Australian Government

Department of Health, Disability and Ageing

Discussion Paper: Restricting Infant Formula Marketing in Australia

Executive Summary

This discussion paper seeks information to support the Australian Government's policy development and legislative processes for introducing mandatory controls for the marketing of infant formula, following the end of voluntary arrangements in February 2025. The feedback will help shape the design of these regulatory controls to strengthen protections for breastfeeding and provide clear, enforceable rules for the marketing of infant formula products.

Exclusive breastfeeding is recommended for around the first six months of a child's life. Infant formula is the only safe alternative to breastfeeding. Although most Australian families begin breastfeeding, exclusive breastfeeding rates drop sharply by six months, with lower rates among First Nations families.

Marketing of breastmilk substitutes has been shown to negatively influence breastfeeding practices. Internationally, the World Health Organisation (WHO) recommends[1] limits on such practices.

The former *Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement* served as a key component of Australia's response to the WHO Code, but faced criticism for its voluntary nature, limited scope and limited enforcement. Bringing toddler milks and retailer marketing into scope for new regulations would better align with the WHO Code, however this needs to be balanced against potential impacts on competition, innovation, and prices. Clearer controls on infant formula company interactions with health professionals may also be required.

The overarching objectives of the proposed regulations are to protect and promote breastfeeding, improve public health outcomes, reduce misleading marketing, and ensure families can make evidence-based feeding decisions.

The paper outlines three options:

1. Status Quo – No new regulations, relying on general consumer and food laws.
2. Legislation aligned with the former MAIF Agreement – Mandatory rules mirroring the former agreement, addressing previous enforcement weaknesses.
3. Expanded Legislation – Building on the MAIF Agreement scope to include toddler milk and/or retailer marketing, to more fully reflect WHO Code recommendations.

Implementation would likely involve amendments to the *Food Standards Australia New Zealand Act 1991,* supported by education, monitoring, complaint mechanisms, and civil penalties. Stakeholders are invited to provide input on evidence and data, legislation scope, implementation considerations and other relevant perspectives for consideration.

[1] WHO International Code of Marketing of Breast-Milk Substitutes (WHO Code)

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Introduction

Purpose

In October 2024 the Australian Government announced its intention to mandate the Marketing in Australia of Infant Formula: Manufacturers and Importers (MAIF) Agreement.

The MAIF agreement, established in 1992, was a voluntary agreement between infant formula manufacturers and importers to not advertise and market infant formula products (for use from 0 to 12 months) in order to support breastfeeding in Australia. The MAIF Agreement ended on 28 February 2025 after the Australian Competition and Consumer Commission's (ACCC) decided not to reauthorise it. Further information on the ACCC's decision and the MAIF Agreement is provided in the 'Background' section of this paper.

The Department of Health, Disability and Ageing (Department) is now seeking views on options to mandate infant formula marketing controls in Australia. This would be one part of a suite of measures taken by the Government to promote and support breastfeeding.

Evidence and perspectives gathered through this consultation will inform future regulatory arrangements, including the scope of any legislation on infant formula marketing. Stakeholder submissions will also help to assess the feasibility of the options and contribute to an impact analysis.

While the Government has committed to introducing regulations on infant formula marketing in line with the former MAIF Agreement, this consultation paper considers whether to broaden the scope of the controls to include toddler milk products[2] and/or marketing activity by retailers.

For the purposes of this paper, 'infant formula' refers to all breastmilk substitutes as products for use from 0 to 12 months. This includes infant formula (stage 1, for infants aged up to 6 months), follow-on formula (stage 2, for infants aged from 6-12 months) and formulas for special medical purposes. 'Toddler milk/s' refers to formula products for children aged from 1 to 3 years (including toddler milks and junior milks, marketed as stages 3 and 4). Where 'breastmilk substitutes' is used, it may capture both infant formula and toddler milk depending on the origin of the regulation or research.

The options presented for consideration are:

- Option 1: Status quo – no regulation;
- Option 2: Australian Government legislation aligned with the scope of the former MAIF Agreement; and
- Option 3: Australian Government legislation aligned with the scope of the former MAIF Agreement, plus controls on retailer and/or toddler milk marketing.

[2] Regulated by Standard 2.9.3 – Division 4 of the Australia New Zealand Food Standards Code as formulated supplementary foods for young children.

Each option is discussed more in detail in the 'Policy Options' section of this paper. Background information, evidence and context is provided in the 'Background' and 'Problem Identification' sections. Additional supporting information is provided in *Appendix A – Background Evidence Summary*.

To ensure the consultation is as useful as possible, where possible respondents are requested to provide specific information on:

- Costs and benefits,
- Barriers and enablers,
- Impact on priority populations,
- Monitoring, enforcement and evaluation considerations.

Background

Infant feeding in Australia

Breastfeeding is widely recognised as essential for giving infants the best start to life as breastmilk provides optimal nutrition for healthy growth and development. The World Health Organization (WHO) and Australian policies, including the *Australian National Breastfeeding Strategy: 2019 and Beyond* (Breastfeeding Strategy), strongly promote this practice. The *Australian Dietary Guidelines* and *Infant Feeding Guidelines* recommend exclusive breastfeeding until around six months of age. From six months, solids should be introduced while continuing breastfeeding until at least 12 months and beyond, as desired by parent and child. If breastfeeding is not possible, commercial infant formula is the only safe alternative.

Breastfeeding offers extensive benefits for both infants and mothers. Breastmilk provides all essential nutrients for healthy growth and development, with a dynamic composition that adapts to a child's changing nutritional and immunological needs. Breastmilk contains unique components such as microbes and hormones that cannot be replicated. Breastfeeding protects infants against illness and infectious diseases and has long-term benefits, including reduced risk of obesity, diabetes and asthma, with potential benefits for cognitive development. For mothers, breastfeeding is linked to lower risks of type 2 diabetes, cardiovascular disease, and breast and ovarian cancer, as well as short-term benefits like weight management and enhanced physical and mental wellbeing.

The Breastfeeding Strategy aims for 50% of babies to be exclusively breastfed to six months by 2025. While breastfeeding initiation rates are high, exclusive breastfeeding declines sharply. The 2010 Australian National Infant Feeding Survey (ANIFS) reported that 96% of infants commenced breastfeeding, however only 15% were exclusively breastfed at five months. More recent data from the National Health Survey suggests 37% were exclusively breastfed for six months in 2022, however methodological differences limit comparisons. Findings from academic studies align with this trend. Exclusive breastfeeding rates are lower among First Nations populations, particularly in urban settings.

Infant formula is the only recommended substitute for breastmilk and is designed to replicate its composition as closely as possible, often including components like human-identical milk oligosaccharides. Infant formula use in Australia is common. The 2010 ANIFS reported 40% of infants received formula by one month, rising to 55% at six months and nearly 80% by 12 months. OzFITS 2021 found over half of infants had received infant formula by six months, with 40% introduced within the first month—mostly in hospital. After discharge, 58% continued mixed feeding, while 9% relied solely on formula. Sales data collected through Euromonitor shows strong growth despite declines in purchases made in major supermarkets, suggesting a trend towards purchasing through pharmacies and online vendors.

The Australian Government acknowledges breastfeeding as a personal choice influenced by biological, cultural, and social factors. The 2010 ANIFS found mothers reported choosing breastfeeding as it was healthier for the child, convenient, promoted bonding, and benefited maternal health. Cost was also a factor, with 47% citing affordability compared to infant formula.

It is important to acknowledge that breastfeeding may not always be possible, and some families rely on infant formula. Regardless of how they feed their child, families should feel supported in their decision and be free from shame and stigma. Common barriers include difficulties breastfeeding, desire for partner involvement in feeding, perceptions that formula is equivalent to breastmilk, and certain health conditions. Concerns about milk supply are a leading cause of early formula use, alongside factors such as caesarean birth, maternal age, weight status, and cultural background. Studies highlight the importance of breastfeeding intention, self-efficacy, education, health system resourcing, and support networks in sustaining breastfeeding.

Marketing of breastmilk substitutes can influence breastfeeding initiation, exclusivity, and duration. There are longstanding concerns about the marketing practices of infant formula and toddler milk companies and impact on breastfeeding rates globally. It is important that families receive evidence-based information from health professionals and independent information sources that are free of commercial influence.

International policy context

The WHO and UNICEF emphasise breastfeeding as vital for infant health and nutrition. To protect breastfeeding, the International Code of Marketing of Breast-milk Substitutes (WHO Code), adopted in 1981, sets global recommendations for restricting the marketing of substitutes such as infant formula, follow-on formula, toddler milks, and feeding equipment. The Code advocates breastfeeding as the preferred infant feeding option and states breastmilk substitutes should be available when necessary but not promoted. Subsequent World Health Assembly resolutions have updated the Code, including a 2025 expansion to digital marketing. Australia, as a WHO Member State, is encouraged to align domestic policies and regulatory frameworks with these recommendations with consideration of national context and priorities.

