



australian  
breastfeeding  
association

# Australian Breastfeeding Leadership Plan

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*August 2004*





## **Australian Breastfeeding Leadership Plan**

Prepared by the Australian Breastfeeding Association (formerly Nursing Mothers' Association of Australia) to encourage debate and action focused on improving breastfeeding initiation and duration of breastfeeding in Australia.

Australian Breastfeeding Association  
*Australia's leading source of breastfeeding information and support*  
PO Box 4000  
Glen Iris VIC 3146  
Ph. 03 9885 0855  
Fax: 03 9885 0866  
[www.breastfeeding.asn.au](http://www.breastfeeding.asn.au)

## Foreword

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For many it comes as a constant surprise that there is a need for an Australian Breastfeeding Leadership Strategy.

The benefits of breastfeeding exclusively for at least six months are so apparent and the risks of not breastfeeding so great, facts substantiated time and again by rigorous scientific study, that we should not need to develop statistics and implement tactics to promote the value of mothers' milk.

However, as our document states, "It seems that efforts to promote breastfeeding by health authorities and others have achieved little more than to stem the decline rising from commercial and labour market pressures in the last decade."

No-one can deny the advances in public health wrought by industrialisation but at the same time, as the poet Wordsworth wrote, "We lay waste our powers: Little we see in Nature that is ours". The attributable costs of hospitalisation alone of prematurely weaning babies is up to \$120 million annually for just five common childhood illnesses.

The twin economic pressures of commercialisation by the *Hidden Persuaders*, with their increasingly sophisticated marketing of breastmilk substitutes, and the lack of support given mothers returning to paid work, are formidable. They mean that volunteer groups such as Australian Breastfeeding Association have a vital role in reminding Governments and health professionals of the costs of failing to counter commercial propaganda against breastfeeding, and the costs of failing to provide the support structures required to enable women to continue breastfeeding after returning to the workplace.

Our new Leadership Plan is a successor to our first Five Year Plan launched in 1998. It proposes action in four strategic areas across Government, business and family life and comes at a pivotal time for the national health agenda. As a nation we are confronted with obesity and the health burden of ageing. In both, breastfeeding plays key preventative roles.

The first recommendation is for the appointment of a National Breastfeeding Advocate who would report annually to the Australian Parliament on the progress towards re-establishing as national practice the healthiest start we can give our citizens, breastfeeding.

But every element in the strategy counts. This is a strategy that must not gather dust. It is in the nation's interest that it is taken up and acted on.



Wendy Burge  
President  
Australian Breastfeeding Association  
August 2004



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## Introduction

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**‘Breastfeeding is the normal and most appropriate method for feeding infants and is closely related to immediate and long-term health outcomes’<sup>1</sup>**

The Australian Breastfeeding Leadership Strategy has been prepared by the Australian Breastfeeding Association (ABA) to encourage debate and action aimed at increasing the number of babies in Australia that are breastfed exclusively for six months, with ongoing breastfeeding until 12 months of age and beyond combined with family foods.

Breastfeeding is an important preventative health behaviour with implications for both infant and maternal health, and for national health costs. The health benefits of breastfeeding are well documented and continue to accumulate. The past decade has also seen increasing evidence of the important role of breastfeeding in assisting mother-child bonding<sup>2</sup> and prevention of chronic disease,<sup>3</sup> including breast cancer and cardiovascular disease.<sup>4</sup> The risks of **not** breastfeeding include: reduced development of a baby’s eyesight, intelligence/cognitive development and speech, and increased risk of gastro-intestinal, respiratory tract and middle ear infection. Not breastfeeding may increase the risk of SIDS and asthma, increase the development of allergies, and, in later life, increase the risk of obesity<sup>5</sup>, diabetes mellitus, inflammatory bowel disease and lymphomas. Premature weaning also increases the risk to women of pre-menopausal breast cancer, ovarian cancer and osteoporosis.<sup>6</sup>

Such research findings have major public health implications.

Population aging also makes supporting breastfeeding important both to help avoid unnecessary future health cost burdens and to build a healthy, productive workforce.

Awareness about the benefits of breastfeeding is relatively high. However, there is still a general view in the community that formula feeding is ‘almost as good’ and that breastfeeding is a lifestyle choice rather than a modifiable health behaviour. This perception is not scientifically supportable and is a myth that needs to be addressed.

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<sup>1</sup> Binns, C (2003), *Encourage and support breastfeeding*, Food for health – dietary guidelines for children and adolescents in Australia, Commonwealth Department of Health and Ageing, NHMRC

<sup>2</sup> R. Lawrence, *Breastfeeding: a guide for the medical profession*, Fifth ed, Mosby, St Louis, 1999.

