Midwives Pty Ltd
- National Allergy Strategy
- Perinatal Anxiety & Depression Australia
- Public Health Association of Australia
- Royal Australasian College of Physicians
- St John of God Midland Hospital
- South Australian Health and Medical Research Institute
- The Sutherland Hospital Women's and Children's Health
- Women, Work and Leadership Research Group, University of Sydney Business School
- Women's and Children's Healthcare Australasia
- Women's Electoral Lobby Australia
- World Breastfeeding Trends Initiative Australia

Out of 294 responses, 134 or 46% were responding as a 'mother'.

**Figure 2: Respondents' nominated role**



Thirty-three respondents (11%) identified as fathers, as breastfeeding advocates, or as undertaking a combination of roles. Almost 85% of respondents were born in Australia and only 2.7 per cent of respondents identified as Aboriginal and/or Torres Strait Islander people.

## 2. Responses to questions on the draft Strategy

### Structure of the draft Strategy

Most respondents (90%) agreed that the structure of the draft Strategy is appropriate and easy to follow.

Respondents who disagreed with the Structure nominated the key issues which they perceived were missing or should be changed (refer to Table 1).

**Table 1: Summary of comments on the Structure of the draft Strategy**

Issue	Number of comments	Examples of comments
<b>Document structure</b>	57	<ul style="list-style-type: none"> <li>• Include an Executive Summary and a ‘Strategy at a Glance’ or ‘Strategy on a Page’. The strategy is lost in the density of the document.</li> <li>• Clarify the scope of the Strategy early on in the document (e.g. on p 19, does it include pre-term infants and their mothers?).</li> <li>• Use plain English/ simplify language.</li> <li>• Include images/ infographics/ visuals.</li> <li>• Would be good to see a structure that is clear and easy to follow: What is happening now? What needs to happen/ Gaps? Who will do it? How will it be done? How will it be measured? By when?</li> <li>• Provide information on: achievements and lessons learned from the previous Strategy; more information on initiatives; and how the Strategy will be used to inform or direct health-funding decisions. Include in Part 1 a critique of past policy and acknowledge that breastfeeding enabling policies are complex and need to be coordinated. This would demonstrate why the steps in Part 3 are proposed.</li> <li>• The strategy could use more evidence.</li> <li>• Refer to <i>Becoming Breastfeeding Friendly: A guide to global scale up.</i><sup>1</sup> by Dr Perez-Escamilla</li> </ul>
<b>Education and Training for health professionals</b>	29	<ul style="list-style-type: none"> <li>• Specify which health professionals are targeted by the Strategy</li> <li>• Conflicting advice from health professionals</li> <li>• Continuing education for GPs and Community Health Nurses</li> <li>• Educate health professionals (GPs, Paediatricians, Nurses, Midwives) on the risks of infant formula; introduction of solids</li> <li>• Minimum education requirements for health professionals who provide support for mothers</li> </ul>
<b>Awareness/ education</b>	23	<ul style="list-style-type: none"> <li>• Talk about the risks of formula feeding/ not breastfeeding</li> <li>• Provide realistic expectations of breastfeeding – it’s hard</li> <li>• Raise awareness of breastfeeding and the infant microbiome</li> <li>• Incorporate breastfeeding awareness throughout the school curriculum (refer to the UK review of 2009)</li> </ul>

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<sup>1</sup> Rafael Perez-Escamilla, *Becoming Breastfeeding Friendly: A Guide to Global Scale up*, available at: <https://publichealth.yale.edu/bfci/>

Issue	Number of comments	Examples of comments
<b>Infant Feeding Guidelines</b>	22	<ul style="list-style-type: none"> <li>• Acknowledge discrepancy between NHMRC and WHO Guidelines and the need to align with the WHO recommendations for continued breastfeeding until the child is aged 2 years and beyond.</li> <li>• The Australasian Society of Clinical Immunology and Allergy (ASCIA) Guidelines are confusing and should align with NHMRC and WHO Guidelines.</li> </ul>
<b>Baby-Friendly Health Initiative (BFHI)</b>	18	<ul style="list-style-type: none"> <li>• BFHI organisational change is difficult to achieve</li> <li>• Expensive process</li> <li>• Need incentives for BFHI</li> <li>• Introduce neo-BFHI</li> <li>• BFHI for Paediatric Health Care services</li> <li>• Should be mandated</li> </ul>
<b>Postnatal support</b>	18	<ul style="list-style-type: none"> <li>• Women need continuous support in hospital or with home visits until breastfeeding is established.</li> <li>• Postnatal midwifery support for 2-6 weeks/ up to 12 months after birth</li> <li>• Need to recognise breastfeeding support as one element of maternity and postnatal care</li> <li>• Lactation care in the home should be encouraged</li> </ul>
<b>Lactation Consultants</b>	16	<ul style="list-style-type: none"> <li>• Free access to Lactation Consultants</li> <li>• Increase access to Lactation Consultants in rural areas</li> <li>• Integral role of Lactation Consultants</li> </ul>
<b>Maternal/infant factors</b>	13	<ul style="list-style-type: none"> <li>• Impact of maternal mental health/ perinatal depression on breastfeeding</li> <li>• Maternal confidence is critical</li> <li>• Physical and health issues that can prevent breastfeeding</li> <li>• Causes of why a baby is unable to feed well</li> <li>• Impact of previous sexual assault on breastfeeding</li> <li>• Provide information on: maternal health issues that can interfere with breastfeeding; using medications safe for breastfeeding; birth trauma and reduction in breastfeeding initiation and duration.</li> </ul>
<b>WHO Code</b>	13	<ul style="list-style-type: none"> <li>• Replace MAIF with stronger regulatory arrangements</li> <li>• Needs clear alignment to the WHO Code and subsequent WHA resolutions.</li> <li>• Restrict marketing of bottles and teats</li> <li>• Restrict promotion of formula in Early Childhood Education and Care (ECEC) services and playgroups</li> <li>• Stop cross-promotion of formula</li> </ul>
<b>Continuity of care</b>	11	<ul style="list-style-type: none"> <li>• Continuity of Primary Maternity Care</li> <li>• Continuity of care following hospital discharge through midwives and MCAFHNs.</li> </ul>
<b>Governance of the Strategy</b>	10	<ul style="list-style-type: none"> <li>• Include implementation and review timeframes.</li> <li>• Governance should be free of commercial interests</li> </ul>