The WHO monitors global implementation of the WHO Code through status reports that score countries on compliance, with a maximum of 100 points. Scores of 75+ indicate substantial alignment, 50–74 moderate alignment, and below 50 limited provisions. In 2022, 144 countries had adopted the Code into law, but only 32 had substantial alignment. Australia scored 27, reflecting limited provisions — primarily infant formula labelling under the Australia New Zealand Food Standards Code (Food Standards Code). The former MAIF Agreement contributed no points due to its voluntary nature. Countries with higher scores are often low-income or have lower levels of economic development, such as Sierra Leone (99), Maldives (93), and Afghanistan (92). Among comparable nations, the UK scored 40 with stricter marketing controls, while New Zealand matched Australia. The USA and Canada have no legal measures in place.

Domestic policy context

Restricting infant formula marketing is supported by many domestic strategies

Several Australian policies support restricting infant formula marketing, including the Breastfeeding Strategy, National Preventive Health Strategy, National Obesity Strategy, and National Women's Health Strategy. These frameworks recognise breastfeeding's health benefits and the influence of formula marketing on feeding decisions.

A key action under the National Breastfeeding Strategy is to reduce inappropriate marketing of breastmilk substitutes. Broader measures include funding donor human milk banks, the Australian Breastfeeding Association helpline, Healthdirect's Pregnancy, Birth and Baby service, and research projects through the Medical Research Future Fund. Additional actions include reviewing infant formula composition and labelling regulations under the Food Standards Code, updating dietary guidelines, and expanding the Paid Parental Leave scheme, which when fully rolled out, will provide 26 weeks of paid leave by July 2026 to help families to care for their newborn. The Baby Friendly Health Initiative (BFHI), administered by the Australian College of Midwives, also promotes breastfeeding in maternity facilities, with 24.7% BFHI accredited in November 2025.

Australia's voluntary regulations on infant formula marketing ceased in February 2025

The MAIF Agreement contributed to Australia's response to the WHO Code. It applied to signatory companies and aimed to limit marketing of infant formula for children up to 12 months. Signatories agreed not to advertise infant formula to the public, imply superiority to breastfeeding, promote through healthcare systems, provide free samples (except for research), or offer financial incentives for sales. The agreement excluded toddler milks, feeding bottles, teats, and marketing by retailers. Compliance was monitored by the MAIF Complaints Committee, and the agreement was subject to periodic reauthorisation by the ACCC due to competition law implications. An independent review (2021–2023) found the MAIF Agreement was no longer fit for purpose and recommended a mandatory framework. The ACCC's decision not to reauthorise the agreement in February 2025 similarly stated there was likely insufficient public benefit to justify its continuation due to the potential benefits being unlikely to exceed the likely detriment due to competition impacts.

Infant formula and toddler milks are regulated under the Food Standards Code

Food Standards Australia New Zealand (FSANZ) develops and maintains the Food Standards Code, which regulates infant formula products through Standard 2.9.1 and Schedule 29, covering composition, labelling, and sales provisions. Infant formula products are defined as product based on milk or other edible food constituents of animal or plant origin which is represented as nutritionally adequate to serve by itself either as the sole or principal liquid source of nourishment for infants up to 12 months. Standard 1.2.7 prohibits health and nutrition content claims on these products. In 2024, FSANZ approved Proposal P1028, updating standards to align with scientific evidence and strengthen labelling provisions. Key changes include clarifying the prohibition on claims, prohibiting proxy advertising, requiring clear differentiation between formula stages, and prescribing voluntary stage numbering requirements. These amendments have a five-year transition period from September 2024. FSANZ also regulates toddler milks under Standard 2.9.3 and is reviewing these provisions through Proposal P1066 – Review of young child formula, which aims to ensure appropriate regulation of young child formula. Public consultation for P1066 is expected in early 2026.

Problem Identification

Infant formula marketing impacts perceptions of breastmilk and infant formula and infant feeding practices

Marketing of infant formula and toddler milk products has been shown to influence caregivers' infant feeding practices, reducing breastfeeding intention, initiation and duration (Romo-Palafox et al., 2020, Zhang et al., 2013; Piwoz and Huffman, 2015). Infant formula companies use sophisticated language and promotional techniques to target parents and influence health professionals (WHO, 2022). Parents can be highly influenced by advertisements and health professional recommendations to use infant formula (WHO, 2022; Piwoz and Huffman, 2015).

Marketing of breastmilk substitutes can pathologise normal infant feeding behaviours, exploit parental insecurities, undermine confidence in breastfeeding and present formula as a solution to normal infant feeding behaviours (Pérez-Escamilla et al., 2023; Parry et al., 2013). Marketing agencies target advertising strategies at new parents who have less experience and who commonly refer to the internet for information and are more likely to buy something new (Mota-Castillo et al., 2023). Evidence indicates parents/caregivers who believe the advertising and marketing claims on infant formula and toddler milk products were more likely to provide these products to their child (Romo-Palafox et al., 2020).

Digital marketing campaigns have been shown to effectively increase consumer engagement and sales. Advertising and marketing campaigns generally tend to use emotional messaging to appeal to parents and build relationships (Hastings et al., 2020). The WHO report on the scope and impact of digital marketing strategies for promoting breast-milk substitutes highlights the effectiveness of digital marketing including through social media and the use of influencers (WHO, 2022). Case study examples include an Australian social media

campaign which reached 5,000 people with an engagement rate of 33%, greatly exceeding general targets of 1-2%, and an influencer who reached more than a million people and generated 155,000 engagement actions with a single post (WHO, 2022).

An online survey of 1,645 caregivers of infants and toddlers in the USA found 52% of infant caregivers agreed that infant formula can be better for infants' digestion and brain development than breastmilk, while 62% agreed infant formula can provide nutrition that is not present in breastmilk (Romo-Palafox et al., 2020). The same survey found 60% of toddler caregivers agreed toddler milks provide nutrition toddlers cannot receive from foods or beverages in the diet. These findings suggest common infant formula and toddler milk marketing claims mislead caregivers about the benefits and appropriateness for their child (Romo-Palafox et al., 2020).

The impact of infant formula marketing may not be equal across population groups. Recent research from the United Kingdom showed that women from lower socio-economic positions were more likely to have favourable views on breastmilk substitutes despite no difference in marketing exposure to other women (Athanasiadou, 2025). This suggests education status may protect people from the persuasive power of marketing messaging.

Question 1 – Are you aware of any high-quality studies that quantify the impact of infant formula marketing on infant feeding practices, particularly in the Australian context?

Question 2 – What other key concepts around the relationship between infant formula marketing on perceptions of breastmilk and infant formula and infant feeding practices should be considered?

Infant formula marketing is common

Infant formula marketing occurs globally via a range of strategies

Marketing of infant formula and other breastmilk substitutes is common globally, and is increasingly digital (WHO & UNICEF, 2022). A recent review of studies of breastmilk substitute marketing covering 28 countries found recent trends towards increased digital media, with marketing also commonly reported in the health sector and at point of sale (Topothai et al., 2024). Companies use digital media to send newsletters, utilise influencers to promote their products across social media and online blogs, as well as using emotional messaging and health and nutrition claims (Mota-Castillo et al., 2023). This shift to digital marketing increases companies' ability to target their marketing, with limited transparency and observability to those not directly targeted (Northcott et al., 2025).

An analysis of infant formula manufacturer websites in the USA found messaging encouraged infant formula feeding and discouraged breastfeeding (Pomeranz et al., 2023). Messaging about the benefits of formula feeding occurred significantly more often than messaging about the benefits of breastfeeding/breastmilk, at 44% and 26% respectively. Some manufacturers showed images suggesting the ease of formula feeding and the difficulty of breastfeeding. Statements regarding the benefits infant formula such as being good for brain, neural and eye health, and reducing gastrointestinal issues was more prevalent than statements about the benefits of breastmilk. Additionally, terms such as

‘organic’, ‘non-GMO’ and ‘natural’ were commonly used to describe infant formula, but not breastmilk, despite it being naturally occurring (Pomeranz et al., 2023).

Increased use of digital marketing increases the potential for high levels of exposure to marketing for breastmilk substitutes. Although not directly relevant to the Australian context, a study in Mexico found around 94% of parents observed at least one infant formula or infant or young child food advertisement while using a digital device (Unar-Munguia et al., 2022). The number of such products observed was as high as 7 advertisements per 10 minutes of device usage when intentionally searching for them, compared to 2 per 10 minutes with general browsing. Over 40% of advertisements related to toddler milks, while 20% related to infant formula (Unar-Munguia et al., 2022).

Advertisers have described using predictive analytics, AI machine learning and geo-tagging to identify potential customers (Jones et al., 2022). Jones et al., (2022) reported a company in China used AI to create numerous 30 second videos targeted to audience groups based on specific dietary allergies or sensitivities. Another company in Indonesia used location data to link social media advertisements for toddler milk with price discounts available in a consumer’s vicinity, where they then received a link and were directed to nearby stores to purchase the product.

Infant formula marketing in Australia

Australian studies have shown most (91%) parents recall specific infant formula advertisements, as well as claims made through the advertisements, demonstrating some level of exposure to infant formula marketing (Berry et al., 2012). Breastfeeding Advocacy Australia (BAA) is a volunteer charity that reports on marketing activity in Australia that does not align with the WHO Code. In the 2025 report, covering January 2024 to December 2024, BAA documented approximately 931 instances of such marketing activities in Australia. This primarily occurred on social media (68%), as well as through in-store promotions (13%) and retail apps (8%), print (6%), brand websites (1%) and other (4%) (BAA, 2025). It is important to note the scope of the WHO Code and products captured in the BAA report extends beyond that of the MAIF Agreement to all breastmilk substitutes and marketing by retailers. Advertisements for infant formula products in the report comprise less than 20% by product type.