<sup>3</sup> Joint WHO/FAO Expert Consultation 2003. Diet, nutrition and the prevention of chronic diseases: Report of a Joint WHO/FAO Expert Consultation, WHO, Geneva.

<sup>4</sup> Collaborative Group on Hormonal Factors in Breast Cancer 2002, ‘Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50,302 women with breast cancer and 96,973 women without the disease’, *Lancet*, vol. 360, no. 9328, pp. 187-95; Singhal, A., Cole, T.J., M., F., and Lucas, A. 2004, ‘Breastmilk feeding and lipoprotein profile in adolescents born preterm: follow up of a prospective randomised study’, *Lancet*, vol. 363, no. May 15, pp. 1571-78.

<sup>5</sup> Healthy weight 2008 - Australia’s future: Report of Obesity Task Force, Canberra, 2003.

<sup>6</sup> American Academy of Pediatrics 1997, ‘Breastfeeding Policy of American Academy of Pediatrics’, *Pediatrics*, vol. 100, no. 5, Dec, pp. 1035-39.

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Parents and health workers need to be informed of the adverse health impacts and risks of **not** breastfeeding, and community opinions and institutional frameworks reworked to support exclusive and ongoing breastfeeding by mothers.

Although breastfeeding is a natural act, it is also a learned skill. Mothers need access to practical, accurate and relevant information on breastfeeding along with skilled and knowledgeable support from their families, community and the health system. For example, with fathers known to play a crucial role in supporting breastfeeding,<sup>7</sup> ensuring influential family members have access to relevant breastfeeding information will contribute to stronger family relationships and parental bonding as well as encourage informed infant feeding choices.

Governments in other countries are increasingly recognising the public health significance of nutrition in infancy and establishing new policy and institutional frameworks to protect, promote and support breastfeeding. With most Australian mothers and babies at least initiating breastfeeding, Australia is in a position to achieve public health leadership through innovative, multi-sectoral initiatives drawing on the strengths of community based organisations as well as government agencies and health professionals.

The Australian Breastfeeding Leadership Plan contains strategies and actions that will result in breastfeeding rates and duration in Australia moving closer to the six months exclusive breastfeeding recommended by the World Health Organisation<sup>8</sup> and the National Health and Medical Research Council,<sup>9</sup> with ongoing breastfeeding to 12 months and beyond for as long as mother and child desire. Implementation of the Plan will require a multi sector partnership approach, Governments and the community working together.

This Plan proposes actions in four strategic areas:

- Establish policies, legislation and institutions protective and supportive of breastfeeding.
- Develop a Breastfeeding Friendly Healthcare System - hospitals, health professionals, pharmacies.
- Promote Breastfeeding Friendly Workplaces and Childcare Services.
- Strengthen Breastfeeding Friendly Families and Communities.

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<sup>7</sup> Scott, J., Binns, C., and Aroni, R. 1997. Infant feeding practices in Perth and Melbourne; factors associated with duration of breastfeeding and women's breastfeeding experiences, National Better Health Program, National Health and Medical Research Council, Curtin University of Technology, Perth; La Trobe University, Melbourne, January,

<sup>8</sup> World Health Assembly (Fifty Fourth) 2001, Infant and Young Child Nutrition: Resolution 54.2, Geneva, 13 May.

<sup>9</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003, p. 305.



## Breastfeeding in Australia

In 2003, the Australian National Health and Medical Research Council (NHMRC) revised its Dietary Guidelines for Infant Feeding to reflect the evidence-based World Health Organisation (WHO) recommendation that babies be exclusively breastfed for around the first six months of life, and with continued breastfeeding to the age of two or beyond with appropriate complementary foods.<sup>10</sup>

Most Australian mothers and babies breastfeed initially but the latest National Health Survey for 2001 shows worrying trends. Exclusive breastfeeding rates across Australia are far from the recommended guidelines, with an increasing proportion of infants being fed solids or formula prior to six months. On discharge from hospital, 83 percent of babies were breastfed. However, of all infants 3 months or less in age only 54 per cent were fully breastfed and only 32 per cent of all infants aged 6 months or less were fully breastfed. The survey recorded no infants being fully breastfed at age six months of age in either 1995 or 2001.<sup>11</sup>

The attributable costs of hospitalisation alone of weaning babies prematurely is around \$60-\$120 million annually in Australia for just five common childhood illnesses.<sup>12</sup>

