AUSTRALIAN NATIONAL BREASTFEEDING STRATEGY
2018 AND BEYOND
Draft for public consultation
22 May 2018
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<th>Full Form</th>
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<tr>
<td>ABA</td>
<td>Australian Breastfeeding Association</td>
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<tr>
<td>ALSWH</td>
<td>Australian Longitudinal Study of Women’s Health</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ANIFS</td>
<td>Australian National Infant Feeding Survey</td>
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<td>ASCIA</td>
<td>Australasian Society of Clinical Immunology and Allergy</td>
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<tr>
<td>BFHI</td>
<td>Baby Friendly Health Initiative</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>CEDAW</td>
<td><em>Convention on the Elimination of All Forms of Discrimination against Women</em></td>
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<td>FSANZ</td>
<td>Food Standards Australia New Zealand</td>
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<td>ISSR</td>
<td>Institute for Social Science Research</td>
</tr>
<tr>
<td>MAIF Agreement</td>
<td><em>Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement</em></td>
</tr>
<tr>
<td>NEC</td>
<td>Necrotising Enterocolitis</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<tr>
<td>PPD</td>
<td>Postpartum Depression</td>
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<td>PPL</td>
<td>Paid Parental Leave</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Fund</td>
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<td>USA</td>
<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHO Code</td>
<td><em>International Code of Marketing of Breast-milk Substitutes</em></td>
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PART 1: SETTING THE SCENE

Introduction

This enduring Australian National Breastfeeding Strategy is intended to support all mothers in Australia in their role. The Strategy seeks to create a society supportive of breastfeeding so that breastfeeding is the first option for all mothers. The Strategy also recognises that this is not always possible and that all mothers need support regardless of how they feed their baby.

Why breastfeed?

The World Health Organization (WHO) recommends breastfeeding as the normal way of providing infants with the nutrients they need for healthy growth and development (WHO). According to the WHO, review of the evidence has shown that, on a population basis, exclusive breastfeeding for 6 months is the optimal way of feeding infants.

The WHO recommends:

- early initiation of breastfeeding within one hour of birth;
- exclusive breastfeeding for the first 6 months of life;
- breastfeeding on demand – that is as often as the child wants, day and night; and
- introduction of nutritionally-adequate and safe complementary foods together with continued breastfeeding until the child is at least 24 months of age.

In line with the WHO, the National Health and Medical Research Council (NHMRC) Infant Feeding Guidelines recommend exclusive breastfeeding to around 6 months of age, with continued breastfeeding and introduction of appropriate solid foods until 12 months of age and beyond, for as long as the mother and child desire. (NHMRC, 2012)

The Australasian Society of Clinical Immunology and Allergy (ASCIA) Guidelines for Infant Feeding and Allergy Prevention (Australasian Society of Clinical Immunology and Allergy, 2016) also recommends breastfeeding for at least 6 months and for as long as mother and infant wish to continue. A key recommendation in the ASCIA Guidelines is: When your infant is ready, at around 6 months, but not before 4 months, start to introduce a variety of solid foods, starting with iron rich foods, while continuing breastfeeding.

‘Exclusive’ breastfeeding means that the infant receives breast milk (including expressed breast milk or breast milk from a wet nurse) and allows the infant to receive oral rehydration solution, drops, syrups (vitamins, minerals, medicines), but nothing else (WHO, 2008)
The Lancet Breastfeeding Series Group estimates that worldwide about 40% of infants aged 0-6 months old are exclusively breastfed. Scaling up breastfeeding could prevent over 820,000 children’s lives being lost globally every year among children aged under 5 years (Victora et.al. for the Lancet Breastfeeding Series Group, 2016).

Breastfeeding is an important first step to improved short-term and long-term physical and mental health outcomes for both babies and mothers and facilitates bonding between mother and child. Increasing rates of breastfeeding in Australia in line with the recommendations of the WHO and the NHRMC will improve the health and wellbeing of infants, young children, mothers and families, and society more broadly (Victora et.al. for the Lancet Breastfeeding Series Group, 2016) (Hansen, 2016) (Renfrew, 2012).

The Lancet Breastfeeding Series Group (2016) elucidated the following benefits to child and mother from breastfeeding:

- **Breastfeeding reduces infant mortality and protects children against illnesses** – including sudden infant death syndrome, necrotising enterocolitis (NEC), diarrhoea and respiratory infections, otitis media, overweight or obesity, diabetes, and childhood leukaemia. Breastmilk also provides a personalised medicine for the infant during a critical developmental period.

- **Breastfeeding influences the development of a baby’s microbiome** - A mother’s breastmilk transmits probiotics and prebiotics, including elements of the mother’s own microbiome and immune responses.

- **Breastfeeding also contributes to better health for mothers** – longer periods of amenorrhea lead to greater spacing between pregnancies, reduction in the incidence of invasive breast cancer, reduction in ovarian cancer and reduced maternal depression.

- **Breastfeeding is a smart and cost-effective investment in society because it enhances human capital** – by increasing intelligence, improving school achievement and boosting adult earnings.

Breastfeeding contributes substantial savings in health costs and reduced burden of disease.

- Research has estimated that Australian hospital costs of premature weaning for four conditions (gastrointestinal illness, respiratory illness, eczema and NEC) is in the order of $60-120 million per annum (Smith, Thompson, & Ellwood, 2002).

- The UNICEF report ‘Preventing disease and saving resources’ found that even modest increases in breastfeeding rates in the UK were associated with substantial economic and health benefits (UNICEF: United Kingdom, 2012).

- A United States of America (USA) study showed if 90% of families could exclusively breastfeed for six months, the USA would save $13 billion per year and prevent an excess 911 deaths, nearly all of which would be in infants (Bartick & Reinhold, 2010).
If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics... Breastfeeding is a child’s first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity. (Hansen, 2016)

Breastfeeding also has many benefits and implications beyond health. Breast milk is an environmentally friendly product and the evidence shows that there are economic benefits to families and governments from increasing population breastfeeding rates.

Breastfeeding provides a safe and reliable method of infant feeding in emergency situations, providing a consistent source of adequate nutrition and protection against infections (IFE Core Group, 2017).

Breastfeeding also provides a dependable method of infant feeding in rural and remote locations with limited or sporadic access to alternative infant feeding options. It is important to protect, promote and support breastfeeding at a population level and particularly for those members of the community who are vulnerable to disadvantage, such as Aboriginal and Torres Strait Islander peoples.

**Breastfeeding as a human right**

The WHO and UNICEF’s *Global Strategy for Infant and Young Child Feeding* (“Global Strategy”) is based on respect, protection, facilitation and fulfilment of accepted human rights principles (World Health Organization, 2003). Nutrition is a crucial, universally recognised component of the child’s right to the highest attainable standard of health as stated in the *Convention on the Rights of the Child* (United Nations, 1989).