The MAIF Complaints Committee assessed complaints against the former MAIF Agreement. The volume of complaints varied, with an average of 44 complaints resolved per year from 2021-22 to 2024-25. There was an average of 20 breaches and 15 out of scope complaints per year. Breaches were considered out-of-scope if the marketing activity was by non-signatories or retailers, or related to toddler milks (Department of Health, Disability and Ageing, 2025).

The Australian Ad Observatory found advertisements appeared in various formats including direct product advertising from formula brands; images, videos or carousels; partnerships with content creators and retailers; downloadable content from brands (e.g. cookbooks and guides); containing various calls to action such as ‘learn more’, ‘shop now’, ‘get offer’, ‘review to win’; and highlighting a positive customer review (Parker et al., 2025).

The Australian Ad Observatory also found various health and nutrition content claims were observable via digital marketing, as well as other marketing messages such as 'the secret to stress-free naps' and suggesting products could provide parents with a 'moment of calm' (Parker et al., 2025).

An Australian study of websites advertising infant formula products found 100% of the webpages reviewed contained at least one health claim, 72% contained at least one nutrition content claim, and 12% referenced the nutritional content of human milk (Berry & Gribble, 2017). This was despite the use of such claims being prohibited by the Food Standards Code; however, it is noted that these findings were observed in sections of the websites that identified as educational or informative, rather than on a page promoting the product (Berry & Gribble, 2017).

A study on 60 digital catalogues from four major supermarket chains across 3 months found more than half of the catalogues (55%) promoted infant formula or toddler milks. This included 4 promotions for infant formula, and 22 promotions for toddler milk products (Chung et al., 2025).

The Review of marketing of infant formula by retailers (2025) conducted by Nous Group found infant formula marketing by retailers in Australia is common, both in physical stores and online. Around two-thirds (65%) of respondents to a survey reported seeing some form of retailer promotion of infant formula in the last 6 months. Price promotion was observed by 79% of those that had witnessed any form of retailer marketing. It is important to note that while efforts were made to reach a wide audience with the survey, the sample size was limited (124 participants and limited response rates for many questions), therefore findings from the survey should be interpreted with caution. Price data analysis showed that around a third (32%) had some form of price reduction in a given financial quarter, with average discounts between 11.1-19.9% (Nous Group, 2025).

The Department has commissioned the development of an Artificial Intelligence enabled tool to monitor digital marketing of breastmilk substitutes. This work is being undertaken by Deakin University and will report on instances of marketing that contradicts both the former MAIF Agreement and the WHO Code. The tool will help provide a more accurate picture of the nature of digital marketing of infant formula products and toddler milk occurring in Australia. The tool may also be used to assist monitoring of future infant formula marketing policies.

Question 3 – Please outline the pros and cons of infant formula marketing (if any). Please include contextual information to explain your perspective as required.

Question 4 – What other infant formula marketing prevalence data should be considered?

Voluntary regulation of infant formula marketing has shown limited effectiveness

The MAIF Review identified several weaknesses in the MAIF Agreement that undermined its effectiveness. Key reasons included the voluntary nature of the agreement, a lack of enforcement and consequences, a lack of visibility and transparency regarding MAIF Agreement complaints processes, and timeliness of the complaints process.

In its final determination on the reauthorisation of the MAIF Agreement, the ACCC concurred with concerns raised in the MAIF Review about the lack of penalties for repeated breaches, limited transparency around the decision-making process of the MAIF Complaints Committee, the inclusion of an industry representative as a member of the MAIF Complaints Committee, and limited consequences for breaching the MAIF Agreement. It also noted that cross promotion of infant formula through toddler milk marketing likely undermined the purpose of the MAIF Agreement and the potential public benefit of the agreement.

Incomplete market coverage

As a voluntary agreement, the MAIF Agreement relied on infant formula manufacturers and importers becoming signatories to the agreement. Roughly 85% of the market share were signatories at the time of the MAIF Review (Allen + Clarke, 2023). This incomplete industry coverage limited the effectiveness of the agreement and created an uneven playing field. For the period 2021-22 to 2024-25, the most common reason for a MAIF complaint to be out of scope was due to non-signatory activity, accounting for 44% (n=28) of complaints. This demonstrates the need for comprehensive sector coverage under marketing regulations.

Enforcement

The MAIF Review found many stakeholders considered the consequences of breaches of the MAIF Agreement to be too weak, and that stronger penalties were needed. Over one-third (35%) of survey respondents did not think the publication of breaches on the Department's website was an appropriate enforcement mechanism, which was generally reflective of public health stakeholder views. One quarter (25%) agreed it was appropriate, which was more reflective of industry views (Allen + Clarke, 2023).

The MAIF Review found industry stakeholders considered the approach appropriate as it had flow-on effects for companies that act as a deterrent including negative media attention, reputational damage, and impacts on sales and customer base. In contrast states and territories, public health, and breastfeeding advocacy stakeholders believed stronger penalties and enforcement powers should be introduced (Allen + Clarke, 2023).

In its final determination report, the ACCC noted the ineffectiveness of the MAIF Complaints process, specifically that it did not carry any sanctions or meaningful consequences for a breach, other than the publication of the breach finding on the Department's website (ACCC, 2025).

MAIF Complaints process

Both the MAIF Review and ACCC criticised the timeliness of the MAIF Complaints process, which often took months due to committee reliance on volunteers, infrequent meetings, and Department staff turnover. Submissions to the ACCC also highlighted the lack of consumer representation and potential conflicts within the committee, as well as the dependence on complaints by the public over proactive monitoring. Both also found the process lacked independence, transparency, and efficiency. Public health stakeholders raised concerns about decision-making visibility and many complaints being deemed out of scope, while industry stakeholders called for faster timelines, clearer communication, and greater transparency.

The MAIF Agreement was criticised for its limited scope

Several stakeholders and reviews raised concerns about the scope of the former MAIF Agreement, particularly the omission of toddler milk products and retailer marketing. The WHO and public health community advocate for governments to adopt the entire WHO Code into national legislation. This would see restrictions on all breastmilk substitute marketing, including infant formula products, toddler milks, and commercial foods for infants and young children, as well as bottles and teats. Restrictions would apply to all entities in the supply chain.

A summary of relevant evidence for potential areas for expansion of scope for the new legislation beyond that of the MAIF Agreement is presented below. This includes Australian and international research and findings from the MAIF Review and ACCC determination. Consideration of impacts is included in the Policy Options section.

What entities should be in-scope?

Retailer Marketing

The MAIF Review noted uncertainty around the prevalence and nature of marketing in the retail environment, and a need for evidence on the impacts of including retailers in a regulatory setting. It was recommended the department conduct a review of the scale and impact of inappropriate marketing of infant formula by supermarkets and pharmacies to determine whether retailers should be included in any future regulatory framework.

In 2025 the Department contracted Nous Group to review the scale and impact of retailer marketing on infant formula. Findings from the review suggested retailer marketing of infant formula is common in Australia, both physical and online. A limited survey conducted as part of the review found most consumers 65% (n=79) had seen some form of retailer marketing of infant formula in the last 6 months. Further, it found that people were often unable to distinguish between marketing by manufacturers versus retailers.

Price promotion occurred frequently from 2019 to 2024, with average reductions between 11% to 20% (Nous Group, 2025). This may be influential, with nearly 1 in 3 people who were expecting a child or had a child under 12 months saying they were greatly, somewhat or slightly influenced to purchase infant formula by both general retailer marketing and in-store

price promotions. This influence was also high amongst those who were currently, or had previously, used infant formula, with much less influence seen amongst those who did not have, or were not expecting, a child, or had never used infant formula products. It is important to note the survey sample size was small and the response may include people who are already using infant formula products.

A systematic review conducted across 28 countries found price promotion was the most prevalent type of marketing used by retailers (over 40%) (Topothai et al., 2024). Between 2021-22 and 2024-25, the MAIF Complaints Committee received 17 complaints regarding infant formula marketing by retailers. These were all deemed out of scope as retailers were not included in the scope of the agreement.

Nous Group's review of the scale and impact of retailer marketing of infant formula outlined regulatory options available to Government. This included the status quo, or no regulation, through to full regulation – with options for both total alignment with the WHO Code, and an option that excludes price promotion. It was noted that including retailer marketing in regulations could reduce exposure to infant formula marketing with associated public health benefits, but this would also increase industry compliance costs.

While full regulation would better align with the WHO Code, the absence of price competition may potentially lead to price increases, resulting in equity impacts for those relying on infant formula. Conversely, while full regulation with the exception of price promotion does not fully align with the WHO Code, price competition may lead to reduced pricing of products within scope, and may incentivise product innovation (Nous Group, 2025). Most industry representatives interviewed as part of the review were agnostic towards inclusion of retailers within the scope of infant formula marketing regulations provided price promotion was not included.

Question 5 – Do you think restrictions on marketing by retailers should be included in mandatory infant formula marketing regulations?

Question 6 – What are the potential pros and cons of price promotions on infant formula products?

Question 7 – What other data on retailer marketing should be considered?

What products should be in-scope?