Issue	Number of comments	Examples of comments
		<ul style="list-style-type: none"> <li>Involve women’s organisations and breastfeeding support groups as key players</li> <li>National data set with definitions; data collection for NICU infants</li> </ul>
<b>Targeted support</b>	8	<ul style="list-style-type: none"> <li>Consider the needs of mothers who have breastfed but babies have died; mothers whose babies are in neonatal or paediatric health services</li> <li>Avoid separating mothers and infants going through Family Court</li> </ul>
<b>Milk banks</b>	7	<ul style="list-style-type: none"> <li>More milk banks</li> </ul>
<b>Paid Parental Leave</b>	7	<ul style="list-style-type: none"> <li>Extend Paid Parental Leave (PPL) to 6 months</li> <li>Extend PPL to 12 months</li> <li>To improve breastfeeding rates, women should be entitled to longer maternity leave, paid breastfeeding breaks, part-time work or flexible working arrangements when their babies are under the age of 2 years.</li> </ul>
<b>Breastfeeding in public</b>	5	<ul style="list-style-type: none"> <li>Promote an environment that supports breastfeeding in public</li> <li>Strategy should cover breastfeeding in public through the Anti-discrimination Acts</li> </ul>
<b>Fathers/ partners</b>	4	<ul style="list-style-type: none"> <li>Add more references about fathers</li> <li>Role of father/partner is critical</li> </ul>
<b>Funding</b>	4	<ul style="list-style-type: none"> <li>Strategy must be funded</li> <li>How will the Strategy influence health spending decisions?</li> </ul>

### Part 1: Setting the Scene

Eighty per cent of respondents agreed that Part 1 provides adequate context and background for the Strategy. When asked to explain their selection, 153 (52%) had no response. Those who responded (141) provided the following answers:

- 78 provided **positive** responses e.g. “clear and concise background; clear outline of research; easy to read and understand; comprehensive description of Strategy; good discussion of benefits; good overview and background, provides sufficient detail” etc.;
- 46 suggested **additional information**, e.g. “achievements and learnings from previous strategy; impact of birth interventions on breastfeeding; information on the BFHI Ten Steps; cultural beliefs around breastfeeding, definitions of breastfeeding protection, promotion and support; case study examples” etc.;
- 27 provided comments on the **reference to ASCIA guidelines**; most (23) found this confusing and suggested this should be aligned with WHO breastfeeding recommendations;
- 23 suggested using **language** around the ‘risks of not breastfeeding’ rather than the ‘benefits of breastfeeding’;

- 14 commented on the need to **align with WHO infant feeding recommendations** and to **implement the WHO Code**;
- 12 provided **specific comments** on pages 1-5; and
- 4 commented on the **need to fund the Strategy** and **data to monitor the Strategy**.

## **Part 2: The Challenge of Breastfeeding in Australia**

There was a mixed response to the question, “Does Part 2 provide sufficient coverage of the challenges of breastfeeding in Australia?” Out of 294 respondents, 134 (46%) responded with ‘no’ while 160 (54%) said ‘yes’.

Respondents gave the following explanations for their answers:

- 51 comments related to **maternity and postnatal care and continuity of care**, e.g. support in the early days is necessary to establish breastfeeding but women are discharged early; need to expand funding, resources and support in the postnatal period to initiate breastfeeding; and access to IBCLCs and breastfeeding drop-in clinics;
- 49 comments related to **health professionals**, e.g. inconsistent and incorrect advice and the need for breastfeeding education and training;
- 38 comments related to the **marketing of infant formula**, e.g. need to address limitations of MAIF and the need to fully implement the WHO Code; influence of infant formula companies on the advice provided by health professionals; acknowledge the increase in sales and increasing use of formula in hospital;
- 26 comments were **positive**, e.g. addresses main areas; acknowledges determinants of breastfeeding; easy to follow; good strategies;
- 18 comments were about addressing not just pregnancy and birth but also **motherhood challenges**, including providing realistic advice about breastfeeding, infant behaviours and infant sleep, and a practical knowledge base for first-time parents;
- 15 comments were about extending **Paid Parental Leave** to at least six months to support breastfeeding while 10 respondents suggested additional information on the **impact of returning to work** on breastfeeding rates;
- 13 respondents suggested acknowledging challenges for **priority groups** such as migrants and refugees, including cultural beliefs; and including mothers of pre-term babies as a priority/at risk group;
- 11 respondents suggested including more information on the impact of **birth interventions** on breastfeeding while 12 respondents suggested including information on **other medical issues** for both mother and baby that impact on breastfeeding, such as tongue ties;
- 10 respondents suggested more focus on the role of **partner and family support and community based peer support**; and

- 8 comments related to **breastfeeding in public** and the need for supportive public spaces for breastfeeding.

When asked to nominate what is missing or should be changed in Part 2 of the draft Strategy, 134 (51%) did not answer. Table 2 provides a summary of the key issues nominated and sample comments from those who responded:

**Table 2: Summary of responses to ‘What is missing or should be changed in Part 2?’**

<b>Issue</b>	<b>Number</b>	<b>Examples of comments</b>
<b>Health professionals’ education and training</b>	39	<ul style="list-style-type: none"> <li>• Mention conflicting advice from health professionals</li> <li>• Identify negative effects of poor medical advice</li> <li>• Educate GPs on breastfeeding</li> <li>• Educate health professionals on introduction of solids</li> </ul>
<b>PPL, returning to work, and employer support for breastfeeding</b>	30	<ul style="list-style-type: none"> <li>• More emphasis on the impact of returning to work on breastfeeding</li> <li>• PPL should be extended to 6 months/ 12 months so mothers can breastfeed for longer</li> <li>• PPL not available for women in unsecure employment</li> <li>• More support for maternity and parental leave</li> <li>• How Australia rates in terms of implementing International Labour Organization recommendations on paid lactation breaks.</li> <li>• Positive impact of breastfeeding friendly policies and provision of facilities within workplaces.</li> </ul>
<b>Specific comments</b>	27	<ul style="list-style-type: none"> <li>• Update Australian Breastfeeding Association (ABA) statistics on page 17 from 2012 to 2017 data</li> <li>• Evidence gaps – references provided</li> <li>• Suggested wording changes</li> <li>• Add visual cues to link conceptual framework to each section</li> </ul>
<b>WHO Code</b>	25	<ul style="list-style-type: none"> <li>• Revise the section on marketing of infant formula.</li> <li>• As this is an enduring strategy, it should seek full implementation of the WHO Code.</li> <li>• There is no evidence for the effectiveness of voluntary arrangements such as MAIF.</li> <li>• Include the WHO 2016 guidance on ending inappropriate promotion of foods for infants and young children.</li> </ul>
<b>Postnatal support</b>	24	<ul style="list-style-type: none"> <li>• There should be more information on increased postnatal support in the home.</li> <li>• Awareness of the benefits of breastfeeding is high so focus resources on breastfeeding support.</li> <li>• Support from Maternal, Child and Family Health Nurses and Lactation Consultants</li> </ul>
<b>Infant Feeding Guidelines</b>	15	<ul style="list-style-type: none"> <li>• The NHMRC Infant Feeding Guidelines should align with the WHO recommendation of breastfeeding up to 2 years and beyond.</li> <li>• FSANZ allows infant foods to continue to be labelled</li> </ul>