The Global Strategy describes breastfeeding as an ‘unequalled way of providing ideal food for the healthy growth and development of infants. It is also an integral part of the reproductive process with important implications for the health of mothers’ (World Health Organization, 2003).

*Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* requires that women have equal access to health services in relation to pregnancy and postnatal care and that mothers have the right to make decisions about their own lives and their children’s (including infant feeding decisions) (United Nations, 1979).

In 2016, the Office of the UN High Commissioner on Human Rights released a joint statement urging States to do more to support and protect breastfeeding and end inappropriate marketing of breastmilk substitutes. (United Nations, 2016).
Women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding. They also have the right to good quality health services, including comprehensive sexual, reproductive and maternal health services. And they have the right to adequate maternity protection in the workplace and to a friendly environment and appropriate conditions in public spaces for breastfeeding which are crucial to ensure successful breastfeeding practices (United Nations, 2016).

Breastfeeding policy in Australia

In August 2007, The Best Start: Report on the inquiry into the health benefits of breastfeeding was released (House of Representatives Standing Committee on Health and Ageing, 2007). The Report’s first recommendation was “that the Department of Health and Ageing coordinate and oversee the implementation of a national strategy to promote and support breastfeeding in Australia, including providing leadership in the area of monitoring, surveillance and evaluation of breastfeeding data”.

In response to this recommendation, the Australian National Breastfeeding Strategy 2010-2015 was developed (Department of Health and Ageing, 2009). It provided a framework for priorities and action for governments at all levels to protect, promote, support and monitor breastfeeding throughout Australia. The Australian National Breastfeeding Strategy 2010-2015 also included an implementation plan which identified ten action areas based on the goals and objectives of the Strategy (Department of Health, 2011).

A Final Progress Report was provided to the Australian Health Ministers’ Advisory Council (AHMAC) in 2016 to track progress against the implementation plan (Department of Health, 2016). The Final Progress Report noted that while progress had been made across all ten action areas, Australia still does not have a sustainable data set on breastfeeding that can be used to report on national breastfeeding rates.

Despite these efforts, many other issues raised in The Best Start Report remain.

- While the majority of Australian women intend to breastfeed their baby and 96 per cent initiate breastfeeding after birth, only a small proportion (15-25%) continue exclusive breastfeeding to around 6 months (Australian Institute of Health and Welfare, 2011) (Australian Bureau of Statistics, 2016).
- While these results reflect breastfeeding rates for the Australian population, some groups are at higher risk of discontinuing breastfeeding earlier, including Aboriginal and Torres Strait Islander women, women under the age of 25, culturally and linguistically diverse women, and women of low socioeconomic status (Hector, 2010).
- Feedback from departmental stakeholder consultations conducted in 2017 indicated that mothers still do not receive consistent, accurate and timely support for breastfeeding from the health system and community members more broadly (Department of Health, 2017).
Breastfeeding rates in Australia, like in other high-income countries, are lower among employed mothers and especially among mothers returning to paid employment full time. Employment and breastfeeding decisions interact. Some mothers and families cannot afford to forego employment earnings in order to accommodate breastfeeding (Smith et. al., 2018).

**Australia’s mothers and babies**

This Strategy is designed to support all mothers and babies in Australia, but primarily mothers. Often it is mothers who make decisions (including infant feeding) that influence short- and long-term health outcomes. The AIHW’s Mothers and Babies report (Australian Institute of Health and Welfare, 2017) provides a profile of Australia’s mothers more generally (see Figure 1).

![Figure 1: Key facts about Australia’s mothers](attachment:image.png)

Evidence also shows poorer breastfeeding outcomes, defined as either earlier supplementation or earlier cessation of breastfeeding, for primiparous mothers; mothers who deliver via caesarean section; younger maternal age; lower maternal education level; living in disadvantaged accommodation and low infant birth weight; and mothers who smoked during pregnancy (Hector, 2010). While not all of these factors are modifiable, they provide opportunities for education, awareness and early intervention. This is further explored under **Part 2: Priority populations**.
PART 2: THE CHALLENGE OF BREASTFEEDING IN AUSTRALIA

Determinants of Breastfeeding

Nearly all women are biologically capable of breastfeeding except those with severely limiting medical disorders (Rollins, 2016). Figure 2 presents the determinants of breastfeeding and interventions to protect, promote or support improved breastfeeding (Rollins, 2016). However, breastfeeding women encounter numerous barriers to breastfeeding. Breastfeeding practices are influenced by: social and cultural attitudes to breastfeeding in public; employer attitudes and support provided to women breastfeeding at work; health care providers’ knowledge and skills to support breastfeeding; short hospital stays; free samples of breastmilk substitutes; and the length of maternity leave. (Smith et al., 2018)

Priority populations

Priority populations are at highest risk of not meeting optimal breastfeeding recommendations in comparison to the general population. These population groups often encounter a greater burden of mortality, morbidity and health care costs due to social and other barriers, the risk of which may be reduced to both mother and child when optimal breastfeeding outcomes are reached. Influencing breastfeeding outcomes for these groups may require more intensive, enhanced, or specialised support; however there are greater gains to be realised from improving breastfeeding rates for these groups (Smith et al., 2018)

Due to the complexity of reasons for breastfeeding cessation, defining priority populations poses a challenge. However, the Australian National Infant Feeding Survey (ANIFS) provides a picture of the population groups that are less likely to breastfeed (Australian
Institute of Health and Welfare, 2011). According to the ANIFS, the mothers that are less likely to breastfeed are: young; disadvantaged; have low education levels; are daily smokers; and mothers with pre-pregnancy obesity.

<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Findings from ANIFS</th>
</tr>
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<tbody>
<tr>
<td>Young mothers</td>
<td>Mothers aged 24 years and younger are less likely to exclusively breastfeed to 4 months compared to older mothers (35+ years of age). Younger mothers are also more likely to introduce infant formula at comparatively younger infant ages than older mothers. For example, by 4 months of age, nearly 3 out of 4 infants with younger mothers (74%) had received infant formula compared with half of infants with older mothers (53%).</td>
</tr>
<tr>
<td>Low socioeconomic status</td>
<td>Initiation of breastfeeding by mothers of lowest socioeconomic status was 88% compared to 92% of mothers of highest socioeconomic status. This discrepancy between income quintiles was also seen in exclusive breastfeeding rates and continued to 5 months of age.</td>
</tr>
<tr>
<td>Low education levels</td>
<td>Higher proportions of children of lower-educated mothers/carers were introduced to infant formula at younger ages than children of higher-educated mothers/carers.</td>
</tr>
<tr>
<td>Daily smoking</td>
<td>The lowest rate of breastfeeding initiation is observed in mothers who smoke daily (81%), compared to those who don’t smoke at all (91%). Parental/family smoking is negatively associated with breastfeeding outcomes, including initiation and duration. Maternal smoking may affect the mother’s milk supply and may cause gastrointestinal upsets in the infant (NHMRC, 2012).</td>
</tr>
<tr>
<td>Obesity</td>
<td>Breastfeeding rates were significantly lower among mothers who were obese compared with those whose weights fell within the normal Body Mass Index (BMI) range.</td>
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</tbody>
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Table 1: 2010 Australian National Infant Feeding Survey results: mothers at greater risk of early breastfeeding cessation (Australian Institute of Health and Welfare, 2011)