Toddler Milks

Toddler milks are generally marketed for consumption by children aged from 1-3 years and usually made from powdered milk, vegetable oils, added sugars and sweeteners and vitamins and minerals (Baker et al., 2016; McCann et al., 2021). The WHO has stated that toddler milks are unnecessary for the optimal growth and development of children and is unsuitable when used as a breastmilk replacement from 6 months of age onwards (WHO, 2013). The Australian Dietary Guidelines do not recommend the use of toddler milks, with exclusive breastfeeding recommended until around 6 months of age, when solid foods are introduced, and continuation of breastfeeding until 12 months or longer if desired.

Toddler milks are common in Australia. A 2019 study of four supermarket chains making up 80% of the Australian market and one pharmacy representing 25% of market share identified 32 toddler milk products from 15 different brands (McCann et al., 2021). Given data from 16 large high- and middle-income countries found toddler milks to be the fastest growing category of breastmilk substitutes (WHO, 2017), it is likely the number of toddler milk products in Australia has since increased. Sales data analysed by Ching et al. (2025) shows toddler milk sales have increased from less than 2,000 tonnes in 2005 to around 15,000 tonnes in 2024. While consumption data are limited, Willcox et al., (2021) found 31.5% of mothers surveyed in Australian capital cities reported feeding their children toddler milks once or more per week.

Toddler milk labelling will be considered further by FSANZ through proposal *P1066 – Review of young child formula*, therefore only non-label marketing and advertising are relevant to the current policy discussion. It is also important to note that the objective of including toddler milk in any new marketing specific policy would be to reduce consumer confusion and potential proxy marketing of infant formula products with the aim of increasing breastfeeding rates, rather than reducing toddler milk consumption.

The MAIF Review concluded there was insufficient evidence to justify expanding the scope of products included under the MAIF Agreement to include toddler milks. It was however noted that toddler milk products may lead to consumer confusion and serve to cross-promote infant formula, and that including toddler milk marketing within regulations would likely have a positive cost:benefit ratio.

Stakeholder consultations through the MAIF Review revealed opposing views. Many public health stakeholders highlighted concerns about toddler milks serving as a cross-promotion tool due to similar packaging to infant formula product lines. This is supported by findings from several studies showing that consumers often cannot differentiate between toddler milks and infant formulas (Romo-Palafox et al., 2020; Berry et al., 2012; Richter et al., 2024), product packaging influences perceptions of product quality (Pereira-Kotze et al., 2022; Horwood et al., 2022), and toddler milks may act as 'proxy advertising' or cross-promotion for infant formula products (Richter et al., 2024; Thatcher, 2022; Berry et al., 2010).

The ACCC's 2025 determination noted exclusion of toddler milks from the MAIF Agreement likely results in cross-promotion of infant formula, undermining the potential benefit of the agreement. Changes to the Food Standards Code resulting from proposal *P1028 – Infant Formula* implemented in September 2024 seek to address the issues of cross-promotion and similar packaging of product lines, but do not extend to other forms of marketing.

In contrast, industry stakeholders consulted through the MAIF Review were concerned an expansion of the MAIF Agreement scope to include toddler milks could negatively impact competition and product innovation, leading to a reduction in incentives to invest in these areas.

Global research indicates a shift towards toddler milk marketing by infant formula companies (Topothai et al. 2024). This was observed in research on breastmilk substitute marketing in Australian print media from 1950-2010, which found that while infant formula

companies had reduced infant formula marketing in response to the WHO Code, this was often replaced with marketing for toddler milks (Smith & Blake, 2013).

The ADM+S Australian Ad Observatory collection of Facebook advertisements donated by approximately 1,200 Australian adults in 2022 included 21 different ads for formula brands: 5 for infant formula, 11 for toddler formula, 4 for kids' formula products and 1 for a brand only. Advertisements were shown up to 4 times each, with a total of 36 impressions for the 21 advertisements. Data collected in 2025 from Facebook, Instagram, Tik Tok and YouTube from a smaller sample of 127 participants showed around 1 in 4 people observed a total of 122 advertisements from formula brands or retailers advertising breastmilk substitutes. This included 1 infant formula advertisement and 115 advertisements for toddler milks and 6 brand only advertisements (Parker et al., 2025). These observations provide further evidence of the trend towards increased toddler milk advertising.

Toddler milk marketing practices appear to be similar to the practices used to market infant formula. The scoping review by Richter et al., (2024) discussed the use of a range of advertising strategies such as the frequent use of health claims and images of babies/toddlers, rational and emotional messaging, and branding/slogans in several international studies.

In their systematic review, Topothai et al., (2024) found widespread advertisements of unregulated formula products around the world, especially of toddler milks. They also found several studies indicating cross-promotion strategies such as similar branding and product design were commonly used to indirectly promote regulated products (Topothai et al., 2024).

Australian and international research has shown pregnant women and parents are often unable to differentiate between advertisements for toddler milk and infant formula, and tend to believe the health claims and marketing messages presented in the ads (Berry, Jones & Iverson, 2010; Berry, Jones & Iverson, 2012; Berry et al., 2011; Cattaneo et al., 2015; Richter et al., 2024).

A study assessing the effectiveness of breastmilk marketing restrictions showed restrictions on media promotion has been generally successful for regulated products, however marketing of unregulated products such as toddler milks generally continued often with similar branding and product design to the regulated product (Topothai et al., 2024).

Question 8 – Do you think restrictions on marketing of toddler milk products should be included in mandatory infant formula marketing regulations?

Question 9 – Are you aware of other data sources that should be considered, including research on the impact of toddler milk marketing on cross-promotion of infant formula and links to infant feeding decisions and breastfeeding rates?

Bottles and teats

Bottles and teats are commonly used to feed infants and young children, for both expressed breastmilk and infant formula (Theurich et al., 2024). Globally, the infant feeding bottle market was estimated to be valued at nearly $3.5 billion in 2022 and is expected to grow to around $5.5 billion by 2030 (Theurich et al., 2024). The WHO Code includes provisions on the inappropriate marketing of equipment that can be used for formula feeding, including bottles and teats. Information and distribution of equipment/resources that may be seen as encouraging the use of breastmilk substitutes or bottle-feeding is considered marketing/promotion under the WHO Code. Bottles and teats were not within the scope of the former MAIF Agreement.

The Australian Infant Feeding Guidelines state there is no evidence that teats assist with problems such as colic (AIFG, 2012). A German study analysing the marketing of feeding bottles and teats identified common marketing claims included 'equivalency to breastfeeding', 'disease prevention' and 'naturalness' (Theurich et al., 2024). Other claims were around infant autonomy, mechanics of breastfeeding, claims by parents, and endorsements by health professionals (Theurich et al., 2024). Similarly, a 2025 UK study found that claims related to the prevention and reduction of nipple confusion and bottle refusal, aiding combination feeding, mimicking the breast/nipple and/or the physiology of breastfeeding, aiding latching, high teat acceptance, and positively impacting breastfeeding (Maxwell et al., 2025).

There is currently limited evidence on the marketing of bottles and teats in Australia. Noting limitations in data availability, the Department is proposing not to include feeding paraphernalia such as bottles and teats in the impact analysis and legislation.

Question 10 – Do you think restrictions on marketing of bottles and teats should be included in mandatory infant formula marketing regulations?

Question 11 – Are you aware of other data sources that should be considered, including research demonstrating a link between marketing of bottles and teats and attitudes around breastmilk, infant formula and infant feeding patterns?

<u>Are stronger restrictions on engagement with healthcare workers required?</u>

The WHO Code outlines recommendations on limiting the marketing of breastmilk substitutes to health professionals and in healthcare facilities. It also urges health professionals to encourage and protect breastfeeding, and states that healthcare professionals and representatives should not promote or advertise breastmilk substitutes.

Similarly, the former MAIF Agreement outlined restrictions on the use of healthcare facilities to promote, advertise and distribute materials provided by infant formula manufacturers. Both the WHO Code and former MAIF Agreement outline that healthcare professionals should not receive financial or material inducements to promote infant formula, or free samples of products.

Both the WHO Code and the former MAIF Agreement do however permit industry representatives to engage with healthcare workers on the basis they provide factual and scientific information regarding their products. Healthcare professionals are permitted to provide factual information to parents and the public about breastmilk substitutes under both policies.

Health professionals are influential in feeding decisions. Healthcare professionals have been observed to engage with manufacturers or their representatives in several countries, with many perceiving no conflict of interest (Topothai et al., 2024). Although not directly relevant to the Australian context, a study of Indonesian mothers showed that those who used breastmilk substitutes were nearly twice as likely to have received a recommendation to feed breastmilk substitutes from inside the health system (Green et al., 2021). Parents have also been observed to be less willing to switch infant formula brands if the products were recommended by health professionals (Huang et al., 2013).

Data from OzFITS 2021 showed the main reason for exclusive breastfeeding cessation for infants under one month of age was exposure to breastmilk substitutes while in hospital (Netting et al., 2022). Infant formula companies have been observed promoting products through health systems by sponsoring meetings and webinars, providing free gifts, and providing free infant formula samples (Piwoz and Huffman, 2015; Mota-Castillo et al., 2023). Topothai et al. (2024) showed breastmilk substitute marketing was commonly conducted through healthcare facilities.