The World Health Organisation *Code on the Marketing of Breast Milk Substitutes* (WHO Code)<sup>13</sup> aims to ensure practices of Governments, health workers and the private sector protect and promote breastfeeding. The primary vehicle established for the implementation of the WHO Code in Australia is the *Marketing in Australia of Infant Formula* (MAIF). The MAIF agreement is voluntary, and narrow in scope and membership.<sup>14</sup> It does not apply to retailing, or to the marketing of other products within the scope of the WHO Code such as baby food, baby juices, and bottles and teats. The Knowles independent review warned in 2001 that APMAIF was 'dysfunctional' and, with 'widespread concern and frustration with the operation of the agreement ... the current arrangements for the marketing of infant formula are in very real danger of unravelling'.<sup>15</sup> Knowles concluded that 'if there is not a commitment by Industry to cooperatively work with Government on issues that are outside the current MAIF Agreement, then it is recommended that serious consideration be given to legislative reform to achieve the required public health outcomes, and to ensure Australia's commitment and integrity to the WHO Code remains strong'.<sup>16</sup> There is minimal demonstrable evidence that industry will seriously address issues outside the current MAIF agreement.

<sup>10</sup> World Health Assembly (Fifty Fourth) 2001, Infant and Young Child Nutrition: Resolution 54.2.

<sup>11</sup> Australian Bureau of Statistics report on Breastfeeding in Australia, 17 September 2003;

<sup>12</sup> Smith JP, Thompson JF, Elwood DA. Hospital system costs of artificial infant feeding: Estimates for the Australian Capital Territory. *Australian and New Zealand Journal of Public Health* 2002; 26:543-551.

<sup>13</sup> WHO, *International Code of Marketing of Breastmilk Substitutes*, Geneva, World Health Organization, 1981, and subsequent Resolutions of the World Health Assembly.

<sup>14</sup> As at 30 June 2001, six manufacturers and distributors of infant formula were signatories to the MAIF Agreement.

<sup>15</sup> Knowles, R. 2001, *Independent Advice on the Composition and Modus Operandi of APMAIF and the Scope of the MAIF Agreement*, Department of Health and Aging, Commonwealth of Australia, Canberra, p. 2.

<sup>16</sup> *Ibid*, p.16.

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Further, there is growing evidence that manufacturers are utilising marketing strategies including gifts for health professionals, free samples and supplies to health professionals, hospitals, and childcare centres, and direct marketing to mothers, which do not comply with the MAIF and which breach the spirit and letter of the WHO Code.

Increased labour force participation by mothers of infants also presents new challenges to protecting breastfeeding. Based on the 2001 National Health Survey, one in ten mothers weaned their baby before six months in order to return to work.<sup>17</sup> In Australia in 1996, 25 per cent of mothers with a child less than 12 months of age were in the paid labour force.<sup>18</sup> This means some 50,000 mothers may reduce or stop breastfeeding because of pressures of employment. Recently quoted figures suggest that some 70 percent of mothers are now employed in the paid workforce and one third of these women return to work before their child is six months old, some after only a few weeks.<sup>19</sup> Only 23 per cent of Australian workplaces offer paid maternity leave to working mothers, and the average period of leave is 8 weeks.

It seems that efforts to promote breastfeeding by health authorities and others have achieved little more than stem the decline rising from commercial and labour market pressures in the last decade.

For Australia to improve breastfeeding rates in line with the NHMRC recommendations, a new approach is required, backed up by active measures to protect, promote and support breastfeeding. Breastfeeding should be seen as the normal and expected way to feed not only newborn babies, but babies up to the age of 12 months and beyond following introduction of family foods after six months of age.<sup>20</sup>

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<sup>17</sup>Australian Bureau of Statistics, *Breastfeeding in Australia*, 17 September 2003

<sup>18</sup>Organisation for Economic Cooperation and Development 2002, *Babies and bosses: Reconciling work and family life*, Australia, Denmark and the Netherlands, OECD, Paris.

<sup>19</sup>Figures quoted by the Sex Discrimination Commissioner, Ms Pru Goward, in an interview with Mr Philip Lasker on the Business Report, Radio National, August 2003

<sup>20</sup>National Health and Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*, Canberra, National Health and Medical Research Council, 2003, p. 305.

## Governments and the community working together to achieve improved breastfeeding outcomes

The Australian Breastfeeding Leadership Plan contains strategies and actions that will result in breastfeeding rates and duration in Australia moving closer to the six months exclusive breastfeeding recommended by the World Health Organisation<sup>21</sup> and the National Health and Medical Research Council,<sup>22</sup> with ongoing breastfeeding for as long as mother and child desire.

The strategies and actions are based on the premise that breastfeeding is the normal and expected way to feed a baby. They are evidence based and in line with the *Ottawa Charter Framework for Health Promotion*, *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*, the *International Code of Marketing of Breast-milk Substitute* and *Global Strategy for Infant and Young Child Feeding*. The proposed strategies and actions also accord closely with the principles and approach of the Obesity Task Force which focus on encouraging healthy behaviours through promoting supportive environments in schools, family and community care, primary care, workplace and childcare settings.