The Evidence Check notes that these groups may require more specialised support that is tailored to their particular needs, social and health characteristics, or institutional context. (Smith et. al., 2018). But the Evidence Check also suggests that improving breastfeeding opportunities and practices for these mothers and their young children may require changes to public or institutional policies, or procedures and practices, and not be limited to interventions targeting individual women. Examples of changes to policies or procedures are:

- Facilitating breastfeeding among medically ‘at risk’ mothers such as obese mothers, those with particular health conditions, or those whose breastfeeding is affected by obstetric or childbirth complications, including premature, epidural or caesarean section deliveries;

- Regulatory, education and training and clinical interventions are available which may assist mothers or their support persons who are considering using medications

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or undergoing treatments or procedures which are known to adversely affect breastfeeding;

- Strategies or interventions supporting optimal feeding of ‘at risk’ infants such as preterm infants or twins, or those affected by maternal drug or alcohol abuse;

- In matriarchal cultural groups such as Indigenous Australians and some Asian cultures, engaging maternal elders will facilitate breastfeeding support; and

- For some demographic groups, a focus on involving fathers in breastfeeding education may be effective.

An example of this is the Clinical Practice Guidelines on Pregnancy Care (Pregnancy Care Guidelines (Department of Health, 2018), which recognise that body mass index prior to pregnancy, and weight gain during pregnancy, are among important determinants of health for both babies and mothers. There is considerable evidence linking maternal pre-pregnancy obesity to poorer breastfeeding intention, initiation, intensity and duration outcomes (Hector, 2010). This may have a psychological, cultural, behavioural, or biological basis, (such as the association between obesity and delayed lactogenesis) (Turcksin, 2014) but most likely an intertwined combination of all these factors.

Aboriginal and/or Torres Strait Islander peoples

Infants with Aboriginal and/or Torres Strait Islander parents are generally less likely to be breastfed. In 2014-15, 80% of Aboriginal and Torres Strait Islander children aged 0–3 years had been breastfed, which had not significantly changed since 2004–05 (80%) (Australian Health Ministers’ Advisory Council, 2017). This proportion differed between remote areas (87%) and non-remote areas (79%) (Australian Bureau of Statistics, 2016).

Exclusive breastfeeding of infants aged less than 1 month of age is comparable between Indigenous infants (59%) and non-Indigenous infants (61%). This rate declines with infants’ age for both Indigenous and non-Indigenous infants but the decline is steeper for Indigenous infants. By the recommended age of around 6 months, the proportion of Aboriginal and Torres Strait Islander infants exclusively breastfed is just 7%, compared with 16% of non-indigenous infants. Likewise, Indigenous infants were less likely than non-Indigenous infants to have been breastfed for 12 months or more (4% compared with 12%). (Australian Health Ministers' Advisory Council, 2017).

Aboriginal and/or Torres Strait Islander infants are also more likely to receive foods before 6 months of age with 45% of infants receiving soft, semi-solid or solid food by the age of 4 months, compared with 28% of non-Indigenous infants (Australian Institute of Health and Welfare, 2011).

All infants and mothers gain benefits from breastfeeding, however the benefits may be greater within population groups at higher risk for disease and infection. For example, Aboriginal and Torres Strait Islander peoples are at particular risk for otitis media. Otitis media is an inflammation of the middle ear and is a significant cause of hearing loss and subsequent learning difficulties in Indigenous children. It is characterised by earlier onset, higher frequency, greater severity and greater persistence than non-Indigenous children.
In remote communities where Aboriginal and Torres Strait Islander people may live, there are frequently poor environmental conditions, housing and hygiene. Breastfeeding provides the optimum protection to infants against infection and under-nutrition in these conditions, particularly where hygiene practices required for sterilising bottles may not be easily achieved or maintained. Where infant formula is used, cost and water supply are important factors in assuring adequate infant feeding standards. In remote communities formula is more expensive than metropolitan areas and supply can be challenging during seasonal weather events when transport routes are cut. Health workers need to be culturally sensitive in promoting the benefits of breastfeeding in communities.

### Structural determinants

#### Restricting advertising and promotion of infant formula

The World Health Organization’s (WHO) *International Code of Marketing of Breast-milk Substitutes* (“the WHO Code”) (World Health Organization, 1981) seeks to protect and promote breastfeeding within a broader agenda of maternal and child health, by seeking to address factors affecting the prevalence and duration of breastfeeding. This is in recognition of the fact that breastmilk and infant formula are not interchangeable substances due to their different compositions and that marketing and promotion of infant formula undermines breastfeeding.

The infant formula industry is large and growing globally. Sales volume per child is increasing, with positive associations seen between growth and country income level, according to the Lancet (Rollins, 2016). Other countries have varying initiatives and levels of legislative enforcement of the WHO Code. When comparing breastfeeding policy and initiatives between the USA and UK, the Lancet found that legislative enforcement of the WHO Code is not necessarily going to improve breastfeeding rates.

Australia currently has several mechanisms in place that only partially implement to the WHO Code and many of these measures are voluntary. The *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement* (the MAIF Agreement) gives effect in Australia to the principles of the Code. The MAIF Agreement is a voluntary, self-regulatory, code of conduct between the manufacturers and importers of infant formula in Australia and only applies to signatories to the MAIF Agreement. The MAIF Agreement is limited to the marketing of infant formula for infants up to 12 months of age, therefore allowing advertising of toddler formulas. The MAIF Agreement does not apply to retailers and distributors, such as supermarkets and pharmacies. Compliance with the agreement is monitored by the public who submit complaints against the MAIF Agreement to the Australian Government Department of Health. The Department of Health considers whether complaints are in-scope or out-of-scope of the MAIF Agreement. If determined as in-scope, the complaints are submitted to an independent MAIF Complaints Tribunal to determine if the in-scope complaints are in breach of the MAIF Agreement. Currently, the Australian Government has aimed to reduce regulatory burden on industry and therefore it

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(Australian Health Ministers’ Advisory Council, 2017). This is just one example of the increased benefits attributed to breastfeeding within vulnerable populations.
would be unlikely that mandatory regulations for the advertising of infant formula would be implemented. However, a review of the MAIF Agreement complaint system was undertaken in 2017 and stakeholder feedback will be considered in options for potential amendments to the complaints system for the MAIF Agreement.