Data regarding marketing by breastmilk substitute companies in Australian health care facilities and to health professionals is limited, however a recent study of documents on professional ethics for 19 medical, nursing, midwifery and lactation professional associations in Australia found minimal requirements around marketing of breastmilk substitutes (Hull, Iellamo & Smith, 2025).

Anecdotal reports of industry sponsored attendance at conferences and professional development opportunities are common. This may be due to differing perceptions of ‘financial or material inducements’, or due to such sponsorships not being explicitly linked to a requirement to promote specific products per the wording of the former MAIF Agreement. This presents an opportunity to clarify these provisions through the development of new mandatory controls on infant formula marketing.

Question 12 – Do you think stronger regulations on infant formula company engagement with healthcare workers is required, such as stipulations on where and when such engagement can occur?

Question 13 – Do you consider infant formula company sponsorship of professional development opportunities such as webinars, training courses and conference attendance as appropriate in any circumstances?

Question 14 – What other key data sources and interactions between infant formula companies and healthcare professionals should be considered?

Objectives of Government Action and Rationale for Intervention

What are the policy objectives?

The ultimate goal of the policy is to help protect and promote breastfeeding to improve public health outcomes. The long-term objective is therefore to increase breastfeeding rates. This includes rates of exclusive breastfeeding up to around 6 months, as well as continued breastfeeding beyond 6 months as solid foods are introduced.

The short- and medium-term objectives will be to:

- Reduce marketing of infant formula products in Australia and the impact this has on families' infant feeding decisions.
- Reduce consumer confusion about the benefits of breastfeeding.
- Ensure evidence-based information informs decision-making by parents and caregivers.

The policy will also serve to create a level playing field for industry, ensuring all infant formula companies are bound by the same marketing regulations.

Question 15 – Do you agree with the policy objectives? If not, please provide alternatives for consideration.

Why is Government intervention needed?

While many infant formula companies engage in responsible marketing practices, Australian families remain exposed to infant formula marketing. Former voluntary regulation of infant formula marketing in Australia was deemed not to provide adequate protection to families or result in a net benefit for society.

Introducing legal measures to restrict infant formula marketing will ensure greater protection of breastfeeding, create a level playing field for industry through clear and consistently enforced requirements. Families, civil society and industry will be assured that the Government is monitoring and enforcing infant formula marketing regulations and that non-compliance will be dealt with appropriately.

Government intervention is required to correct market failures arising from information imbalances between parents and infant formula companies, and to help mitigate the broader health impacts associated with low breastfeeding rates.

How will we measure success?

Considerations around how to measure the success of the policy are included in the 'Monitoring, enforcement and evaluation' below. It is important to acknowledge breastfeeding is influenced by many social, economic and cultural factors, of which marketing is just one. Directly attributing any increase in breastfeeding rates to this policy will be difficult.

Policy Options

This section outlines 3 options for consultation:

- Option 1: Status quo – no regulation;
- Option 2: Australian Government legislation aligned with the scope of the former MAIF Agreement; and
- Option 3: Australian Government legislation aligned with the scope of the former MAIF Agreement, plus controls on retailer and/or toddler milk marketing.

For each, a high-level description of the policy is provided along with a summary of relevant costs and benefits. An important next step, after this consultation, will be a detailed cost:benefit analysis as part of the Australian Government impact analysis requirements.

The Australian Government's Policy Impact Analysis Framework requires assessment of all feasible options, including voluntary and quasi-regulatory approaches. However, the Government has already announced its intention to introduce mandatory controls on infant formula marketing. This follows the cessation of the former voluntary MAIF Agreement. This means that non-regulatory options have limited relevance and will not be progressed for detailed analysis. Option 1 (status quo) is retained as good regulatory practice and to provide a baseline for comparison. Under the status quo, no regulations govern infant formula marketing, enabling an assessment of the relative costs and benefits of proposed mandatory controls.

Option 1: Status Quo – No regulation

Description

This option would see no regulations on infant formula marketing introduced. Marketing practices outside food labels would be determined by individual company policies. As per current regulations, potential breaches of the Food Standards Code would be dealt with by the state and territory government agencies with responsibility for food regulation, and breaches of Australian Consumer Law would be handled by the ACCC.

Impacts

Costs

It is estimated more than US$300 billion is lost globally each year from the unrealised benefits of breastfeeding to health and human development (Walters, Phan & Mathisen, 2019; Jegier, Smith, & Bartick, 2024), which could translate to losses of up to AU$5 billion per year in Australia (HMA, 2025). The costs of having no regulation would be associated with the unrealised potential to reduce inappropriate marketing of infant formula and the flow on benefits to breastfeeding rates. This includes costs related to morbidity and mortality, as well as education impacts and lost productivity. These costs would largely accrue to families via direct healthcare costs and reduced productivity and governments via health system costs and reduced productivity. It is also important to note many infant formula companies continue to comply with the provisions of the former MAIF Agreement

pending the development of mandatory regulations. If no regulations were progressed, there is a risk some infant formula companies may increase marketing and advertising of infant formula, potentially impacting breastfeeding rates.

Benefits

Benefits associated with the status quo largely relate to minimising regulation for industry. Under the status quo, there are no additional compliance costs, companies can market new products, which may increase incentives for new product development. Confirming this position would provide a level playing field for industry and provide regulatory certainty to enable finalisation of marketing policies which may currently be in limbo awaiting the adoption of new regulations. Companies would experience competition benefits associated with being able to market their products, particularly new market entrants. Other benefits include cost savings for Government associated with not developing and enforcing new legislation, increased access to information for consumers and increased collaboration between infant formula companies and healthcare professionals.

Question 16 – What are the advantages and disadvantages of Option 1? Please explain your reasoning.

Question 17 – Do you have data on the costs and benefits associated with Option 1 that could contribute to a cost-benefit analysis to inform the policy development process?

Option 2: Australian Government legislation aligned with the scope of the former MAIF Agreement

Description

This option would see Australian Government legislation/regulations developed to restrict infant formula marketing in Australia. The policy would cover the full scope and all provisions of the previous MAIF Agreement. It is anticipated the legislation will prohibit manufacturers and importers of infant formula products from advertising infant formula to the public via all media and settings that may be used to market and advertise these products.

Aligning with the provisions of the previous MAIF Agreement, the legislation would also:

- Prohibit direct marketing by manufacturers and importers of infant formula products to health professionals, including all material inducements such as sponsorships of health professional conferences, training courses and materials (exemption for factual information regarding infant formula feeding),
- Prohibit the provision of free samples of infant formula products and related utensils to the general public (exemptions for donations and low-priced-sales to institutions and organisations such as hospitals and other health care facilities),
- Mandate the disclosure of conflicts of interest relating to any manufacturer or importer of infant formula products held by any health professional,

- Prohibit the inclusion of sales targets and bonuses related to sales volume for employees of infant formula manufacturers and importers,
- Prohibit employees of infant formula manufacturers and importers from performing educational functions relating to pregnant women or parents of infants and young children.

Impacts

Costs

Costs of implementing new or amended legislation would be realised by governments, industry and families:

- Government: costs associated with developing, monitoring and enforcing new legislation, including consultation processes, legislative drafting, staff training, systems development, compliance monitoring and enforcement costs.
- Industry: staff training, cost of penalties for non-compliance, and potential profit losses and employment impacts in infant formula and advertising industries, competition impacts for new market entrants.
- Families: reduced access to information from companies, potential for reduced new and improved products.

Benefits

Benefits of the legislation would also be realised by governments, industry and families:

- Government: reduced health system costs, increased productivity.
- Industry: level playing field for marketing.
- Families: reduced potential for misleading information and reduced influence on healthcare professionals by infant formula companies leading to increased breastfeeding rates and resulting health and productivity benefits.

Question 18 – What are the advantages and disadvantages of Option 2? Please explain your reasoning.

Question 19 – Do you have data on the costs and benefits associated with Option 2 that could contribute to a cost-benefit analysis to inform the policy development process.

Option 3: Australian Government legislation aligned with the scope of the former MAIF Agreement, plus controls on retailer and/or toddler milk marketing

Description

This option would expand the scope of legislation in Option 2 to include retailer marketing and/or toddler milks. Expansion of scope to include retailers and toddler milk products would more closely align with the WHO Code and reduce the potential for regulatory loopholes, with the primary difference being exclusion of bottles and teats. This option would address the concerns regarding the scope of the former MAIF Agreement and provide

greater assurance that families are receiving information on infant feeding from impartial, evidence-based sources free of vested interests. While the WHO Code captures short term price promotions, there may be a case to exempt such conduct due to cost of living pressures.

Impacts

Costs

Costs of implementing new or amended legislation with expanded scope would be realised by governments, industry and families. Costs additional to those already identified for Option 2 above would include:

- Government: additional monitoring associated with inclusion of additional in-scope products and/or businesses (i.e. retailers).
- Industry: reduced marketing of toddler milks may lead to decreased sales and advertising industry revenue.
- Families: potential for reduced incentive for new product development and innovation. Families would lose the ability to capitalise on sales and discounts if price promotions by retailers were restricted – this could be addressed through an exemption for price promotions.