Implementation of this Plan will require a multi-stakeholder approach. Governments (Commonwealth and States/Territories) must take the lead in ensuring structural barriers to breastfeeding are removed and protective legislative environments are created. Governments must also implement measures to ensure breastfeeding friendly policies are implemented throughout the health system, workplaces and childcare system, and this requires support and commitment to breastfeeding by health professionals and their organisations.

Businesses, employers and employees, whether they are based in the public or private sector, need to be made aware of the direct economic benefits of supporting women to continue to breastfeed if they return to the paid workforce with a young baby. This should include the types of institutional and low cost practical support required. The creation of institutional healthy settings will complement community based activities, education and support mechanisms.

It is widely acknowledged that community-based breastfeeding support networks have an important role to play and need be recognised, supported and encouraged as an effective partner in planning and providing services.<sup>23</sup> Community organisations like the Australian Breastfeeding Association are well placed to identify areas of need, to provide grass roots peer support and mentoring programs, and to develop and advocate innovative and evidence-based breastfeeding support and promotion strategies.

This Australian Breastfeeding Leadership Plan is divided into four strategy areas. Each strategy will be achieved with the implementation of actions that are described in broad terms.

<sup>21</sup> World Health Assembly (Fifty Fourth) 2001, Infant and Young Child Nutrition: Resolution 54.2, Geneva, 13 May.

<sup>22</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003.

<sup>23</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003; WHO, Infant and young child nutrition Global strategy on infant and young child feeding, Geneva, World Health Organization, 2002.

## Strategy 1 Establish policies, legislation and institutions protective and supportive of breastfeeding

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Breastfeeding decisions are made in a socio-cultural and institutional context which is shaped by public policies and institutional arrangements as well as by markets.

In recent decades governments have acted in a number of ways to promote and encourage breastfeeding. This has included:

- legislative change, such as to protect breastfeeding mothers against discrimination as consumers or in the workforce.
- funding support, for example, for breastfeeding promotion and community support.
- some measures restraining commercial marketing of breastmilk substitutes that promote early weaning from breastfeeding.

Despite this heightened recognition of the public health importance of protecting breastfeeding, little progress has been made in increasing breastfeeding over the last decade. Factors behind this stagnation appear to be institutional and attitudinal barriers to combining breastfeeding and paid work, and the increasingly sophisticated marketing of breastmilk substitutes.

There remains a pressing need to tackle such structural and institutional barriers in a systematic and comprehensive way comparable with for example, the highly successful vaccination programs or anti-smoking campaigns of the past two decades.

Appropriate policy frameworks and institutional reforms are needed to ensure the effectiveness of funding initiatives for breastfeeding. Such frameworks will give greater policy priority to breastfeeding, and provide a context for clearer incentives to work for better breastfeeding outcomes at the institutional and agency level.

The effective breakdown of the MAIF agreement and more sophisticated marketing of commercial breastmilk substitutes suggests an urgent need to strengthen and update the implementation of the WHO Code in Australia in order to protect current breastfeeding rates. Underpinning the need for more effective action on the marketing and promotion of breastmilk substitutes is agreement that infant feeding raises unique issues that make usual commercial marketing and promotion arrangements inappropriate.<sup>24</sup> The NHMRC Guidelines noted strong evidence that feeding choices were influenced by commercial marketing practices.<sup>25</sup> The increasing participation of mothers of young babies in the paid labour force also requires far reaching and effective labour force and other measures to ensure the health and well being of Australian mothers and babies is not compromised by pressures to wean prematurely.

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<sup>24</sup> WHO, International Code of Marketing of Breastmilk Substitutes, Geneva, World Health Organization, 1981, Preamble, p. 12.

<sup>25</sup> National Health and Medical Research Council, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, Canberra, National Health and Medical Research Council, 2003, p. 13-15

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### **Action 1 Appoint a Breastfeeding Advocate**

- A. To illustrate and give effect to a government priority for breastfeeding, appoint a National Breastfeeding Advocate as recommended in the *Innocenti Declaration*. The National Breastfeeding Advocate is to take responsibility for breastfeeding rates in Australia, ensure a coordinated approach by government, and to report to the Australian Parliament annually on progress towards the national breastfeeding targets. The National Breastfeeding Advocate would work in an inclusive way with State based Breastfeeding Advocates and the many relevant sectors, to lead, inspire and educate.

### **Action 2 Breastfeeding targets and benchmarking**

- A. Ensure ongoing Australian Government budget commitments of adequate resources to fund necessary parental education on the risks of not breastfeeding and community support for breastfeeding.
- B. Announce a near term breastfeeding target, for 2008, of 50% exclusive breastfeeding for the first six months, and a medium term target of 80% by 2012.
- C. Establish breastfeeding benchmarks for each State/Territory.
- D. Phased introduction of measuring breastfeeding rates at six months as a performance indicator for health care services.