Another measure is inclusion in the Food Standards Australia New Zealand (FSANZ) Code of mandatory labelling and composition provisions for infant formula, consistent with the WHO Code. Under Standard 2.9.1 of the Australia New Zealand Food Standards Code, labels of infant formula products must contain a statement that a doctor or health worker should be consulted before deciding to use the product. (NHMRC, 2012) Standard 2.9.1 is currently under review.

The Infant feeding guidelines for Health Workers (NHMRC, 2012) also includes guidance for health workers on interpreting the WHO Code in Australia. These guidelines state that ‘health workers have a responsibility to promote breastfeeding first but, where it is needed, to educate and support parents about formula feeding and to respect a mother’s informed decision not to breastfeed should be respected and supported’. Health workers should demonstrate feeding with infant formula to mothers or other family members who need to use it and health workers should explain the hazards of improper use of infant formula.

**Breastfeeding in public**

Although breastfeeding in public is protected in Australia, many mothers perceive or experience a cultural environment that is unsupportive of this. This can be a deterrent to breastfeeding.

In Australia, the Commonwealth Government and all state and territory governments have introduced laws to protect mothers from discrimination and harassment on the basis of breastfeeding (Australian Human Rights Commission, 2014).

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Legislation</th>
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<tbody>
<tr>
<td>Commonwealth</td>
<td>Sex Discrimination Act 1984</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Discrimination Act 1991</td>
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<tr>
<td>New South Wales</td>
<td>Anti-Discrimination Act 1977</td>
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<tr>
<td>Northern Territory</td>
<td>Anti-Discrimination Act 1996</td>
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<td>Queensland</td>
<td>Anti-Discrimination Act 1991</td>
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<tr>
<td>South Australia</td>
<td>Equal Opportunity Act 1984</td>
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<tr>
<td>Tasmania</td>
<td>Anti-Discrimination Act 1998</td>
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<tr>
<td>Victoria</td>
<td>Equal Opportunity Act 2010</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Equal Opportunity Act 1984</td>
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Table 2: National and local laws to protect mothers from discrimination and harassment on the basis of breastfeeding (Australian Human Rights Commission, 2014)

This means that it is illegal to discriminate against a woman because she is breastfeeding. Mothers must not be asked to stop breastfeeding in public places and employers must make reasonable accommodation for breastfeeding employees (Brodribb, 2012).
The Evidence Check examined the use of social marketing in influencing public acceptance of breastfeeding in public. It found that while there was some evidence that public awareness can be modified by acceptance campaigns, it can be costly to sustain these interventions long enough to change behaviour (Smith et. al., 2018). Therefore social marketing should be viewed as a medium to longer term strategy.

**Breastfeeding and the media**

Mass media influences community attitudes towards parenting, child care and infant feeding. Breastfeeding is often portrayed as being problematic or difficult and formula milk and bottle feeding as normal (Brown, 2017). The active and aggressive promotion of breast milk substitutes by their manufacturers and distributors continues to be a substantial global barrier to breastfeeding (McFadden, et al., 2016).

Promotion of breastfeeding often becomes about breastmilk, leaving the mother out.

“By placing breastfeeding focus on the biomedical and nutritional benefits of breast milk, as opposed to maternal experience associated with nursing her infant, health care providers are perpetuating the patriarchal conceptualization of the ‘good mother’ as one who is defined as selflessly giving by nursing her child while asking for nothing in return.” (Benoit, Goldberg, & Campbell-Teo, 2016)

**Settings**

**In hospital support (BFHI)**

The UNICEF/WHO Baby Friendly Hospital Initiative (BFHI) is a quality-of-care intervention based on the evidence-based ‘Ten Steps to Successful Breastfeeding’ (World Health Organization and UNICEF, 2018). Each ‘Step’ addresses an organisational or clinical practice within the hospital system: from creating organisation-wide breastfeeding policies and practices that are disseminated to all staff, through individualised support that addresses pregnant, birthing and postnatal women and babies’ needs and culminating in a seamless transition into community services (Smith et. al., 2018). The Evidence Check found that individually and more so in combination, these Ten Steps reduce such barriers and create a more enabling environment in which a mother-baby dyad can establish breastfeeding and lactation (Smith et. al., 2018).

In 2017, only 23 percent of maternity facilities in Australia were accredited. Qualitative research has found that while there was a positive perception of the BFHI among stakeholders, its expansion in Australia had been negatively influenced by intangible government support and suboptimal capacity building. Prioritisation, stakeholder collaboration and adequate resourcing of the BFHI are required. (Atchan, 2017)

**Health care providers’ influence and skills**
All health workers in Australia have an important role in promoting and supporting breastfeeding as the first option. Systematic review evidence supports that education and training of health care workers results in improved knowledge of breastfeeding (Smith et. al., 2018). Anecdotal evidence indicates that mothers received inaccurate advice from health professionals on infant feeding. For example, mothers gave examples of the lack of support in hospital to establish breastfeeding. Mothers indicated they were offered formula as the first option even if they had not requested it and this reduced their breastmilk supply (Department of Health, 2017).

Family support

The Evidence Check found evidence that attitudes and beliefs of grandmothers/in-laws and partners about breastfeeding and formula are major influences on infant feeding in the first few weeks of a baby’s life. It could be very hard for a new mother to carry on breastfeeding if she did not get support from her family.

- A 2016 systematic review by Negin investigated grandmother influence on a mother’s breastfeeding practices (in high, middle and low-income countries) and found there was a significant positive impact on breastfeeding when grandmothers had had their own breastfeeding experience or were more positively inclined towards breastfeeding. (Smith et. al., 2018)

- A randomised controlled trial by Maycock involving education and support for fathers conducted in 8 public maternity hospitals in Australia found that a minimal intervention involving 2-hour antenatal education session and postnatal support provided to fathers significantly increased any breastfeeding at 6 weeks. Infants with older fathers were more likely to be breastfed at 6 weeks than infants of younger fathers, as were infants with fathers of high socio-economic status compared to infants with fathers of low socio-economic status (Smith et. al., 2018).

Returning to work

Earnings from employment are an important financial incentive and significant economic determinant of infant feeding practices and in Australia, hence breastfeeding rates are lower among employed mothers (Smith et. al., 2018). Since 2007, Australian studies have also found that having workplace settings permitting reduced and flexible hours, access to breaks and a supportive workplace culture on return to work is effective in supporting breastfeeding among employed women (Smith et. al., 2018).