Benefits

Benefits of the legislation with expanded scope would also be realised by governments and families. Additional benefits would include:

- Government: complete market coverage and reductions in loopholes resulting in further reduction in marketing of breastmilk substitutes leading greater health system savings and increased productivity.
- Families: Further reduced potential for misleading information via all settings, increased breastfeeding rates, greater adherence to the Australian Dietary Guidelines and associated improvements to health, reduced costs and greater productivity.

Question 20 – What are the advantages and disadvantages of Option 3? Please explain your reasoning.

Question 21 – Do you have data on the costs and benefits associated with Option 3 that could contribute to a cost-benefit analysis to inform the policy development process?

Question 22 – Which is your preferred policy option?

Implementation Considerations

Legislative development

The legislation will be developed following this public consultation, with the scope of the legislation to be informed by the consultation and impact analysis. The Department will develop the legislation working with other relevant government departments. It is anticipated the legislation will be enacted through the *Food Standards Australia New Zealand Act 1991* (FSANZ Act), noting it is the most relevant existing legislation in Australia.

There are several complexities associated with amending the FSANZ Act for the purposes of regulating infant formula marketing, including:

- While the FSANZ Act is Australian legislation, amendments require negotiation with New Zealand under the 'Agreement betwen the Government of Australia and the Government of New Zealand Concerning a Joint Food Standards System'. While the legislation would impact Australia only, this may extend timeframes and introduce additional considerations.
- Australian states and territories are responsible for enforcing food standards under the Food Standards Code. Any infant formula marketing legislation developed within or as a result of amendments to the FSANZ Act would require clear separation of responsibilities to ensure state and territory governments are not inadvertently conferred monitoring and enforcement responsibilities. Consultation with state and territory governments will be required.
- Any amendments to the FSANZ Act regarding infant formula marketing would ideally be implemented with other anticipated changes to address the findings of the Review of the FSANZ Act.

The best available alternative approach would be to develop standalone Australian Government legislation. This could reduce some of the complexities outlined above and provide a legislative mechanism for any future food related legislation not suitable for inclusion in the FSANZ Act and Food Standards Code. However, this is likely to take longer than enacting through the FSANZ Act.

Timeframes for legislative processes vary and depend on several factors including availability of drafting resources within the Office of Parliamentary Counsel, consultation processes, and parliamentary scheduling. They also depend on Government decisions to introduce the legislation and the passage of the Bill through Parliament.

Information for affected stakeholders

To facilitate compliance with the legislation, educational materials will be developed for industry, health professionals, other impacted stakeholders, and the public explaining the purpose of the legislation and how to ensure compliance.

Question 23 – What other considerations should be addressed in the legislative development process?

Monitoring, enforcement and evaluation

Any effective regulation requires thorough, systematic processes for monitoring, enforcement and evaluation. These processes will be tailored to the scope of the legislation and refined through the legislative development process. A high-level outline of potential processes is provided below.

Monitoring

It is anticipated monitoring will be undertaken through a combination of active and passive monitoring, with specific methods tailored to the media and setting being monitored. The WHO NetCode (Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes) provides countries with a standardised system to monitor compliance with the WHO Code. It aims to detect, report, and address inappropriate marketing of breastmilk substitutes.

NetCode offers two complementary approaches:

1) Ongoing monitoring, which integrates into national regulatory systems for continuous oversight.
2) Periodic assessments conducted every 3–5 years to evaluate overall compliance.

Australian infant formula marketing legislation could adapt relevant principles from NetCode to the local context while also drawing on relevant domestic experience in regulating marketing and advertising such as for pharmaceutical and tobacco products.

Active monitoring could utilise technological solutions such as the AI tool currently being developed by Deakin University and data from the Australian Ad Observatory for digital marketing surveillance. Periodic checks on TV advertisements could be conducted using media tracking services. If retailer marketing was included, physical retail marketing could be monitored by Australian Government staff from relevant agencies such as FSANZ or the Department. The review of retailer marketing of infant formula by Nous Group highlighted there are nearly 10,000 supermarkets and more than 4,000 pharmacies in Australia. Establishing efficient, cost-effective monitoring processes will be important.

Passive monitoring via complaints would comprise an important part of the monitoring system as per current food and beverage and alcohol advertising schemes, as well as the former MAIF Agreement. Complaints would be lodged with and processed by the relevant enforcement team.

Personnel responsible for monitoring would identify and document relevant details of potential breaches and refer them to the relevant decision-maker (e.g. government senior executive or the FSANZ Board) to determine breach outcomes and issue penalties or pursue stronger actions such as prosecution if required. The (re)establishment of a "Complaints Committee" arrangement modelled on the former MAIF Complaints Committee is not proposed.

As with the former MAIF Agreement, a public-facing dashboard could be established to transparently report breaches, outcomes (including company responses and actions to address the breach), and penalties associated with the breach (if any).

Enforcement

The appropriate enforcement body would be FSANZ, the Department, or a combination of both agencies. Enforcement options will be informed by legal advice, and could include civil penalties and triggering the operation of the *Regulatory Powers Act 2014*. Penalties for non-compliance would be proportionate to the severity of the breach and behaviours of the offending company, with greater penalties for more severe breaches and repeat offenders.

Evaluation

It is envisaged that the arrangements will be subject to periodic, independent evaluation. These evaluations would inform ongoing improvements to monitoring and enforcement arrangements and ensure the legislation is meeting its objectives. Evaluation could be included as a requirement of the legislation to ensure public accountability and effective and efficient use of public resources.

Ideally baseline data would be collected to effectively compare the prevalence of infant formula (and toddler milks if included) product marketing present before and after the legislation is place. Evaluations could be conducted in the short-, medium-, and long term – for example, at 1-, 3- and 5-years post legislation. It will be important to evaluate monitoring and enforcement processes and costs, and the value of penalties issued/received to determine the ongoing cost-effectiveness of the policy and identify opportunities for improvement. Evaluation will focus on the policy objectives:

Reduced levels of inappropriate infant formula marketing

Evaluating the volume and type (media/setting) of marketing and advertising of in-scope products occurring e.g. social media, online, broadcast and print media, and in the health system will be necessary. Useful data sources may include:

- The AI enabled tool under development could be used to observe marketing practices (frequency and appropriateness) by infant formula companies. While this would not measure population level exposure to infant formula marketing, it would help identify changes in marketing practices by companies.
- The Australian Ad Observatory could be used to gauge people's exposure to marketing by infant formula companies. This could be complemented by other academic research on exposure to digital marketing of breastmilk substitutes.

- Proportion of companies complying with legislation and trends in breaches.
- Number of warnings/infringements/penalties issued.

Reduced consumer confusion and ensuring evidence informed infant feeding decisions

- Consumer surveys could be undertaken to gauge people's understanding of infant feeding issues, including breastfeeding and infant formula, and influences on their feeding decisions.
- It will also be important to measure knowledge of the legislation (industry and public).

Increased breastfeeding rates

- Breastfeeding data from the National Health Survey provides regular updates on several breastfeeding indicators. While this survey has a limited sample size, it is the only regular national data source available.
- Academic studies on breastfeeding rates can highlight changes in breastfeeding rates. While not a regular or consistent data source, such studies provide useful observations and have potential to capture more specific population trends and issues.

More comprehensive data (for example, from a new National Infant Feeding Survey) would provide more insights into whether breastfeeding rates have improved since 2010 and since the introduction of the legislation, however, would require significant resources.

Question 24 – Do you have any suggestions regarding the most appropriate and enforcement arrangements for this policy?

Question 25 – What other monitoring, enforcement and evaluation considerations should be considered?

Next Steps

The Department will analyse all submissions to this consultation and intends to make submissions public with appropriate consideration to confidentiality. Findings from the consultation will be considered in the cost-benefit analysis and broader Impact Analysis. The Impact Analysis will be published on the Office of Impact Analysis website.

The Department will continue developing the policy, with further public consultation anticipated on exposure draft legislation when developed. Passage of any legislative changes will be subject to a decision of Government.

Question 26 - Please provide any other comments or points for consideration that may not have been addressed in this consultation.

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Appendix A – Background Evidence Summary

Breastfeeding and Infant Formula in Australia

Australian and International recommendations

Breastfeeding is recognised as an important practice to providing the best possible start in life for infants. It is encouraged at an international level by the World Health Organization (WHO), and in Australia through dietary guidelines and the *Australian National Breastfeeding Strategy: 2019 and Beyond*.

The Australian Dietary Guidelines (ADGs) provide information on the types and amounts of foods, food groups and dietary patterns required to promote health and wellbeing and reduce the risk of diet-related conditions and chronic disease (NHMRC, 2013). The Australian Infant Feeding Guidelines (AIFG) provide advice about breastfeeding and infant feeding, aiming to support optimal nutrition for infants and toddlers (NHMRC, 2012).

Both the ADGs and AIFG recommend infants be exclusively breastfed (breastmilk only with no other foods or fluids) up to the age of approximately 6 months, when solid foods are introduced, as breastfeeding provides optimal nutrition for the infant (NHMRC, 2012; NHMRC, 2013). Breastfeeding should continue while introducing solids until 12 months of age and beyond, for as long as the parent and child desire. If breastfeeding is not possible, the ADGs and AIFG recommend commercial infant formula should be used as the only safe alternative (NHMRC, 2013; NHRC, 2012).