Issue	Number	Examples of comments
		from 4-6 months undermines the NHMRC Guidelines message to exclusively breastfeed to around 6 months.
<b>Public Education and Awareness/ Media Challenges</b>	16	<ul style="list-style-type: none"> <li>• Acknowledge media challenges – social media; targeted formula advertisements; conflicting messages and trends.</li> <li>• Raise awareness of the amazing qualities and benefits of human milk.</li> <li>• Public education and awareness is necessary to normalise breastfeeding in public.</li> </ul>
<b>Barriers to breastfeeding</b>	17	<ul style="list-style-type: none"> <li>• Birth interventions and impact on breastfeeding</li> <li>• More info on medical/ physical challenges (e.g. lip ties and tongue ties)</li> <li>• Acknowledge circumstances where breastfeeding is not possible</li> <li>• Impact of obesity on breastfeeding</li> </ul>
<b>Lactation Consultants</b>	11	<ul style="list-style-type: none"> <li>• There is no mention of Lactation Consultants supporting mothers to breastfeed; it is critical in the antenatal and postnatal periods.</li> <li>• All Maternal and Child Health Nurses should require International Board Certified Lactation Consultant Lactation Consultant (IBCLC) qualifications to ensure correct and up to date information is given to mothers.</li> <li>• Access to Lactation Consultants through Medicare rebates or private health insurance</li> </ul>
<b>Continuity of Care</b>	10	<ul style="list-style-type: none"> <li>• Continuity of midwifery care</li> <li>• Continuity of care between hospital and community health services</li> </ul>
<b>Priority populations</b>	10	<ul style="list-style-type: none"> <li>• Better targeted support for rural and remote women, recent arrivals, refugees, families going through Family Court, people with disabilities, mothers of pre-term babies, mothers with special needs (e.g. drug and alcohol addiction).</li> <li>• Section on Aboriginal and Torres Strait Islander people should acknowledge issues for those living in urban areas, not just rural areas.</li> </ul>
<b>Settings</b>	8	<ul style="list-style-type: none"> <li>• Add Early Childhood Education and Care settings</li> <li>• Add Primary Health Care settings</li> </ul>
<b>BFHI</b>	7	<ul style="list-style-type: none"> <li>• Add BFHI Community</li> <li>• Adopt Neo-BFHI</li> <li>• Note differences in take-up of BFHI by jurisdiction</li> </ul>
<b>Cost of breastfeeding</b>	7	<ul style="list-style-type: none"> <li>• GST on breastfeeding aids e.g. pumps</li> <li>• Cost of breastfeeding does not cover other supports</li> </ul>

### Part 3: A National Breastfeeding Strategy for 2018 and Beyond

#### **Vision**

The proposed Vision in the draft Strategy was:

*Australia is recognised as a nation where breastfeeding is protected, promoted, supported and valued by the whole of society as the biological and social norm for infant and young child feeding.*

Respondents were asked whether the Vision reflects the intent of the Strategy and its Objectives. Two hundred sixty two or 89% said 'Yes' (see Figure 3).

**Figure 3: Responses to 'Do you believe the Vision reflects the intent of the Strategy and its objectives?'**



One hundred nine respondents (37%) provided comments on the Vision, of which 34 respondents or 31% provided support for the Vision. Other respondents provided suggested wording changes and detailed comments. Respondents also reiterated the importance of acting on the Vision and being bold, as this is an enduring Strategy.

#### **OBJECTIVES**

The proposed Objectives in the draft Strategy were:

- *Raise awareness of the value of breastfeeding in achieving optimal health for both child and mother throughout the life course;*
- *Protect the rights of the child and mother to optimal health and nutrition through breastfeeding;*
- *Enable women and their families to make informed infant feeding decisions; and*
- *Increase the number of babies that are breastfed to optimal levels, in line with NHMRC and WHO recommendations.*

Respondents were asked whether the Objectives reflect the intent of the Strategy. 245 respondents or 83% said 'Yes' (refer to Figure 4).



**Figure 4: Responses to ‘Do you believe the Objectives reflect the intent of the Strategy?’**



Ninety respondents (or 30%) provided comments on the Objectives. Of these, 21 (or 23%) agreed with the Objectives while 69 (or 76%) suggested changes. A number of comments raised the discrepancy between the NHMRC Infant Feeding Guidelines and the WHO recommendations and proposed that the Strategy should align with the WHO recommendations.

Other comments related to strengthening the objectives, including ensuring that they are SMART (specific, measurable, achievable, relevant and time bound).

Examples of other objectives proposed:

- Promote the risks associated with not breastfeeding or breast milk feeding for mothers and children across the life course.
- Increase the number of health settings that are BFHI accredited.
- Ensure adequate support is available for women to achieve their breastfeeding goals.
- Women and babies have the medical support necessary to translate pre-natal intention to breastfeed to action.
- Provide equal opportunity for mothers, infants and young children in priority groups to benefit from optimal breastfeeding.

### **PRINCIPLES**

The Principles proposed in the draft Strategy were:

- *Mother, Child and Family*
- *Ecological Context*
- *Access*
- *Diversity*
- *Integrated Care*
- *Evidence-based*
- *Accountability*
- *Monitoring and data collection*
- *Protection*

Respondents were asked to comment on the statement, “The Principles of the Strategy are appropriate and comprehensive.” A total of 248 respondents (or 84%) said ‘Yes’ (see Figure 5).

**Figure 5: Responses to the statement, “The Principles of the Strategy are appropriate and comprehensive.”**



When asked to nominate what is missing or what should change among the Principles, the main comments were:

- **Mother, Child and Family** – ‘include focus on fathers not grouped with other family members’, ‘if a child is separated from the mother, then breast milk should still be a priority’, ‘requiring separation of the mother-infant dyad, for whatever reason is inimical to the rights of the child and mother to optima breastfeeding and should be avoided’, ‘change *but* to *and*’, ‘the objective, *Protect the rights of the child and mother to optimal health and nutrition through breastfeeding* should be highlighted in the Principles’.
- **Ecological context** – ‘address the economic and time costs of breastfeeding’, ‘should be broadened to bring in more of the social and community aspects’.
- **Access** – ‘to appropriate support especially in the early days and weeks following childbirth’, ‘to ABA peer support counsellors’, ‘to Lactation Consultants’, ‘continuity of midwifery care’, ‘access to evidence-based, clinically appropriate information about breastfeeding technique, challenges and strategies for addressing those challenges’, ‘increasing access to donated breast milk’
- **Diversity** – ‘culturally safe care and education around breastfeeding’, ‘targeted support for young mothers under 25 years’, ‘support for families going through the Family Court system’, ‘ensure breastfeeding or breastmilk feeding continues for children in out of home care’
- **Integrated care** – ‘continuity of care at key transition points between the antenatal, birth and primary care and community health services is seamless’, ‘greater emphasis on staff training and support for funded lactation specialists and dedicated lactation clinics’, ‘add non-government organisations’
- **Evidence-based** – ‘provision of evidence-based information by health professionals is welcomed’, ‘would like to see a more explicit reference to the need for health professionals caring for families to be provided with ongoing, evidence-based education and supervised clinical practice (as per the BFHI guidelines)’, ‘delete *clinical*, any breastfeeding research is valuable’, ‘expand the research to include the full range of research into lactation and breastfeeding’, ‘health professionals provide clinical care as well as information and support’, ‘industry should not be involved in providing education or information to health professionals’, ‘invest in relevant and high quality clinical and

academic research’, ‘promote scientific information about suitable alternatives to breast milk’