As part of the consultation process in the development of this Strategy, women provided examples of the challenge of balancing motherhood and returning to work. While some mothers are able to stay home for at least 12 months, some mothers have to return to work early for financial reasons. Women who have had to return to work early spoke of the stress, guilt and anxiety of leaving their child and of their reduced milk supply. Women cited the following barriers to breastfeeding at work: negative attitudes for needing time to express milk; no paid lactation breaks; and pumping difficulties (Department of Health, 2017).
Some women acknowledged the support provided by flexible work arrangements and the Paid Parental Leave (PPL) Scheme. One mother said, “I can without a doubt, say that were it not for [the PPL] there is no way I would have continued breastfeeding as long as I did.” This is supported by the PPL evaluation which found that while PPL appears to have had no impact on already high breastfeeding initiation rates, there was a small increase in the proportion of mothers who were still breastfeeding when their child was six months and older (Institute for Social Science Research, 2014).

**Individual factors**

**Maternal confidence and self-efficacy**

Breastfeeding is not a one-time decision made in hospital. It requires ongoing commitment that is regularly challenged and reassessed. Maternal confidence in the ability to initiate and keep breastfeeding results from a dynamic interaction between each woman’s expectations, the physical aspects of breastfeeding, her baby’s breastfeeding behaviour, sources of support and the complex social context within which breastfeeding and motherhood is embedded. A woman’s resilience and confidence in her ability to overcome encountered problems is also a determinant of breastfeeding success. Going into breastfeeding with more realistic than idealistic expectations contributes to more maternal confidence, self-efficacy and ultimately breastfeeding success (MacKean, 2012).

**Antenatal and postnatal support**

The Pregnancy Care Guidelines recommend that health professionals routinely offer education about breastfeeding as part of antenatal care. This is because there is evidence from randomised controlled trials that breastfeeding initiation rates and, in some instances, breastfeeding duration can be improved by antenatal breastfeeding education, particularly if this is interactive and takes place in small informal groups. One-to-one counselling and peer support in the antenatal period are also effective (Department of Health, 2018).

The Pregnancy Care Guidelines also recommend including psychological preparation for parenthood as part of antenatal care as this has a positive effect on women’s mental health postnatally (Department of Health, 2018). The prevalence of postnatal depression in the 1973-78 cohort of the Australian Longitudinal Study of Women’s Health (ALSWH) was almost 16% of 5,219 mothers. Breastfeeding for less than six months was one of the factors associated with postnatal depression. (Holden L, 2013) Recent research which aimed to identify the causal effect of breastfeeding on postpartum depression found that the effect of breastfeeding on postpartum depression differed according to whether women had planned to breastfeed their babies and by whether they had shown signs of depression during pregnancy. For mothers who were not depressed during pregnancy, the lowest risk of postpartum depression was found among women who had planned to breastfeed, and who had actually breastfed their babies.

Evidence shows that education; counselling and support are effective in the antenatal, extended postnatal period and both periods combined. Ongoing one-to-one education/counselling/support especially in the postnatal period, over a long duration is an effective method of promoting breastfeeding. (Smith et. al., 2018)
Physical challenges of breastfeeding

Breastfeeding may be associated with mild to severe physical discomfort and pain. The intensity and duration of this may be enough of a disincentive for women to stop breastfeeding (Kelleher, 2006). Such negative experiences can impact on the mother-child relationship and future determination to breastfeed, and be interpreted by the mother as failure at motherhood (Brodribb, 2012).

Further physical factors that negatively influence initiation and duration of breastfeeding include maternal obesity prior to getting pregnant; maternal diabetes; low infant birthweight or prematurity; multiple birth; and congenital anomalies.

The cost of breastfeeding

Whilst breastfeeding is considered a free and convenient method of feeding a baby, it does have high time costs for mothers. Research using time use data suggests that exclusively breastfeeding mothers spend approximately 18 hours per week on average breastfeeding their infant, an additional 3.3 hours compared to mothers who had introduced infant formula or other foods (Smith & Forrester, 2013).

The intensive time and energy required by mothers to breastfeed their infant, creates economic costs that are not recognised by the current economic environment and may contribute to premature weaning before six months of age. Gaining the public health benefits of exclusive breastfeeding requires strategies to share maternal lactation costs more widely, such as additional help with housework or caring for children, enhanced leave and workplace lactation breaks and suitable child care (Smith & Forrester, 2013).

Peer support and networks

The Evidence Check found that community-based breastfeeding peer counsellor support is well established as improving breastfeeding duration and exclusive breastfeeding, particularly in countries with high initiation rates and where substantial training is provided for peer counsellors. (Smith et. al., 2018)

In Australia, the Australian Breastfeeding Association (ABA) is funded to deliver peer support through a national 24-hour toll-free helpline staffed by trained volunteer breastfeeding counsellors. The 2012 evaluation of ABA’s Breastfeeding Helpline found high levels of satisfaction, and reports of improved breastfeeding outcomes. Economic evaluation provided evidence supporting the cost-effectiveness of the volunteer service from the health funder perspective but there was no evaluation of the sustainability and long term impact of this service delivery model on the organisational infrastructure. (Smith et. al., 2018)

“Utilizing only medical evidence to promote ‘breast is best’ fails to recognize the experience of the mother and the social constraints that breast feeding imposes on personal and professional facets of a woman’s life”. (Benoit, Goldberg, & Campbell-Teo, 2016)
An enabling environment for breastfeeding

Rather than considering breastfeeding as an individual issue that the mother is solely responsible for, breastfeeding must be considered a public health issue that requires investment at a societal level. Focusing solely on solving individual issues will not lead to the cultural changes needed to normalise breastfeeding. Countries that have adopted a multi-component public health strategy to increase breastfeeding levels have had significant success (Brown, 2017).

Brown (2017) suggests the following key investment areas:

- **Health services provision** – Women need better knowledge and enhanced support during the antenatal, birth and postnatal period from well-qualified, knowledgeable staff.

- **Societal public health messages** - Societal experience, knowledge and understanding of infant feeding is often heavily weighted towards bottle feeding and around a third of the public in the USA, UK and Australia consider that a baby should not be breastfed in public. Interventions to improve breastfeeding should not be targeted solely at the mother but should include fathers, grandmothers, and wider public health campaigns.

- **Policy and law to protect breastfeeding mothers** – Mothers in Australia are protected by law to breastfeed their infants in public however, despite this many women report receiving negative comments. Increased maternity leave is associated with longer breastfeeding duration. Workplace policies that support mothers to return gradually to work and ensuring that workplace regulations, such as paid lactation breaks, are in place are important.

- **Protection of maternal wellbeing** – Greater investment is needed more widely into supporting new mothers. Mothers need to feel socially supported in their new role. Enhancing community support for new mothers would likely reduce postnatal depression and enhance breastfeeding rates.