Breastfeeding has health benefits for mothers and children

Breastfeeding has many benefits for both the mother and infant (Pérez-Escamilla et al., 2023). The benefits of breastfeeding are well documented in scientific research and breastfeeding is encouraged in many public health policies around the world. Breastfeeding and breastmilk provide infants with all the essential nutrients they need and promote healthy growth and development.

The composition of breastmilk is dynamic and changes over time as the child grows to meet the child's nutritional, immunological and developmental needs (Martin et al., 2016; Kim and Yi, 2020; AIHW, 2024). Breastmilk composition also changes throughout a feed. Studies report that breastmilk is irreplaceable and almost always provides adequate essential nutrients for an infant's growth and development (Koletzko et al., 2021; Kim and Yi, 2020). The composition of breastmilk cannot be replicated through infant formula; some components of breastmilk (such as microbes and hormones) are only available in humans through lactating mothers and other people who lactate (Kim and Yi, 2020; Pérez-Escamilla et al., 2023).

Breastfeeding has been shown to be protective and reduce the risk of illness and infectious disease in infants (WHO, 2017; Victoria et al., 2016). The benefits of breastfeeding have been shown to extend into adult life (WHO, 2017). For example, improved cognitive development and a reduced risk of living with overweight and obesity and chronic conditions such as

diabetes and asthma in adolescence and adulthood have been associated with breastfeeding (Pereyra-Elías et al. 2022; Lefebvre and John 2014; Morris 2018; Miliku and Azad 2018).

For the mother, breastfeeding is associated with many long-term health benefits such as reduced risk of developing Type 2 diabetes, cardiovascular disease, and breast and ovarian cancer (Chowdhury et al., 2015; Victoria et al., 2016). Research suggests shorter-term benefits may include maintenance of a healthy weight and enhanced maternal wellbeing (Ip, Chung & Raman, 2007).

Breastfeeding rates in Australia are below national targets

The *Australian National Breastfeeding Strategy: 2019 and Beyond* target for the proportion of babies who are exclusively breastfed to 6 months of age are 40% by 2022 and 50% by 2025. The 2025 target is reflected in the National Preventive Health Strategy and National Obesity Strategy acknowledging the lifelong benefits of breastfeeding.

Data from the 2010 Australian National Infant Feeding Survey (ANIFS) found Australia's breastfeeding initiation rate is high at around 96% (AIHW, 2011), however exclusive breastfeeding rates dropped to 15% by 5 months of age (AIHW, 2011). More recent data from the Australian Bureau of Statistics (ABS) National Health Survey (NHS) suggests around 37% of infants were exclusively breastfed to the age of around 6 months in 2022 (ABS, 2023). It should be noted differences methodologies and sample sizes from these two studies limit the validity of comparisons.

Academic studies also show high breastfeeding initiation rates are followed by sharp declines in exclusive breastfeeding by 6 months. An Australian study on 356 mother-infant pairs in New South Wales found breastfeeding was initiated in 97% of infants, however only 1% were exclusively breasted to 6 months of age (Delaney et al., 2025). The Australian Feeding Infants and Toddler Study 2021 (OzFITS 2021) found breastfeeding was initiated in 98% of infants, however the duration of exclusive breastfeeding to 6 months was less than 1%. Only 59% of infants were exclusively breastfed to one month, and 39% were exclusively breasted to 4 months. It was also found that nearly 40% of children were breastfed beyond 12 months, and 10% of toddlers were still receiving some breastmilk at 20 months of age (Netting et al., 2022).

Infant Formula

Infant formula is recognised as the only appropriate substitute to breastmilk and is developed to mimic the composition of breastmilk as closely as possible (Martin et al., 2016). Infant formula products are often include artificial breastmilk-specific ingredients, such as human-identical milk oligosaccharide (HiMO), the third most abundant component of breastmilk after lactose and lipids (Vandenplas et al., 2018; Hegar et al., 2019).

Data from the 2010 ANIFS indicated 40% of infants aged one month received non-human milk or infant formula, with this rate increasing to 55% at 6 months old, and to nearly 80% in infants aged 12 months (AIHW, 2011). OzFITS 2021 observed that by 6 months of age, just over half of infants had been given breastmilk substitutes, with 40% (n=455) of infants being introduced within the first month of life. 78% (n=350) of these infants received breastmilk

substitutes while in hospital after birth, with 33% ceasing breastmilk substitutes after being discharged from hospital. 58% continued to receive both breastmilk substitutes and breastmilk, and 9% received breastmilk substitutes only after hospital discharge. (Netting et al., 2022). Exclusive and total breastfeeding rates are also lower in First Nations populations, documented in both academic studies and government surveys (Springall et al., 2024).

The Australian Bureau of Statistics reports on the apparent consumption of selected foodstuffs using sales data from major Australian supermarkets. The 2023-24 report shows infant formula and toddler milk products purchased has declined over recent years, with sharp reductions from over 21,000 tonnes in 2018-19 to 8,700 tonnes in 2023-24 (ABS, 2025). This contrasts with data collected through Euromonitor by Ching et al. (2025), which shows strong sales volume increases across all formula products over the same period, particularly toddler milks. This indicates significant quantities of these products in Australia may be purchased through pharmacies and sources such as online vendors.

Factors influencing infant feeding decisions

The Australian Government recognises breastfeeding is a personal decision. There are many factors that may influence parents' decision to breastfeed, including biological factors, attitudes/beliefs, and support (AIHW, 2024). The 2010 ANIFS found the reasons most cited for mothers choosing to breastfeed were that breastmilk was healthier for the child (94%), convenient (64%), that breastfeeding helps with mother-infant bonding (64%), and that breastfeeding was healthier for the mother (54%). Price was also influential, with 47% of respondents breastfeeding as it was cheaper than purchasing infant formula (AIHW, 2011).

The Government acknowledges breastfeeding may not always be possible and that some parents may not be able to breastfeed or may choose not to breastfeed and may need to rely on the use of infant formula as the primary source of nutrition for their infant. The most common barriers/reasons for not breastfeeding as reported in the ANIFS included previous unsuccessful experiences with breastfeeding, choosing not to breastfeed so their partner can share feeding responsibilities, believing infant formula was as good as breastmilk, and medical reasons (AIHW, 2011). Studies have also indicated concerns regarding milk supply as a primary factor in the use of infant formula in the first month of an infant's life (Mallan et al., 2018; Kuswara et al., 2020; Huang et al., 2022; Reynolds et al., 2023). Other factors such as caesarean birth, cultural and linguistic diversity, maternal weight status and maternal age were found to impact the likelihood of breastfeeding (AIHW, 2011).

A study examining infant feeding patterns in the first year of life including breastfeeding exclusivity and infant formula introduction among Chinese Australian mothers found breastfeeding intention, self-efficacy and awareness of infant feeding recommendations were the most important factors associated with exclusive breastfeeding from birth to 4 months of age (Kuswara et al., 2020). Furthermore, a study on young Australian mothers aged 18-25 concluded support networks including professional, partner, family and peer support were important in choosing to breastfeed, while education and wider public awareness regarding the benefits of breastfeeding was also identified as a need (Buckland et al., 2022).

A cross-sectional study on 536 Australian women conducted between 2019 and 2020 regarding breastfeeding practices found the most common self-reported reasons for breastfeeding cessation were breastfeeding challenges and low milk supply (Reynolds et al., 2023). Health system influences such as resourcing for post-natal support services and midwifery workforce availability impact the level of breastfeeding support provided to new mothers (Mora Garces et al., 2025).

Research indicates that marketing of breastmilk substitutes such as infant formula may negatively impact breastfeeding intention, initiation, exclusivity and duration and has been associated with early cessation of breastfeeding (Piwoz and Huffman, 2015; Sobel et al., 2011).

International policy context

The WHO International Code of Marketing of Breast-milk Substitutes

The World Health Organization (WHO) and UNICEF have long emphasised the critical role of breastfeeding in promoting the health and nutrition of infants and young children.

The International Code of Marketing of Breast-milk Substitutes (WHO Code) was adopted in May 1981 with the aims to protect and promote breastfeeding by ensuring that marketing of breastmilk substitutes is ethical and does not undermine breastfeeding. The WHO Code is a set of international policy recommendations on restricting the marketing of infant formula. The scope of the WHO Code covers the marketing and practices related to breastmilk substitutes including infant formula; other milk products such as follow on formula and toddler milks, foods and beverages, including those that are marketed to replace breastmilk; and feeding bottles and teats. The Code advocates that infants are breastfed, and if they are unable to be breastfed, the Code advocates that infants should be fed safely on the best-available alternative. The Code states that breastmilk substitutes should be available when required, but not be promoted (WHO, 2023).

Subsequent WHA resolutions since the WHO Code's development in 1981 have been adopted, in effect updating the provisions of the WHO Code. A recent WHA resolution of note is the expansion to include regulations on the digital marketing of breastmilk substitutes in May 2025, as the WHA recognised that digital marketing, including influencer marketing has become the dominant form of marketing in many countries (WHO, 2025). Australia, as a WHO Member State, is encouraged to consider these international recommendations when developing domestic policies and regulations.