- **Accountability** – ‘could be demonstrated by prioritising implementation of BFHI’, ‘it is unclear who and how will this responsibility be monitored’, ‘add appropriate consultation, engagement and collaboration with key civil society, breastfeeding support and women’s organisations’, ‘reword to ensure transparency around who will be held accountable for implementation’, ‘needs to include a permanent breastfeeding advisory committee that includes community representation and is free from commercial interests’
- **Monitoring and data collection** – ‘are essential and have been difficult to achieve comprehensively in the past’, ‘must be prioritised and addressed early during the implementation phase’, ‘data should be used to report progress against the Strategy and to provide benchmarks and comparison to other nations and across jurisdictions to identify areas in which we are excelling or where we need improvement’, ‘should include evaluation of breastfeeding services by women, including satisfaction with those services’, ‘using internationally comparable indicators and indicate timeframes, e.g. every 5 years’
- **Protection** – ‘the only objective that can be acted on decisively and with immediate effect’, ‘all health professionals and their organisations, health education institutions and bodies, and consumer protection bodies, have a duty of care to educate and protect the community from false and misleading industry marketing’, ‘definitions and any references to the WHO Code need to include subsequent WHA resolutions and WHA Guidance’, ‘does health institutions include health professionals, health workers and their representative organisations, e.g. sponsorship of health professional education, conferences, and travel by infant formula and baby food manufacturers’

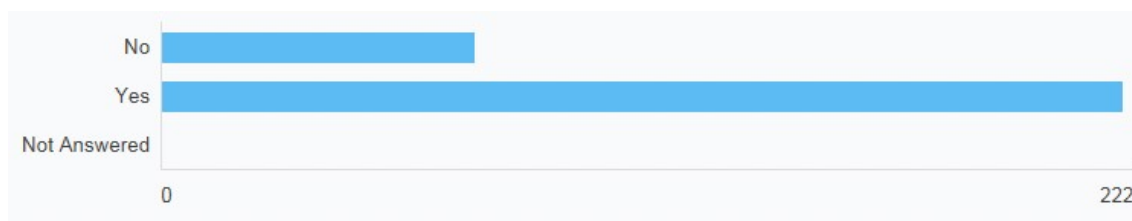
## **INITIATIVES**

The Initiatives proposed in the draft Strategy were:

- *Community education and awareness*
- *Restriction of advertising of infant formulas*
- *Dietary guidelines and growth charts*
- *Health professional education and training*
- *Baby Friendly Health Initiative*
- *Milk banks*
- *Breastfeeding friendly workplaces*
- *Breastfeeding friendly early childhood education and care settings*
- *Universal breastfeeding education, support and information services*
- *Targeted/ specialist breastfeeding support services*

Respondents were asked, “Do you believe the Initiatives identified in the Strategy will assist in achieving the Vision and Objectives?” Most respondents (76%) said ‘Yes’ (see Figure 6).

**Figure 6: Responses to the question, “Do you believe the Initiatives identified in the Strategy will assist in achieving the Vision and Objectives?”**



When asked to explain their responses, most respondents were after more specific information on the initiatives or examples, including implementation timeframes and accountability.

Most of the specific comments on the Initiatives were on **restricting the advertising of infant formula**. Respondents suggested that Australia should fully implement the WHO Code and subsequent World Health Assembly (WHA) resolutions. They noted that there is no evidence for the effectiveness of voluntary arrangements, such as the MAIF Agreement, in restricting the marketing of infant formula. In the meantime, the MAIF Agreement should be expanded to include all retailers and distributors and all breast milk substitutes (including toddler milk), there should be more effective monitoring and compliance, and the MAIF Agreement should be mandatory until the WHO Code has been fully implemented. Others suggested that codes of conduct for health professionals should prohibit gifts, education or training from infant formula companies. Medical colleges’ statements and standards should align with the WHO Code. There should also be changes to the promotion and labelling of infant/baby food so that they are not marketed as suitable for four-month old babies.

**Health professional education and training** should include practice and be targeted at all health professionals who come in contact with women of childbearing age, children and families. These include GPs, Obstetricians, Paediatricians, Midwives, Practice Nurses, Maternal, Child and Family Health Nurses, Allergy specialists, Paediatric Gastroenterologists, Psychologists, Anaesthetists, Speech Pathologists, Pharmacists, Dentists and Dietitians. There should be a core curriculum, skills matrix and national competency standards and health professionals need to maintain this level of competency through ongoing professional development activity. Health professionals’ level of breastfeeding competency should be visible to the women consulting them, perhaps through a ‘Breastfeeding-friendly Health Professional Accreditation Scheme’. To support health sector service delivery, a breastfeeding/ infant feeding research program must be implemented.

A number of comments noted the need to provide affordable and accessible **universal postnatal support services** given the reduced length of hospital stays/ in-hospital support for breastfeeding. There should be increased funding for Midwifery postnatal support in the first six weeks after birth and for Maternal, Child and Family Health Nurses’ support thereafter. In this context, respondents also raised the critical role of **International Board Certified Lactation**

**Consultants (IBCLCs)** in the antenatal and postnatal periods, the need for additional support such as an MBS item for IBCLCs and increasing access to IBCLCs in hospitals or maternal, child and family health services.

There was a lot of support for mandatory **BFHI accreditation** for all maternity hospitals and community health services. This should be supported with funding and/or incentives. Once this has been achieved, consideration should be given to Neo-BFHI and BFHI for Paediatric Health Care Services.

Respondents also commented that support for **breastfeeding in the workplace** (such as the ABA's Breastfeeding Friendly Workplace Accreditation) should be compulsory in all government departments, particularly health departments, with other workplaces to follow. Paid Parental Leave should be extended to 26 - 52 weeks after birth to increase breastfeeding duration. It was also suggested that there should be legislative support for all businesses/ employers to provide flexible work practices, work breaks and facilities to enable women to combine breastfeeding and work. Also, there needs to be coordination with the Department of Jobs and Small Business and other state and territory departments.

In relation to **breastfeeding friendly early childhood education and care (ECEC) services**, the following were suggested. ECEC legislation and the Early Years Learning Framework (EYLF) curriculum should include infants with specific infant feeding examples. All ECEC services should have an infant feeding policy or section within their nutrition policies in line with the NHMRC Infant Feeding Guidelines or WHO guidelines. Breastfeeding support should be part of accreditation as an ECEC service or training as an ECEC worker. Consider existing initiatives that promote breastfeeding in ECECs such as NSW Health's Munch and Move program and the Breastfeeding Friendly Child Care piloted by the Australian Breastfeeding Association (ABA), University of New South Wales (UNSW), Flinders University and the Australian National University (ANU).