- **Reducing the reach of the breastmilk substitute industry** – Governments must take responsibility for ensuring that the WHO Code is met. Simple interventions such as preventing hospitals from advertising products in discharge bags increase breastfeeding. A more active approach is needed in using similar tactics as those used by formula companies to promote breastfeeding.

“We need to get people to understand what breastfeeding is really like, why it is important and why we need to support it. We need to get everyone to recognise their small part in the bigger jigsaw puzzle of the societal responsibility for breastfeeding. We need to stop blaming mothers and realise what we’re doing to their chances of successfully feeding their babies in the way they want”. (Brown, 2016)

The Evidence Check found that integrated, coordinated strategies work better than uncoordinated single interventions, because of the need to maximise beneficial synergies between components (Smith et. al., 2018) and provided the example of the ‘Breastfeeding Gear’ model. This ‘complex adaptive systems’ approach involved strategies which protected, promoted and supported breastfeeding throughout a life stage continuum – from
pre-pregnancy to birth, the postnatal period, and childhood – and in multiple settings (such as outpatient services, clinics and other health facilities). Effective strategies involved, for example, increasing community awareness regarding breastfeeding, hospital or health system support through the BFHI, and hope and family support through counselling. Counselling by peers or health personnel, baby friendly hospital support and community mobilisation were identified as key interventions to promote optimal breastfeeding practices.
PART 3: A NATIONAL BREASTFEEDING STRATEGY FOR 2018 AND BEYOND

About this Strategy

This Australian National Breastfeeding Strategy: 2018 and Beyond seeks to build on the lessons learned from the Australian National Breastfeeding Strategy 2010-2015 and provide a national roadmap to improve breastfeeding rates in Australia. It has been developed in collaboration with all states and territories and in line with national and international policies on breastfeeding.

The Australian National Breastfeeding Strategy: 2018 and Beyond seeks to achieve the WHO’s global nutrition target of increasing the rate of exclusive breastfeeding in the first six months up to at least 50% by 2025. The Strategy aims to promote, support and protect breastfeeding as the biological and social norm and the routine method for infant and young child nutrition by making it the easier option for mothers.

The Australian National Breastfeeding Strategy: 2018 and Beyond fits within the AHMAC’s Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health, the overarching policy that draws together other frameworks and policies that relate to child and youth health. The Healthy, Safe and Thriving Framework was developed as an evidence-based and measurable set of national priorities in continuing and emerging health issues for children and young people. Strategic Priority One aims to equip children and young people with the foundations for a healthy life and one of the actions to achieve optimal health is to increase breastfeeding rates.

Figure 3: Links between the Strategy and other national child and youth health policies

The Australian National Breastfeeding Strategy: 2018 and Beyond is intended to guide Australian states and territories’ breastfeeding policies and guidelines and align or work towards relevant international policies on breastfeeding identified in Figure 4.
The Australian National Breastfeeding Strategy: 2018 and Beyond is also intended to contribute to the achievement of the Sustainable Development Goals (Figure 5). In 2015, countries adopted a set of 17 Sustainable Development Goals to end poverty, protect the planet and ensure prosperity for all as part of a new sustainable development agenda (United Nations, 2015).

Breastfeeding has the strongest links to sustainable development goals 2 (zero hunger) and 3 (good health and well-being). The benefits of breastfeeding are observed in both child and mother, with evidence showing both short and long-term health benefits. The link between breastfeeding and intelligence also links breastfeeding to goals 1 (poverty), 4 (education), 8 (promote inclusive and sustainable economic growth) and 10 (reduced inequalities).
Audience

The Australian National Breastfeeding Strategy: 2018 and Beyond is designed to be used as a resource across governments at all levels, policy makers, stakeholder organisations, the public and private health sectors, industry, researchers and academics, families and communities as a tool to promote and support breastfeeding. The Strategy provides guidance on evidence-based approaches to promote, support, protect and monitor breastfeeding.

Timeframe

The Australian National Breastfeeding Strategy: 2018 and Beyond is enduring with no end date, however periodic reviews of the evidence are proposed to be undertaken every five years. It is also proposed that the Strategy Logic be reviewed every two years and that an evaluation of the Strategy is undertaken every five years. Further information on Program Logic is in Part 4: Monitoring and Evaluation Framework.

Governance

It is proposed that the Department of Health establish a national coordination body responsible for implementing the Australian National Breastfeeding Strategy: 2018 and Beyond. This group would oversee activities, establish a national system to monitor breastfeeding in Australia, monitor progress and report every two years to Australian Health Ministers on the achievement of the Strategy’s intended outcomes.
The Strategy

Vision

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

Objectives

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

Principles

1. **Mother, Child and Family** – The mother and child should be central to all breastfeeding activities but the woman’s partner and other family members enable support for the initiation and duration of breastfeeding.

2. **Ecological Context** – Breastfeeding is influenced by a range of family, social, cultural, economic and environmental factors and is a public health issue, not an individual woman’s issue. Governments should invest in integrated, multi-level strategies to protect, promote and support breastfeeding.

3. **Access** – All members of a community should have universal and timely access to evidence informed, appropriate information and services provided by skilled health professionals and peer support counsellors that protect, promote and support breastfeeding.

4. **Diversity** – The diversity of Australian families should be targeted through breastfeeding promotion and support activities that are sensitive and responsive to health literacy, individual circumstances and culture.

5. **Integrated Care** – Services and health professionals should work in partnership with women and their families and other support services to provide holistic and evidence-based care. Continuity of care at key transition points between antenatal, birth, and primary care and community health services is seamless from the perspective of mothers and their families and referring services.

6. **Evidence-based** – Governments should invest in clinical breastfeeding research to ensure that protection, promotion and support activities reflect the best available evidence, free of bias and conflicts of interest. Health professionals should provide evidence-based information education and support to mothers.

7. **Accountability** – There should be clear responsibility for breastfeeding protection, promotion, support and monitoring activities at local, state/territory and national levels, and appropriate consultation and collaboration with the community sector.

8. **Monitoring and data collection** - National breastfeeding data should be collected, monitored and reported to measure progress against the Strategy’s objectives.
9. **Protection** – There should be clear accountability of government, all health care and education institutions in protecting the community from inappropriate marketing and advertising of breast milk substitutes that fall within the WHO Code.

**Initiatives**

The *Australian National Breastfeeding Strategy: 2018 and Beyond* aims to provide women with an enabling and empowering environment that protects, promotes, supports and values breastfeeding as the biological and social norm for infant and young child feeding. This requires action to address the determinants of breastfeeding discussed in Part 2.

Table 3 presents the key initiatives proposed and supporting evidence based on the Evidence Check rapid review commissioned to inform the development of the Strategy (Smith et al., 2018).