### **Action 3 Implementation of the World Health Organisation Code for the Marketing of Breastmilk Substitutes**

- A. Introduce enforceable regulation to replace the current ineffective self regulatory system. The WHO Code could be implemented via legislative amendments to the Trade Practices Act or the States' Fair Trading legislation. As first priority, the legislative provisions would ensure the marketing of infant formula in Australia is in line with the WHO Code. Following this, the provisions would address other items within the scope of the WHO Code including bottles and teats, solid food and drinks and follow on and toddler formulas and apply to retailers as well as manufacturers and importers.
- B. Immediately amend Food Standards Australia New Zealand food labelling standards to implement the NHMRC 6 months recommendation for exclusive breastfeeding.
- C. All Commonwealth funded health care providers such as maternity hospitals or maternal and child health centres and childcare services should be required to demonstrate compliance with the WHO Code.
- D. Ensure no government employees receive conference funding or support contrary to the WHO Code.
- E. Educate health workers on the WHO Code and on the conflict of interest for health workers receiving gifts from baby food companies and require them to fully disclose such gifts to clients.

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#### **Action 4 Raise health policy priority of breastfeeding**

- A. Specifically incorporate breastfeeding measures into plans addressing Health Priority Target Areas of cardiovascular disease, cancer control, diabetes mellitus, asthma and obesity.
- B. Include breastfeeding in national food production statistics and measures of Gross Domestic Product<sup>26</sup>.

#### **Action 5 Remove financial disincentives to breastfeeding**

- A. Secure States/Territory Government agreement to remove the goods and services tax (GST) on breastpumps and other lactation aids.
- B. Remove GST free status from 'follow on' and 'toddler' formulas and manufactured baby foods and juices.
- C. Hypothecate revenues gained from removing GST-free status from these items to new breastfeeding support programs targeting low income and disadvantaged mothers.

#### **Action 6 Maternity Leave**

- A. Funding for maternity leave should be available for all new mothers (not just in workforce), concentrated on the months when breastfeeding is being established. Those women most at risk of being forced back to work financially and not breastfeeding, that is, disadvantaged and lower socio economic status women, should be especially targeted.

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<sup>26</sup> Smith, J.P., and Ingham, L.H. 2001, 'Breastfeeding and the measurement of economic progress', *Journal of Australian Political Economy*, vol. 47, no. June, pp. 51-72.

## Strategy 2 Develop a Breastfeeding Friendly Healthcare System - hospitals, health professionals, pharmacies

In recent years there has been a mass of new scientific evidence revealing the protective role of breastfeeding in women's and children's health and the health risks of premature weaning. There is also considerable research identifying evidence-based health care and breastfeeding management practices for protecting, supporting and promoting breastfeeding, including by ensuring mothers have access to breastfeeding support groups.

There are roles and responsibilities for the Australian and State/Territory Governments to ensure that Australia's healthcare system is breastfeeding friendly.

Although breastfeeding is known to play a role in the prevention of National Health Priorities such as certain cancers, high blood pressure and cardiovascular disease, obesity, diabetes, and asthma, there is a need to increase awareness of this among health policymakers and health professionals. The pervasive long term health effects of premature weaning are not fully acknowledged and addressed in individual preventative strategies and/or action plans on National Health Priorities. Similarly, the role of breastfeeding in facilitating appropriate intellectual and emotional development remains to be fully reflected in early childhood health and development strategies and action plans.

The health care system provides structural and institutional incentives which play a critical role in determining whether or not mothers have consistent, accurate and evidence based health care and advice on breastfeeding. Systematic, up to date, evidence based training and education for health care providers and health professionals is needed to ensure mothers benefit from best practice in breastfeeding support and management advice across the healthcare system. Some surveys including some in Australia, suggest the need to improve education and training for health professionals in breastfeeding management.<sup>27</sup>

There is also strong evidence about the importance of maternity services referring mothers to breastfeeding support groups in the community.<sup>28</sup> It is essential for the health system to link new mothers with breastfeeding support groups to ensure timely and adequate breastfeeding support in their community after discharge from hospital, as well as to ensure health system based mothers' groups complement and foster rather than compete with community based breastfeeding support groups such as ABA.

Actions to support breastfeeding need to be well coordinated and based on agreed objectives, strategies and responsibilities between the Australian and the States/Territory Governments. For example, funding of maternity and child health services extends across both State and Commonwealth areas of responsibility.