Comments on **Community education and awareness** activities were mainly on topics that should be covered: infant feeding and behaviour; the risks/ harms of not breastfeeding; tongue ties and lip ties; breastfeeding and the infant microbiome. There were also suggestions to develop simple, easy to read resources, including a publicly available online knowledge base on breastfeeding techniques and issues for mothers, to investigate innovative models of delivering universal breastfeeding education and to review the current Health and Physical Education curriculum. There should also be incentives for local governments to promote breastfeeding friendly environments.

In terms of **targeted support** for breastfeeding, respondents suggested including CALD women, especially those with low breastfeeding rates, mothers of pre-term infants, and mothers and children going through the Family Court. A dedicated lactation support service in the community (alongside peer support) with timely access to lactation specialists (IBCLC) for the more complex feeding issues was also proposed.

Other specific initiatives that were proposed included:

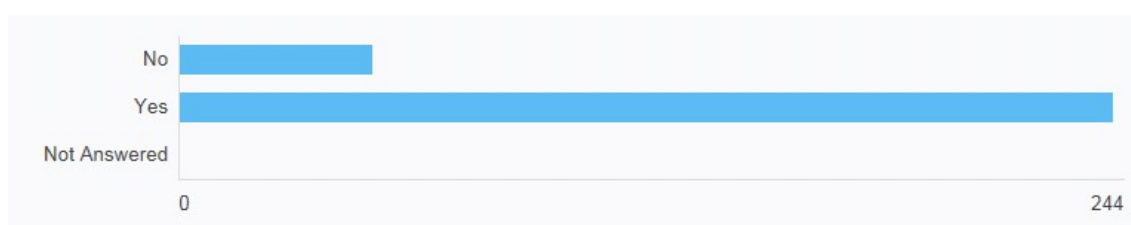
- reinstate the ABS National Time Use Survey to allow valuation of women’s care work including breastfeeding;
- conduct breastfeeding social marketing campaigns to match the marketing spend of industry;
- implement consumer law prohibition on inappropriate promotion of commercial foods for infants and young children (0-36 months) and violations to ACCC;
- run an awareness campaign on breastfeeding rights and redress;
- introduce Medicare rebates and health grants to states and territories for all maternity and newborn care services conditional on implementation of the BFHI Ten Steps; and
- develop plans and policies to ensure that in difficult circumstances, breastfeeding relationships are established and maintained as appropriate with priority given to the best interests of the child including the human rights of the mother and child.

#### **Part 4: Monitoring and Evaluation Framework**

The draft Strategy proposed a draft structure for a monitoring and evaluation framework that was yet to be completed. The draft Strategy referred to a planned workshop in late June 2018 with Expert Reference Group and Breastfeeding Jurisdictional Officers Group members during which the monitoring and evaluation framework would be discussed. The workshop was held on 25 June 2018 and the workshop report is at Attachment A.

Despite an incomplete framework, most respondents (83%) agreed that the proposed headings and content for the framework were appropriate and comprehensive (see Figure 7).

**Figure 7: Responses to the question, ‘Do you believe the Monitoring and Evaluation Framework is appropriate and comprehensive?’**



The main comments on research, monitoring and evaluation were:

- a national data set for monitoring is vital and monitoring should be more than just breastfeeding rates and should include a regular infant feeding survey;
- concerns with the involvement of the Infant Nutrition Council in monitoring and evaluation as this is perceived as a conflict of interest;
- stakeholders such as the Australian Medical Association (AMA), Australian Children’s Education and Care Quality Authority (ACECQUA), National Aboriginal Community Controlled Health Organisation (NACCHO), Federation of Ethnic Communities’ Councils of Australia (FECCA), Raising Children Network, Royal Australasian College of Physicians (RACP), Royal Australian College of General Practitioners (RACGP), should be included;

- include research on women’s experiences of breastfeeding, breastfeeding and work, the psycho-social aspects of the mother-child breastfeeding relationship, and the reasons why women achieve/ do not achieve their breastfeeding goals;
- include research on effective interventions/ strategies to increase breastfeeding rates;
- evaluate the Initiatives – evaluation must be planned and articulated before initiatives are implemented.

Some respondents also proposed using the indicators in the World Breastfeeding Trends Initiative (WBTI) Australia report. Others suggested indicators such as:

- intention: intended duration at antenatal and postnatal discharge
- initiation: within 1 hour of birth & prior to discharge
- exclusive breastfeeding: infant formula or other fluids given during postnatal inpatient stay; prevalence of EBF 1m<6m using WHO indicator; duration of exclusive breastfeeding (age at introduction of food or fluid other than breastmilk)
- duration – age at cessation – WHO 24 hr recall indicator

There were also suggestions to collect data on pre-term infants, using consistent routine measures of infant feeding at each gestational age to be collected at each hospital, with collation for benchmarking.

Comments in relation to governance:

- model the national breastfeeding committee after the USA’s Breastfeeding Committee
- the national committee should be free from commercial influence and should make transparent any involvement of the infant formula industry;

### Strategy Logic

Respondents were asked whether they thought the Strategy Logic was meaningful and feasible. Most respondents (77%) said ‘Yes’ (see Figure 8).

**Figure 8: Responses to the question, ‘Do you think the Strategy is meaningful and feasible?’**



Due to an error with the text box for this question, respondents could not provide further comments or explanations for their answers. Consequently, some respondents used the text box for the next question to provide comments and these are included in Table 3.

## Final Comments on the Strategy

Sixty three percent of respondents provided feedback on the Strategy (refer to Table 3).

**Table 3: Final comments on the Strategy**

Issue	Number of comments	Examples of comments
<b>Support for the Strategy</b>	68	<ul style="list-style-type: none"> <li>• <i>a really important topic</i></li> <li>• <i>about time</i></li> <li>• <i>applaud government for recognising importance of breastfeeding</i></li> <li>• <i>comprehensive, easy to follow</i></li> <li>• <i>excellent</i></li> <li>• <i>hope this makes a real difference</i></li> <li>• <i>Strategy Logic is a good snapshot</i></li> <li>• <i>Thank you</i></li> <li>• <i>Well done on good work to date</i></li> </ul>
<b>Funding</b>	52	<ul style="list-style-type: none"> <li>• <i>Strategy must be funded</i></li> <li>• <i>Need financial incentives to support breastfeeding</i></li> <li>• <i>Challenge will be funding</i></li> </ul>
<b>MAIF Agreement/ WHO Code</b>	47	<ul style="list-style-type: none"> <li>• <i>Fully implement the WHO Code and subsequent resolutions</i></li> <li>• <i>Better regulation of marketing of infant formula</i></li> <li>• <i>Marketing of infant formula neutralises the impact of breastfeeding initiatives</i></li> </ul>
<b>Access to universal breastfeeding support services</b>	42	<ul style="list-style-type: none"> <li>• <i>Focus on the real physical issues and provide practical support</i></li> <li>• <i>IBCLC support is required not only in hospital but in the community to manage the complex feeding issues faced by families.</i></li> <li>• <i>More in-hospital support to establish breastfeeding – start with staffing maternity care appropriately; fix ratios so midwives have more time to support initiation of breastfeeding.</i></li> <li>• <i>If women have a known midwife the education starts early in the antenatal period and is integrated throughout their pregnancy, the period immediately after birth and for the first six weeks.</i></li> <li>• <i>Emphasis should be placed on the critical transition period from hospital to home (community).</i></li> <li>• <i>Address the lack of access of women in the first days and weeks after childbirth to non-admitted postnatal support (ideally home visits).</i></li> <li>• <i>The first six weeks is crucial. If there is a problem, they need someone to sit with them now and watch that baby feed. They cannot wait until next week for an appointment.</i></li> </ul>
<b>Paid Parental Leave/ return to work</b>	39	<ul style="list-style-type: none"> <li>• <i>Extend PPL to 6-12 months</i></li> <li>• <i>Acknowledge tension between needing to return to work and breastfeeding</i></li> </ul>