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community education and awareness</strong></td>
<td>• There is overall evidence that mass media or social marketing campaigns can be effective in raising awareness but needs to be sustained long enough to effect behaviour change.</td>
</tr>
<tr>
<td>• Implement a national social marketing campaign</td>
<td>• A major UK evidence review (2009) recommended public health interventions for breastfeeding promotion, including national media campaigns and celebrity endorsements promoting breastfeeding and inclusion of breastfeeding education in the national curriculum for primary and secondary schools, parenting programs and child development courses.</td>
</tr>
<tr>
<td>• Promote breastfeeding champions and positive media images/ stories about breastfeeding</td>
<td>• There is a need to investigate cost effectiveness of ongoing large-scale media/social media campaigns, social marketing and counter marketing in high income countries in changing behaviour. There is also a need to investigate the effectiveness and cost-effectiveness of sustained school based social marketing or health education programs.</td>
</tr>
<tr>
<td>• Implement lactation education in schools</td>
<td>• Fully implementing the WHO Code into law or regulation is necessary and can be effective in restricting the marketing of breast-milk substitutes.</td>
</tr>
<tr>
<td><strong>Restriction of advertising of infant formulas</strong></td>
<td>• Reviews and expert consensus indicate that self-regulation is ineffective and legislation is necessary. However, effective enforcement</td>
</tr>
<tr>
<td>• Strengthen the Marketing in Australia of Infant Formula (MAIF) Agreement with effective monitoring and</td>
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</table>

Australian National Breastfeeding Strategy: 2018 and Beyond – Draft for public consultation - 21 -
<table>
<thead>
<tr>
<th>Settings</th>
<th>Initiatives</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| Australian National Breastfeeding Strategy: 2018 and Beyond – Draft for public consultation - 22 - | compliance measures. and public monitoring of compliance is also necessary. Adequate sanctions and penalties for noncompliance are important including loss of public reputation. | Dietary guidelines and growth charts  
- Update and promote the Infant Feeding Guidelines for Health Workers and the Australian Dietary Guidelines.  
- Embed the Infant Feeding Guidelines and the Australian Dietary Guidelines in health professional education and training. | National dietary or other guidelines or protocols, such as for infant feeding or growth monitoring also interact with health care delivery systems and health professional education and training, to strongly influence individual women’s infant and young child feeding practices. | Health professional education and training  
- Implement breastfeeding education and training for health professionals.  
- Implement a clinical breastfeeding research program. | There is evidence that education and training of health care workers results in improved knowledge of breastfeeding. The type of education and training that is most effective remains unclear.  
- Evidence of translation into improved practices and breastfeeding outcomes is more mixed and may depend on the attitudes and values of healthcare staff and perceived constraints in the hospital work setting. | Baby Friendly Health Initiative (BFHI)  
- Develop a work plan to include the BFHI in national accreditation. | There is strong evidence on the effectiveness of individual components of the BFHI in protecting breastfeeding initiation, duration and exclusivity in the early post-natal months.  
- The more BFHI steps are experienced by mothers in maternity facilities, the greater the effect on improved breastfeeding outcomes.  
- Evidence also supports the importance of discouraging supplementation and of ensuring mothers are connected to breastfeeding support in the community after discharge from hospital.  
- BFHI implementation may be more effective if implemented comprehensively through |
<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk banks</td>
<td>• Options to expand milk banks and for a national regulatory and quality framework are trialled.</td>
</tr>
<tr>
<td></td>
<td>• Systematic review evidence supports human milk banking as an intervention that facilitates transition towards breastfeeding.</td>
</tr>
<tr>
<td></td>
<td>• A 2013 expert review identified protection against necrotizing enterocolitis as its major clinical benefit. Limited data also suggested unfortified donor human milk is associated with improved feeding tolerance. It concluded that presence of a human milk bank does not decrease breastfeeding rates at discharge but decreases the use of formula during the first weeks of life.</td>
</tr>
<tr>
<td>Support for breastfeeding in the workplace</td>
<td>• Seek stakeholder engagement in providing breastfeeding-friendly workplaces.</td>
</tr>
<tr>
<td></td>
<td>• Interventions to address barriers to breastfeeding in work settings appear effective, including in Australia.</td>
</tr>
<tr>
<td></td>
<td>• Workplace programs cannot be relied on to provide equitable access to breastfeeding support for employed women. This is because most ‘at risk’ mothers, confronted by multiple barriers to breastfeeding, may be less likely to be employed in the ‘breastfeeding friendly’ and supportive work settings and occupations evaluated in such studies.</td>
</tr>
<tr>
<td>Support for breastfeeding in early childhood education and care settings</td>
<td>• Pilot and evaluate a Breastfeeding-Friendly Child Care program.</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding by mothers and infants or young children is likely to be higher in childcare settings where there are specific and active support strategies in place.</td>
</tr>
<tr>
<td></td>
<td>• Such strategies cannot be relied on to provide equitable access to breastfeeding education and support nor will interventions in these settings provide sufficient support to ‘at risk’ mothers and babies.</td>
</tr>
<tr>
<td>Universal breastfeeding education, support and information services</td>
<td>• Implement universal breastfeeding support services in the antenatal and postnatal periods delivered by health workers and community-</td>
</tr>
<tr>
<td></td>
<td>• Any additional education or support in the antenatal or postnatal periods increases breastfeeding initiation and duration, especially if delivery includes peer counselling support and a schedule involving several contacts in the postnatal period.</td>
</tr>
<tr>
<td></td>
<td>• Community-based breastfeeding peer counselling support is well-established as improving breastfeeding duration and exclusive</td>
</tr>
</tbody>
</table>
**Initiatives**

- Evidence-based peer supporters.
  - Provide support for partners and other family members.
  - Build on existing family support, parenting and mental health initiatives to support mothers and families in the postnatal period to deal with normal infant behaviours and challenges.

- Targeted/specialist breastfeeding support services
  - At risk mothers
  - Aboriginal and Torres Strait Islander women

**Evidence**

- Breastfeeding, particularly in countries with high initiation rates and where substantial training is provided for peer counsellors.
  - Limited systematic review and quasi-experimental evidence supports the effectiveness of interventions which improved social support for breastfeeding, such as by male partners or female relatives such as grandmothers.

- Evidence suggests that additional support targeted to at risk mothers may increase breastfeeding. Effectiveness is greater if peer counsellor support is also provided alongside health professional support and if delivered one-on-one and face-to-face.
  - There is a need for culturally sensitive interaction and communication and maternity and newborn care that is also integrated with programs addressing the multiple health and social issues which are barriers to optimal infant and young child feeding.

Table 3: Evidence for proposed initiatives in the Strategy
PART 4: MONITORING AND EVALUATION FRAMEWORK

Background

With the conclusion of the Australian National Breastfeeding Strategy 2010-2015, the Australian Government Department of Health was tasked by the Australian Health Ministers’ Advisory Council (AHMAC) in 2016 with the “development of an enduring framework for breastfeeding in Australia and for scoping of an enduring jurisdictional data reporting mechanism to enable national reporting of breastfeeding data in Australia”.