In view of the particular importance of human milk feeding for the long term health and development of infants, especially premature or otherwise vulnerable babies, it is increasingly unacceptable for babies whose mothers cannot for whatever reason give them breastmilk to be given artificial infant formulas as a matter of course. Where a mother cannot breastfeed, the next best alternative should still be seen as human milk feeding.<sup>29</sup>

<sup>27</sup> Anderson, J., and Day, J. 2002. *Giving breastfeeding a boost: A community based approach to improving breastfeeding rates*, Centre for Clinical Effectiveness, Monash Institute of Health Services Research and the Australian Breastfeeding Association, Melbourne; Downie, J., and Juliff, D. 1999. 'The nature of breastfeeding: implications for nursing practice', *Neonatal, Paediatric and Child Health*, vol. 3, no. 1, pp. 3-9.

<sup>28</sup> WHO. Division of Child Health and Development, *Evidence for the Ten Steps to Successful Breastfeeding*, Vol. WHO/CHD/98.9, World Health Organisation, Geneva, 1998.

<sup>29</sup> The WHO comments that: 'for those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – expressed breastmilk from an infant's own mother, breastmilk from a health wet-nurse or a human-milk bank, or a breastmilk substitute fed with a cup, which is a safer method than a feeding bottle and teat – depends on individual circumstances' (WHO, *Infant and young child nutrition Global strategy on infant and young child feeding*, Geneva, World Health Organization, 2002, [www.who.int/gb/EB\\_WHA/PDF/WHA55/ea5515.pdf](http://www.who.int/gb/EB_WHA/PDF/WHA55/ea5515.pdf), p. 7).



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Economic studies in the United States and Australia demonstrate the very substantial health system costs of not providing breastmilk and the clear cost savings in ensuring vulnerable babies receive breastmilk feedings.<sup>30</sup> Supported by appropriate guidelines, milk banks operate successfully in Europe and North America, and contribute to the near universal breastfeeding rates among babies at 3 months of in Norway. Encouraging establishment of human-milk banking networks in Australia would show government and health system commitment to breastmilk feeding as the norm for **all** infants, and ensure vulnerable infants are not further disadvantaged by lack of access to breastmilk.

#### **Action 1 Support and extend Baby Friendly Hospital Initiative**

- A. Provide Australian Government funding and support for the WHO/UNICEF Breastfeeding Friendly Hospital Initiative (BFHI) in Australia.
- B. Set a target of 50% of all maternity hospitals in Australia being BFHI accredited by 2008.
- C. Move towards linking public funding of maternity hospitals to achievement of BFHI standards by 2014.
- D. Develop processes and protocols to ensure all maternal and child health facilities refer mothers to community based breastfeeding support.
- E. Foster active participation by community based groups in the provision of health services, including avoiding duplication or displacement by government.

#### **Action 2 Enhance health professionals breastfeeding knowledge and breastfeeding management skills**

- A. Extend BFHI training principles to all relevant health professionals on public payroll including nutritionists and dieticians as well as doctors, midwives, nurses, maternal and child health nurses and hospital staff.
- B. Support the development and introduction of professional development courses providing consistent and accurate education for all health professionals dealing with mothers in the area of lactation. This should include practical and evidence-based ways in which to support mothers to exclusively breastfeed, the ongoing benefits of breastfeeding and the risks of premature weaning.
- C. Raise priority of breastfeeding in health policy priorities including by campaigns to raise health professional and public awareness of links between lack of breastfeeding and conditions which are Health Priority Target Areas, such as cardiovascular disease, cancer control, diabetes mellitus, asthma and obesity.

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<sup>30</sup> Weimer, J. 2001, *The economic benefits of breastfeeding: a review and analysis*, United States Department of Agriculture, Washington DC., and Smith, J.P., Thompson, J.F., and Ellwood, D.A. 2002, 'Hospital system costs of artificial infant feeding: Estimates for the Australian Capital Territory', *Australian and New Zealand Journal of Public Health*, vol. 26, no. 6, pp. 543-51.



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- D. Ensure wide access to professional development and information on breastfeeding for health professionals to ensure they are fully aware of current breastfeeding recommendations, health implications and appropriate breastfeeding management practices.
  - E. Encourage programs for education and training of pharmacists and their staff to achieve Breastfeeding Friendly Pharmacies.

**Action 3 Recognise and value acquisition of breastfeeding knowledge skills and qualifications**

- A. Ensure appropriately qualified lactation consultants (recognised by the International Board of Lactation Consultant Examiners (IBCLC)) working within the public health system can advertise their expertise to differentiate them from staff who do not have specific qualifications in breastfeeding support and management.
- B. Provide pay incentive for IBCLC qualification of staff working in maternal and child health.
- C. Set minimum lactation qualifications for all agency staff employed in maternal and child health.
- D. Encourage professional bodies to develop appropriate mechanisms to ensure breastfeeding is a priority area for ongoing education or accreditation.