Actions to address infant formula marketing internationally

The WHO reports on country progress of measures to implement the WHO Code through the 'Marketing of breast-milk substitutes: national implementation of the international code' status reports. Countries' regulatory measures are scored with an algorithm which assigns points for each provision of the WHO Code, with 100 points possible if a country is implementing all provisions in the WHO Code. Countries with legal measures that scored 75 or greater are considered "substantially aligned with the Code", those with scores of 50 to

less than 75 are considered “moderately aligned”, and those with scores below 50 are considered to have “some provisions” (WHO, 2022).

Most countries have introduced some regulatory measures to restrict infant formula marketing. The WHO Code status report for 2022 stated that 144 countries have adopted the WHO Code into national law, with 32 having laws that substantially align with the code (WHO, 2022). Australia was rated as having “some provisions of the Code” with a score of 27 out of 100. All points are attributed to the infant formula labelling provisions in the Australia New Zealand Food Standards Code, with no points attributed to the former MAIF Agreement due to its voluntary status.

Countries with higher scores tend to be less developed, with substantially different social, economic and political contexts to Australia. For example, the top three scores were given to Sierra Leone (99), the Maldives (93), and Afghanistan (92). When assessing countries with more similar social, economic and political contexts to Australia, the United Kingdom has stricter infant formula marketing controls, achieving a score of 40 in 2022, including bans on point-of-sale advertising and price promotions by both manufacturers and retailers. New Zealand achieved the same score as Australia (27) in 2022, however will have fewer provisions in place than Australia following the August 2024 decision to opt out of changes to strengthen the Australia New Zealand Food Standards Code (more information on this is provided in later sections). The United States of America and Canada were assessed as having no legal measures in place.

In a study of 11 countries from Asia and the Pacific, countries with the higher levels of WHO Code implementation had lower per capita consumption of breastmilk substitute products (Ching et al., 2025). While the study was limited to countries where breastmilk substitute consumption data were available and the analysis does not infer causality, it suggests an association between introducing infant formula marketing regulations more strongly aligned with the WHO Code and increased breastfeeding.

Domestic policy context

Alignment with Australian Government strategies

Actions to restrict infant formula marketing are supported by several prominent Australian Government and joint Australian and state and territory government strategies. This includes the *Australian National Breastfeeding Strategy: 2019 and Beyond*, *National Preventive Health Strategy 2021-2030*, *National Obesity Strategy 2022-2032*, and *National Women’s Health Strategy 2020-2030*. These strategies recognise the benefits of breastfeeding for infant and maternal health and the impact infant formula marketing can have on decisions around breastfeeding.

To help support breastfeeding and protect breastfeeding rates in Australia, the Australian Government developed the *Australian National Breastfeeding Strategy: 2019 and Beyond* (Strategy), which provides a national framework to support mothers to breastfeed and aims to increase the number of breastfed infants in Australia. A key action area of the Strategy is

to reduce the occurrence of inappropriate marketing of breastmilk substitutes to create a more breastfeeding-enabled environment to reduce the burden on the health system**.**

The Government acknowledges that actions to reduce marketing of infant formula is just one part of a broader suite of measures required to increase breastfeeding rates. Other key Government activities under the Strategy include:

- Funding to support the Australian Red Cross Lifeblood to maintain and expand a coordinated network of donor human milk bank services;
- Funding to support the Australian Breastfeeding Association's National Breastfeeding Helpline and associated education activities;
- Supporting the review the 2013 Australian Dietary Guidelines, which includes a specific recommendation on breastfeeding;
- Funding to Healthdirect Australia to deliver the Pregnancy, Birth and Baby service;
- Reviewing regulations for infant formula products in the Australia New Zealand Food Standards Code;
- Providing almost $9.0 million in research funding for projects with a focus on breastfeeding through the Medical Research Future Fund.

The expansion of the Paid Parental Leave scheme, when fully rolled-out in July 2026, will provide support for up to 26 weeks of government-funded parental leave. This will provide further support to breastfeeding families. In addition, the Australian College of Midwives administers the Baby Friendly Health Initiative (BFHI) in Australia. BFHI is a joint WHO and UNICEF program designed to protect, promote and support breastfeeding in maternity hospitals and facilities that support breastfeeding mothers and their infants. Breastfed babies are not given breast-milk substitutes, dummies or teats unless medically indicated or it is the parents' informed choice. As at November 2025, approximately 1 in 4 (24.7%, n=64) of maternity facilities in Australia were BFHI accredited.

Previous voluntary regulation of infant formula marketing – MAIF Agreement

The *Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement* (MAIF Agreement) was a voluntary agreement in place in Australia from 1992 to 2025 that outlined obligations for manufacturers and importers of infant formula to ensure appropriate marketing to support the proper use of infant formula in Australia. The agreement focused on limiting the marketing and promotion of infant formula products aimed at children up to 12 months of age, with an aim to encourage breastfeeding as the first option.

The MAIF Agreement was a key part of Australia's response to the WHO Code.

As a voluntary framework, the agreement only applied to participating companies who signed up (signatories). Signatories were required to not:

- Advertise or promote infant formula to the general public;
- Imply that infant formula is better than breastfeeding;

- Advertise infant formula through the healthcare system;
- Provide free samples of infant formula to parents or health professionals (except for research purposes); and
- Give financial incentives to sales staff or health workers for selling or promoting infant formula.

Toddler milk products, infant and young child foods, feeding bottles and teats were not in scope of the MAIF Agreement. Marketing by other entities such as retailers was also not in scope.

To monitor compliance with the MAIF Agreement, the Department established the MAIF Complaints Committee (Committee). The Committee was responsible for assessing complaints made against signatories to the MAIF Agreement.

The MAIF Agreement was periodically subject to a reauthorisation process (exemption) by the ACCC, as the nature of the MAIF Agreement meant activities may break aspects of competition law outlined in the *Competition and Consumer Act 2010*. In July 2021, the ACCC reauthorised the MAIF Agreement for a further 3 years to 2024, recommending a comprehensive review on its effectiveness be conducted prior to the next reauthorisation process.

Review of the MAIF Agreement

An independent Review of the MAIF Agreement (MAIF Review) was conducted by Allen + Clarke Consulting from 2021 to 2023. The MAIF Review final report, published in April 2024, concluded the MAIF Agreement was no longer fit for purpose, and recommended a stronger, mandatory framework should be adopted in its place. Further information on the findings of the MAIF Review is provided in the 'Problem Identification' section.

Cessation of the MAIF Agreement

In March 2024, the Infant Nutrition Council requested the reauthorisation of the MAIF Agreement for a further 5 years. In October 2024, as part of a submission to the ACCC supporting the reauthorisation of the previous MAIF Agreement, the Australian Government (through the Department) announced its intention to develop legislation to restrict the marketing of infant formula in Australia.

On 6 February 2025, the ACCC announced its final determination not to reauthorise the MAIF Agreement, as the public benefit derived from the agreement was no longer likely to outweigh the public detriment. The MAIF Agreement subsequently ceased on 28 February 2025.

Regulation of infant formula products under the Australia New Zealand Food Standards Code

Food Standards Australia New Zealand (FSANZ) is an independent statutory agency responsible for the development and maintenance of the Australia New Zealand Food Standards Code (the Code).

In relation to infant formula, Standard 2.9.1 and Schedule 29 of the Code regulate the composition, labelling and sale of infant formula products. The definition of infant formula products under the Code includes "any food sold as an alternative for human milk for the feeding of infants up to the age of twelve months, formulated in accordance with all relevant clauses of the Code, including Infant Formula Products Standard 2.9.1". In addition, Standard 1.2.7 of the Code prohibits the use of health and nutrition content claims on infant formula products.

In 2024, the FSANZ Board approved Proposal P1028 – Infant Formula – which amended standards related to infant formula in the Code to ensure the regulation of infant formula products continues to be safe and suitable. Amendments to the Code under P1028 include clarifications to product categories, aligning compositional requirements with the latest scientific evidence, and tightening of labelling provisions. These changes will ensure infant formula products continue to be safe for formula-fed infants to consume, and caregivers have the information they need on how to prepare, use and store the products safely.

Changes relevant to infant formula marketing include:

- Clarifying the prohibition on nutrition content and health claims to ensure these claims are not used on infant formula products;
- Prohibiting proxy advertising by prohibiting information relating to other product types on infant formula product labels;
- Requiring products developed by infant formula companies (e.g. infant formula, follow-on-formula and toddler milk) to be differentiated using text, imagery and/or colour; and
- Prescribing requirements that apply if companies use stage numbers.

The amendments are subject to a 5-year transition period from 13 September 2024, during which, products may be sold if they comply with either the Code as currently in force, or the Code as amended by the draft variation. The Code also includes some regulations for young child formula, or 'toddler milk', under Standard 2.9.3 – Division 4 as formulated supplementary foods for young children.

Standard 2.9.3 outlines compositional and labelling requirements for the regulation of formulated supplementary foods for children aged 1 to 3 years. This includes a wide range of formulated supplementary foods, including products used to a supplement a normal diet to address situations where intakes of energy and nutrients may not be adequate to meet an individual's requirements (for example, when a child is not receiving adequate nutrition) and toddler milks.

FSANZ is currently undertaking work on Proposal P1066 - Review of young child formula, which aims to revise and clarify current regulations for young child formula to ensure they remain appropriate and effective. This proposal follows a request from food ministers to review how young child formula (toddler milk) is regulated. FSANZ is expected to call for submissions in early 2026.