Issue	Number of comments	Examples of comments
		<ul style="list-style-type: none"> <li>• <i>Need guidelines/ legal framework for workplaces to support breastfeeding and to protect mothers in the workplace.</i></li> <li>• <i>Involve the Department of Jobs and Small Business and employers</i></li> <li>• <i>Make Breastfeeding Friendly Workplace Accreditation compulsory in all workplaces</i></li> <li>• <i>Mandate all government agencies to be breastfeeding-friendly</i></li> <li>• <i>Need to shift attitudes in male dominated corporate sector</i></li> </ul>
<b>Health professionals</b>	35	<ul style="list-style-type: none"> <li>• <i>Education for GPs, MCAFHNs, Paediatricians, Dentists, Nurses, Mental health professionals, Dietitians</i></li> <li>• <i>MCAFHNs need more support to attend education/ training</i></li> <li>• <i>Midwives' workloads are a barrier to support women to establish breastfeeding</i></li> <li>• <i>Need resources for health professionals to support mothers</i></li> </ul>
<b>Implementation of the Strategy</b>	32	<ul style="list-style-type: none"> <li>• <i>Identify action owners and stakeholders for each Initiative</i></li> <li>• <i>Include Implementation timeframes and monitoring</i></li> <li>• <i>Lacks specific and concrete actions; provide more detail on the Initiatives</i></li> <li>• <i>Need buy-in from all stakeholders, including the private hospital sector</i></li> <li>• <i>For transparency, prepare an annual report on implementation</i></li> </ul>
<b>Data</b>	28	<ul style="list-style-type: none"> <li>• <i>Add data collection to the Initiatives</i></li> <li>• <i>Breastfeeding should be part of core business</i></li> <li>• <i>Comments on indicators at Attachment A</i></li> <li>• <i>Good idea to collect data through the Australian Immunisation Register.</i></li> <li>• <i>Include breastfeeding data and introduction of solids in the MyHealth Record</i></li> <li>• <i>National indicators on breastfeeding</i></li> <li>• <i>Measurable outcomes and indicators</i></li> </ul>
<b>Alignment with national and international policies</b>	18	<ul style="list-style-type: none"> <li>• <i>Align the Strategy with the National Strategic Approach to Maternity Services. Data collection and evaluation should be aligned so that data, women's satisfaction, and clinical outcomes must include breastfeeding.</i></li> <li>• <i>Align with WHO infant and young child feeding policies, the WHO Code and subsequent WHA resolutions, including WHA69.9</i></li> <li>• <i>Breastfeeding also links to Sustainable Development Goals (SDGs) 11 and 12</i></li> </ul>

Issue	Number of comments	Examples of comments
<b>Access to human milk</b>	12	<ul style="list-style-type: none"> <li>• <i>We need to think about expanding milk banks and providing ways to feed infants with breast milk when their mother is unable to provide (for whatever reason).</i></li> <li>• <i>It would be good to have a safe and stable supply of breast milk for adopted infants or foster children to ensure they receive the nutritional benefits of breast milk.</i></li> <li>• <i>Increase the number of milk banks nationwide, as it is currently very difficult to donate excess breast milk.</i></li> </ul>
<b>Awareness and education</b>	11	<ul style="list-style-type: none"> <li>• <i>There needs to be more education in schools and media regarding the lifelong benefits of breastfeeding.</i></li> <li>• <i>Improving education and support systems at the high school level is integral to supporting and improving breastfeeding rates among young people. This will in turn support improved rates among young people across varying socioeconomic and cultural backgrounds.</i></li> <li>• <i>Education and information needs to be basic and easy to understand.</i></li> <li>• <i>The social media strategy is very exciting as it normalises breastfeeding and allows the community to participate.</i></li> <li>• <i>Communications campaign does not need to cost much. There are existing sources of information.</i></li> </ul>
<b>Document structure, Language and referencing</b>	11	<ul style="list-style-type: none"> <li>• <i>Overly bureaucratic; needs to be shortened and rewritten to explain how governments intend to work together to promote higher breastfeeding rates. Initiatives should be reframed as tangible actions, with priority given to investment in more lactation support in the postnatal period, with coordination between hospitals, early childhood services, doctors and child development services.</i></li> <li>• <i>Consider using the ‘significance’ of breastfeeding rather than the ‘benefits’ of breastfeeding.</i></li> <li>• <i>Be mindful of language in terms of the ‘benefits’ of breastfeeding rather than the ‘risks of not breastfeeding’. Talking about ‘benefits’ positions formula feeding as the control group and breastfeeding as the intervention group when it is the other way around. Refer to ‘The Risks of Not Breastfeeding for Mothers and Infants’ by Dr Alison Stuebe.</i></li> <li>• <i>There are references missing.</i></li> </ul>
<b>ABA funding</b>	9	<ul style="list-style-type: none"> <li>• <i>ABA is amazing and supports mums who are not being supported by the community and health care system. They have a great mechanism in place. I</i></li> </ul>