**Action 4 Develop a human milk bank network in Australia**

- A. Support the development of evidence based human milk banking guidelines.
- B. Establish a pilot human milk bank in an appropriate maternity facility to look at a possible rollout of milk banks to all major maternity facilities across the nation.

## Strategy 3 Promote Breastfeeding Friendly Workplaces and Childcare Services

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In Australia in 1996, 25 per cent of mothers with a child less than 12 months of age were in the paid labour force.<sup>31</sup> This means some 50,000 mothers could be juggling paid work and breastfeeding. If NHRMC targets for exclusive breastfeeding to 6 months are to be met with ongoing breastfeeding for 12 months and beyond, ways must be found to assist mothers to sustain breastfeeding after return to the labour force or study.

Financial and other pressures are increasingly impacting on the amount of time women remain at home with their babies. Studies have confirmed the impact the workplace can have on healthy (or unhealthy) behaviour. Many workplaces (and education institutions) can easily become breastfeeding friendly and those that have made this move in terms of policies, flexible arrangements and suitable facilities for breastfeeding employees, can reap direct financial benefits as well as contribute to the community benefits from encouraging health promoting behaviour.

A consistent and co-ordinated program of initiatives in this area will provide practical information of how to combine paid work or study with ongoing breastfeeding. It will also increase community awareness of the health and other disadvantages to mother and child of early weaning arising from paid work or study.

The following strategies aim to build on the work done by ABA and the National Breastfeeding Strategy in the area of breastfeeding and paid work.<sup>32</sup>

### Action 1 Information for employees

- A. Ensure wide distribution and promotion of information on the possibilities for combining paid work and breastfeeding, the health and other advantages for mothers, babies and families, negotiating with employers, legal protections for breastfeeding employees and practical suggestions for combining breastfeeding and work.

### Action 2 Information for employers

- A. Ensure wide distribution of previously developed material and promotion of the financial costs to employers of not providing support for women to continue to breastfeed after returning to work,<sup>33</sup> types of breastfeeding friendly policies required and practical, cost effective support in the workplace.
- B. Promote and support the ABA Breastfeeding Friendly Workplace accreditation scheme across employment sectors.
- C. Encourage integration of breastfeeding into 'work and family' policies and programs and employment conditions.
- D. Develop appropriate campaigns targeting small business employers, and low wage, casual female-dominated industries, such as hospitality, retail and manufacturing.

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<sup>31</sup> Organisation for Economic Cooperation and Development 2002, *Babies and bosses: Reconciling work and family life*, Australia, Denmark and the Netherlands, OECD, Paris.

<sup>32</sup> 2000. *Balancing Breastfeeding and Work Kit*, Commonwealth of Australia, Canberra,

<sup>33</sup> US studies show sixfold higher absenteeism due to infant illness among mothers not breastfeeding (see Cohen, R., Mrtek, M.B., and Mrtek, R.G. 1994, 'The impact of two corporate lactation programs on the incidence and duration of breastfeeding by employed mothers', *American Journal of Health Promotion*, vol. 8, no. 6, pp. 436-41; Cohen, R., Mrtek, M.B., and Mrtek, R.G. 1995, 'Comparison of maternal absenteeism and infant illness rates among breastfeeding and formula feeding women in two corporations', *American Journal of Health Promotion*, vol. 10, no. 2, pp. 148-53.

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### **Action 3 Incorporate breastfeeding friendly criteria into childcare accreditation**

- A. Encourage voluntary adoption of breastfeeding friendly childcare policies through development and promotion of a community based accreditation or award scheme.
- B. Implement breastfeeding friendly childcare through incorporation of criteria, developed in a voluntary scheme, into existing formal accreditation and licencing systems.

### **Action 4 World Health Organisation Code on the Marketing of Breastmilk Substitutes Implemented for Childcare Services**

- A. Progressively incorporate full compliance with the WHO Code as criteria in licencing and quality assurance processes for childcare services. The first step is preventing the promotion and marketing of breastmilk substitutes through childcare centres.

## Strategy 4 Strengthening Breastfeeding Friendly Communities and Families

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While there is much that governments can do to protect and promote breastfeeding at the policy or institutional level, the practical and well informed support of family, friends and community is critically important for a mother to successfully breastfeed. The active encouragement by her partner is especially important for sustaining breastfeeding in the Australian cultural context and is cited as a priority by the NHMRC.<sup>34</sup> Many mothers also depend on support and encouragement from the maternal grandmother to continue breastfeeding.<sup>35</sup>

Community-based peer support and breastfeeding education which is sensitive to local needs and empowers mothers to make healthy infant feeding choices is widely acknowledged as central to cost-effective health promotion. It is a key principle of the Ottawa Charter, the Jakarta Declaration and the evidence based Breastfeeding Friendly Hospital Initiative Ten Steps to Successful Breastfeeding.<sup>36</sup> The NHMRC Dietary Guidelines found strong evidence that antenatal and postnatal peer support programs, and education about the day-to-day practicalities of breastfeeding, are effective health promotion interventions.

Because the image of formula feeding and bottles is so predominant in the cultural portrayal of infant feeding in Australia, it is also important to counteract these infant feeding messages by integrating learning about breastfeeding into school curricula and mass media education campaigns.<sup>37</sup> New mothers' commitment to breastfeeding can also be assisted by campaigns which normalise breastfeeding including breastfeeding in public<sup>38</sup> and promote breastfeeding as comprehensive food security for infants.<sup>39</sup>

Traditional indigenous breastfeeding cultures are particularly vulnerable to rapid social and economic change, yet are potentially a source of new knowledge and insight on successful breastfeeding practices. Australia is in a position to play an important leadership role in our region by ensuring that public health and community development initiatives respect, reinforce and protect breastfeeding knowledge and skills among indigenous women.

### **Action 1 Adopt operational and funding policies to ensure viability and enhance the effectiveness of community based peer support for breastfeeding**

- A. Encourage maternity services to support and promote breastfeeding 'peer support' groups, such as ABA.

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<sup>34</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003, p. 317

<sup>35</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003, pp. 8-9

<sup>36</sup> WHO. Division of Child Health and Development 1998, Evidence for the Ten Steps to Successful Breastfeeding, World Health Organisation, Geneva.; WHO, Health and Welfare Canada, and Canadian Public Health Association 1986, Ottawa Charter for Health Promotion: Statement from the International Conference on Health Promotion, November 17-21, paper presented at the Ottawa.; WHO 1997, The Jakarta Declaration on health promotion in the 21st century, Jakarta.

<sup>37</sup> National Health and Medical Research Council 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, National Health and Medical Research Council, Canberra, 10 April 2003, p. 8.

<sup>38</sup> McIntyre, E., Hiller, J., and Turnbull, D. 2001, 'Community attitudes to infant feeding', *Breastfeed Rev*, vol. 9, no. 3, pp. 27-33.

<sup>39</sup> Australian Breastfeeding Association, Infant feeding in emergencies: Breast is still best, <http://www.breastfeeding.asn.au/media/index.html#210103>, accessed on 1 May 2004.

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- B. Develop and implement protocols and appropriate training for staff of all publicly funded parent Helplines and support services, maternal and child health clinics and hospitals and encourage health services to ensure mothers are linked to a local ABA group or mentor for all parents of children under 2 years.
  - C. Promote wide and ready access to telephone counselling services for breastfeeding related issues.
  - D. Ensure high quality breastfeeding education classes are widely available and promoted for expectant parents as an equal priority with birth education classes.
  - E. Ensure community based volunteer counsellors receive ongoing education and training opportunities to guarantee information and suggestions provided are in line with 'best practice'.
  - F. Strengthen links between the health system and community based ante-natal education on breastfeeding.

#### **Action 2 Encourage participation by indigenous, young, english as a second language and other disadvantaged groups**

- A. Resource indigenous health workers to develop and implement appropriate strategies to restore, maintain and enhance breastfeeding cultures within their communities.
- B. Encourage youth workers to expand existing strategies and activities to help young mothers breastfeed.
- C. Work with english as a second language organisations to ensure appropriate and culturally sensitive breastfeeding resources and policies are developed and implemented.
- D. Ensure AusAID includes community based breastfeeding support and resourcing in its maternal and child health projects, and follows appropriate protocols to support breastfeeding when providing relief for emergencies.

#### **Action 3 Educate future parents on breastfeeding**

- A. Ensure development and dissemination of resources for schools that support a strong curriculum message of breastfeeding as the normal way to feed a baby, and not breastfeeding as increasing the risks of health problems for mother and baby. Resources could include:
  - information on the benefits of breastfeeding for both mother and child
  - Information on the health and development risks of premature weaning from breastmilk

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**Action 4 Promote acceptability of breastfeeding in public**

- A. Fund integrated media and community based campaigns on the rights of mothers and babies to breastfeed in public places, and encourage the community to value and validate public breastfeeding.
- B. Support and expand initiatives that raise the profile of breastfeeding, such as the ABA's Breastfeeding Friendly Business campaign.

**Action 5 Improve amenities for breastfeeding mothers in public**

- A. Encourage building code guidelines to ensure babycare/parent care rooms provide positive messages about breastfeeding.
- B. Support and promote ABA Babycare Room Accreditation in public and private buildings.