Issue	Number of comments	Examples of comments
		<p><i>hope you recognise and resource this.</i></p> <ul style="list-style-type: none"> <li>• <i>Government funding of ABA activities needs to underpin not undermine its sustainability.</i></li> <li>• <i>Funding for the ABA's work on the National Breastfeeding Helpline, LiveChat service and volunteer training could be expanded to include sustained psychosocial support through community groups.</i></li> <li>• <i>Acknowledge the ABA as the leaders in the field of breastfeeding so that health professionals recognise the vast wealth of knowledge.</i></li> </ul>
<b>National breastfeeding committee</b>	9	<ul style="list-style-type: none"> <li>• <i>The proposed national coordination body should include a representative from the early childhood education sector, such as Early Childhood Australia, to inform policy and practice on issues affecting the sector.</i></li> <li>• <i>Please make sure that the national committee is free from commercial interest, industry bias or influence.</i></li> <li>• <i>Important to have a leadership group to champion the Final Strategy and monitor its implementation.</i></li> <li>• <i>National advisory committee on infant feeding must not include industry, must be fully independent and include a broad range of interested members, not just those employed in state health departments.</i></li> <li>• <i>The national breastfeeding committee should have representatives from the ABA as the peak non-government organisation. This committee could have as a subcommittee, a national committee free from industry stakeholders to oversee the implementation to monitor and address inappropriate marketing and media and oversee the plan to accept the WHO Code.</i></li> </ul>
<b>Mixed feeding</b>	9	<ul style="list-style-type: none"> <li>• <i>Provide research on formula to support mothers who choose to mix feed.</i></li> <li>• <i>Despite what the Australian Breastfeeding Network would have you believe, formula is not poison and should be available to supplement breast milk. The black and white dichotomy helps no one and helping women understand there is nothing wrong with letting their baby breastfeed for 20 minutes then give them a formula top up is better than women giving up on breastfeeding completely.</i></li> <li>• <i>It is important to have some information in the Strategy for parents who cannot breastfeed for whatever reason, child protection matters, death of biological mother, mother returning to work, that their babies can and will thrive on formula.</i></li> <li>• <i>Women who mix feed need to be supported through this strategy. This is also a valid choice and if there is</i></li> </ul>

Issue	Number of comments	Examples of comments
		<p><i>more encouragement of mix feeding then breastfeeding will likely last longer.</i></p> <ul style="list-style-type: none"> <li>• <i>More consideration needs to be given to women who are unable to breastfeed or choose not to. We should continue to provide evidence-based information to support a woman in making the best-informed feeding choice for her baby. The mental health of a woman cannot be relegated to a lower priority than breastfeeding her baby.</i></li> <li>• <i>Maintain a respect for those women who cannot or choose not to breastfeed without ridicule or backlash.</i></li> </ul>
<b>Baby-Friendly Health Initiative</b>	8	<ul style="list-style-type: none"> <li>• <i>Fund BFHI accreditation for hospitals and community health services.</i></li> <li>• <i>There is no mention of the 7-Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services. Needs to be included.</i></li> <li>• <i>Maintaining BFHI accreditation in Tasmania has been invaluable. We have seen a steady but small increase in initiation but ongoing challenge with exclusive breastfeeding is due to complex pregnancy and birth outcomes and early parenting stresses.</i></li> <li>• <i>BFHI national accreditation should be in the Structural part of the Strategy Logic.</i></li> </ul>
<b>Breastfeeding in ECEC services</b>	8	<ul style="list-style-type: none"> <li>• <i>Early childhood education and care legislation and EYLF curriculum should include infants. Currently, infants are mainly invisible despite their highly specific needs – covered under the term ‘children’.</i></li> <li>• <i>ECEC services should have an infant feeding policy in line with the Infant Feeding Guidelines/ WHO Guidelines. Currently there is no legislation that requires this.</i></li> <li>• <i>ECEC updated training required across registered training organisations, universities, services.</i></li> <li>• <i>Fund the national implementation of the Breastfeeding Friendly Child Care initiative piloted by the ABA, UNSW, Flinders University and ANU.</i></li> </ul>
<b>Targeted support</b>	8	<ul style="list-style-type: none"> <li>• <i>Peer support is more than telephone help especially for culturally and linguistically diverse (CALD) groups of which Australia currently has 800 languages spoken at home. Bilingual peer support would aim for sensitive addressing of dominant cultural needs.</i></li> <li>• <i>Would also be good to focus on support &amp; education for Aboriginal health workers to be confident &amp; accurate in offering support to mums &amp; encourage them to breastfeed in communities.</i></li> <li>• <i>The ‘Hey Mum’ 3 year funded project to provide educated peer support for young mums in North West Tasmania showed that this was an effective strategy</i></li> </ul>

Issue	Number of comments	Examples of comments
		<i>to improve breastfeeding within a vulnerable group. I would encourage this strategy with young mums and Aboriginal people.</i>
<b>Partner support</b>	7	<ul style="list-style-type: none"> <li>• <i>The support of my husband especially in those first few weeks where breastfeeding seemed to take up all of our time was the biggest contributing factor to our success.</i></li> <li>• <i>There is no mention of fathers in participation. Given the evidence behind the support of partners, this is an important inclusion.</i></li> <li>• <i>As described by Maycock and Smith et al, the active and informed involvement of fathers makes a significant difference in breastfeeding rates.</i></li> </ul>
<b>Infant Feeding Guidelines</b>	6	<ul style="list-style-type: none"> <li>• <i>Should be in line with WHO and encourage breastfeeding until at least 2 years of age.</i></li> <li>• <i>The ASCIA recommendations should not be mentioned as they are contradictory to WHO and NHMRC guidelines on introduction of solids and create unnecessary confusion.</i></li> </ul>
<b>Stakeholders</b>	4	<ul style="list-style-type: none"> <li>• <i>Need broader stakeholder input.</i></li> <li>• <i>Include Perinatal Anxiety and Depression Australia (PANDA) as a stakeholder.</i></li> <li>• <i>Stakeholder engagement will be critical to the successful implementation of the strategy.</i></li> </ul>

## **ATTACHMENT A: REPORT ON MONITORING AND EVALUATION WORKSHOP**

### **Workshop Participants:**

- ACT Health – Ann Burgess and Glenn Draper
- Australian Breastfeeding Association - Susan Day and Alison Boughey
- Australian College of Midwives - Marjorie Atchan, Sarah Stewart and Nav St Louis
- Australian Healthcare and Hospitals Association - Kylie Woolcock
- Australian Institute of Health and Welfare – Anna O’Mahony
- Australian National University – Julie Smith
- Childbirth and Parenting Educators of Australia – Dianne Haworth
- Lactation Consultants of Australia and New Zealand – Heather Gale
- Maternal, Child and Family Health Nurses Australia – Christine Burrows
- NSW Health – Elisabeth Murphy and Joan Stort
- Public Health Association of Australia - Lisa Amir
- Small World Social – Kathy Phelan
- Tasmania Department of Health and Human Services – Ali Graham
- Commonwealth Department of Health – Alan Philp, Maria Luteria, Jenny Booth (facilitator) and Rosie Tira (facilitator)

### **Item 1 - Introductions**

### **Item 2 - Reflections on the previous Strategy**

Participants shared their reflections on what had worked well and what could be improved on in relation to monitoring and evaluation (M&E) and use of M&E information under the previous Strategy. There was general consensus that monitoring, evaluation and use of data was limited under the previous Strategy, and most of the discussion was focused on what should be improved in developing a new M&E Framework.

There is a need to:

- Ensure national and local leadership and coordination of monitoring and evaluation
- Assign accountability to governance structures for reporting against Strategy – e.g. which Committee or other parties are responsible for considering reports?
- Improve information exchange between the States and with the Commonwealth and with other stakeholders
- Set targets (to be collectively striving for)
- Ensure routine data collection is nationally coordinated and regionally controlled
- Focus on aligning overlapping strategies including M&E (e.g. National Strategic Approach to Maternity Services, National Strategic Framework for Chronic Conditions, National Aboriginal and Torres Strait Islander Health Plan)
- Ensure funding for M&E is embedded in initiatives
- Ensure reporting is routine, consistent and fit-for-purpose
- Embed an action learning cycle to enable continuous improvement and confirm direction for an enduring Strategy

### **Item 3 - Features of the overall M&E Approach**

#### **Purpose of monitoring and evaluation was confirmed as:**

- Accountability for Strategy implementation
- Program/Service improvement including engaging with implementers
- Breastfeeding promotion and awareness raising including at community and political levels
- Understanding cost and quality (effectiveness) to ensure a focus on the most effective interventions to make the best use of resources

#### **Cascading Approach to monitoring and evaluation**

- Confirming that the cascade was not uni-directional and it went up and down and across, and was not necessarily coordinated.
- The need for state-level strategies was challenged if there was joint AHMAC sign-off on a national strategy (this wasn't reflecting an intention, but simply that historically states did develop strategies – ideally aligned to the National strategy)
- Assume access to data is a problem – if focusing on individual level data then it must be able to be aggregated. If it cannot be aggregated then a sampling approach may be better.

#### **Use of Program Logic**

- Noted need to change Initiative as “what gets done” to proposals/ areas of work/priorities – given it is not necessarily what is done.
- Noted the reality is a non-linear logic with lots of feedback loops – how can this be better captured?
- Acknowledged the need to monitor and evaluate in non-health (community etc.) as well as health settings.
- Measurable objectives for every outcome
  - Recommend, evaluate, report and publish to ensure transparency
- Define short term, mid-term and long term

#### **Other points**

- Include targets for increased accountability
- Need a standardised (minimum) data set
  - Defining what's being monitored
  - Define how the data points are being monitored
- Coordination of implementation by Commonwealth and AHMAC
- Stocktake of existing data collections – health and non-health – (was this done last time?)
- Can we be also learning from elsewhere

## Item 4 - Evaluation Questions

- There are perhaps different questions for monitoring versus evaluation and at strategy versus initiative levels.

**Table 1: Examples of evaluation questions**

Theme	Question	Strategy (S) or Initiative (I) level
Effectiveness	Are breastfeeding practices improving (including for specific populations)?	S/I
	To what extent are mothers and their supporters satisfied with the support/ programs/ information/ outcomes they get (initiatives)?	I
	To what extent has the education of health professionals involved in the breastfeeding continuum improved?	S/I
	To what extent does public attitudes/sentiment reflect and support positive breastfeeding practices?	S/I
Efficiency	What is the level of governments' investment and expenditure in breastfeeding initiatives and research?	S
	What is the level of overall resources and inputs (including time) committed to breastfeeding initiatives?	S/I
Cost effectiveness	What is the cost and quality/outcomes of the different initiatives (cost-effectiveness) under the Strategy?	S
Quality	What is the quality of breastfeeding data? <ul style="list-style-type: none"> <li>• Linked up, continuous</li> <li>• Descriptive enough</li> <li>• Consistently collected, aggregated and analysed</li> <li>• Used as intended</li> </ul>	S
	What is the progress of BFHI accreditation, implementation and funding?	S
Appropriateness	Do all mothers and their supporters have equitable access to breastfeeding support (including priority and vulnerable groups)?	
	Have initiatives been responsive to the needs of particular groups (cultural, location, vulnerable etc)?	I
	Do mothers and their supporters feel that the initiatives are relevant to their circumstances?	I



## **Item 5 - Measuring breastfeeding outcomes and monitoring changes in breastfeeding practice**

### **Possible sources to monitor key breastfeeding indicators:**

- Immunisation register - attach to immunisation encounters – 2 months, 4 months, 6 months, 12 months, 18 months, and 4 years
- Digital Child Health Record, General Practitioners, Councils
- National Health Survey + oversample infants and young children + ask relevant breastfeeding questions, specific (words including economy)
- Fund national Infant and Young Child Feeding surveys
- Support/ advocate for harmonised national child health record led by New South Wales Health – will enable electronic linkage – family, clinician, Australian Institute of Health and Welfare
- Support for electronic antenatal health record – being developed by Queensland Health
- Birth hospital data (first 7-10 days) – initiation, period of care, discharge through routine collection
- Practice nurses – national database

### **Other points**

- Introduce targets at national level
- Baseline – can current data be used as a benchmark i.e. exclusive for 6 months, initiation but also on other measures
- Need to clarify indicator definitions used by states/territories to assess for comparability and ability to aggregate nationally.
- Consider measuring formula use - How many non-breastfed meals - Euromonitor data base – “dietitian and a calculator”. Cost is an important indicator
  - Ratio total money spent on baby formula per baby per year.

### **Evaluating breastfeeding practice**

- Analyse the gap between aspiration and practice and reasons why
- Explore decisions on breastfeeding
  - Eg. consider how factors such as milk supply and medication influence the decisions of mothers to BF.
  - How “informed” are decisions?
- Can we link breastfeeding with improvement in disease status
- Can we make use of the Australian Longitudinal Study of Women’s Health?

## Item 6 & 7 Measuring Strategy outcomes and initiatives

Potential focus area and measures identified using the Program Logic

### 1. Individual

- Mothers' knowledge of breastfeeding and normal (what to expect) breastfeeding behaviour and experience
- Community knowledge of breastfeeding and normal (what to expect) breastfeeding behaviour
- Hospital to community transition – continuum of services
  - Consider BFHI hospital and community services indicators
- Mothers' experience of support services including:
  - Hospital to community transition – continuum of support
  - Reporting of conflicting advice
- Focus on special cohorts:
  - Aboriginal and Torres Strait Islander mothers - measure total numbers with breastfeeding outcomes (refer to the Australian Nurse-Family Partnership Program)
  - Preterm infants - breastfeeding indicators can be measured (through the Neo-BFHI criteria)
  - Women who are required to be in hospital due to mental health issues – potentially increased mother-baby units and/or supports
  - Other potential factors of disadvantage e.g. rural/remote, access and equity, partners

### 2. Settings

- Increased midwifery caseload
- Tailored Action Plans for each settings made publicly available
  - Regular reporting to demonstrate maintenance of activity
- BFHI Ten Steps embedded in national accreditation (such as the Australian Council on Healthcare Standards)
- Measurement of continuity of care - measurement across the continuum of ante-natal to post-natal
- WHO compliance criteria – hospital purchase of formula at retail price
- WHO 2017 guidance suggests potential “incentives” may be linked to BFHI through performance contracts, financial incentives or awards.
- Initiation and maintenance of initiatives over time
  - Individual action (and Monitoring and Evaluation Plans) plans for each initiative

### 3. Structural

- Significant national health promotion campaign (funded by government)
  - Linking to current social movements such as #metoo
- Link to education programs already being rolled out such as Respectful Relationships
- Midwife Breastfeeding education is part of pre-service education and Continuing Professional Development
- Review other available indicator sets such as UNICEF, WBTI, WHO etc.