One of the guiding principles of the Australian National Breastfeeding Strategy 2010-2015 was that it would be Evidence-based. This was described as “protection, promotion and support activities are consistently informed by the best available evidence” and that “the percentage of breastfed babies is regularly monitored and activities are evaluated”. The 2010-2015 Strategy further stated that the Australian Government would be “responsible for providing national leadership and coordination and play a significant role in monitoring, research and evaluation frameworks” (Department of Health and Ageing, 2009). The development of ‘a new enduring framework for breastfeeding in Australia’ presents an opportunity for the Australian Government to include an enduring monitoring, research and evaluation framework.

As part of the Australian National Breastfeeding Strategy: 2018 and Beyond, a model for an ongoing, nationally consistent and representative mechanism for reporting breastfeeding practices in Australia is being developed. This includes nationally agreed definitions and reporting measures and an agreed model for collecting and reporting national breastfeeding statistics and a monitoring and evaluation framework.

Strategy Logic

The Evidence Check undertaken to establish the context and scope for the Strategy has informed the ‘theories of change’ depicted in the Strategy Logic for the Australian National Breastfeeding Strategy: 2018 and Beyond (Figure 6).

A Program Logic model is a tool to help design, plan, manage, monitor and evaluate a policy or program by depicting how a policy or program is intended to work. It sets out the underlying rationale, theories and assumptions about how a set of investments and actions are intended to achieve or contribute to desired outcomes. The Program Logic model is used as the basis for developing the Strategy Logic.
AIM: To provide women with an enabling and empowering environment that protects, promotes, supports, and values breastfeeding as the biological and social norm for infant and young child feeding.

Figure 6: Strategy Logic
## Monitoring and Evaluation requirements

### Purpose

The proposed Monitoring and Evaluation Framework for Breastfeeding in Australia will outline how the impact of the enduring *Australian National Breastfeeding Strategy: 2018 and Beyond* will be measured over time, including performance monitoring indicators and data collection, the points at which it will be evaluated and the key evaluation questions.

### Stakeholders

The Strategy represents a significant partnership across a range of interested stakeholders.

The following table forms an initial snapshot of the potential interests and roles of stakeholders in monitoring and evaluating the Strategy. The engagement of stakeholders in monitoring, data analysis and continuous learning is integral to the ongoing rollout and success of the Strategy.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Interest in Strategy</th>
<th>Interest/ role in Monitoring and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>COAG Health Council, Australian Health Ministers’ Advisory Council and Health Services Principal Committee</td>
<td>Oversee national health policy and fund and implement actions to promote and support breastfeeding</td>
<td>Fund nationally consistent data collection and monitoring systems – to get an accurate picture of national breastfeeding information</td>
</tr>
<tr>
<td></td>
<td>Interested in implementing cost-effective policies/strategies to improve health, wellbeing and economic outcomes</td>
<td>Learn which interventions/strategies are effective in increasing breastfeeding rates to inform future policy development.</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Develop a Strategy which contributes to increased breastfeeding rates and improved population health outcomes</td>
<td>Develop monitoring and evaluation framework</td>
</tr>
<tr>
<td></td>
<td>National coordination of Strategy’s implementation, monitoring and evaluation</td>
<td>Coordinate national data collection and reporting – to get an accurate picture of national breastfeeding information.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learn which interventions/strategies are effective in increasing breastfeeding rates to inform future policy development.</td>
</tr>
<tr>
<td>State and territory</td>
<td>Collaborate in development of</td>
<td>Oversee jurisdictional data</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Interest in Strategy</td>
<td>Interest/ role in Monitoring and Evaluation</td>
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</tr>
<tr>
<td><strong>departments responsible for maternal, child and family health programs</strong></td>
<td>the national Strategy&lt;br&gt;Develop/ update state/territory breastfeeding policies/ guidelines based on the national Strategy&lt;br&gt;Fund and manage state and territory based initiatives&lt;br&gt;Improve child and maternal health outcomes</td>
<td>collection and reporting processes&lt;br&gt;Learn which interventions/ strategies are effective in increasing breastfeeding rates to inform future policy development.</td>
</tr>
<tr>
<td><strong>Health services that deliver maternal, child and family health programs</strong></td>
<td>Implement strategies to influence breastfeeding rates and child and maternal health outcomes</td>
<td>Collect data to contribute to local and national datasets&lt;br&gt;Learn which interventions/ strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td><strong>Australian Bureau of Statistics/ Australian Institute of Health and Welfare</strong></td>
<td>National breastfeeding data collection and reporting</td>
<td>National data collection and reporting</td>
</tr>
<tr>
<td><strong>National Health and Medical Research Council</strong></td>
<td>Maintain currency of dietary guidelines for infants</td>
<td>Participate in evaluation&lt;br&gt;Learn which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td><strong>Australian Breastfeeding Association</strong></td>
<td>Provide community education and counselling through the National Breastfeeding Helpline, face-to-face through local ABA groups, Live Chat, and education for health workers and health professionals.&lt;br&gt;Administer the Breastfeeding Friendly Workplace Program</td>
<td>Participate in evaluation&lt;br&gt;Learn which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td><strong>Australian College of Midwives</strong></td>
<td>Host to the Baby Friendly Health Initiative</td>
<td>Data collection and reporting on BFHI</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Interest in Strategy</td>
<td>Interest/ role in Monitoring and Evaluation</td>
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</tr>
<tr>
<td>Professional associations and colleges</td>
<td>Interested in how midwives can support early initiation of breastfeeding and improve child and maternal health outcomes.</td>
<td>Provide input to evaluation Learning about which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td>Australian Private Hospitals Association</td>
<td>Assess health professionals’ current knowledge, attitudes and skills relevant to breastfeeding.</td>
<td>Learn about effective interventions for health professional education on breastfeeding</td>
</tr>
<tr>
<td></td>
<td>Develop effective professional education and training programs on breastfeeding.</td>
<td>Build the evidence base on breastfeeding education and training for health care staff.</td>
</tr>
<tr>
<td>Australian Healthcare and Hospitals Association</td>
<td>Represents the broad continuum of healthcare services including area, regional and district health services, hospitals, community and primary health centres, aged and extended care facilities</td>
<td>Learn which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td>Childbirth and Parenting Educators of Australia</td>
<td>Support childbirth and parenting educators as they strive to provide high quality, accessible and responsive education to women and their families during pregnancy and early parenthood</td>
<td>Learn which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td></td>
<td>Interested in improving child and maternal health outcomes.</td>
<td></td>
</tr>
<tr>
<td>Women’s Healthcare Australasia</td>
<td>Peak body for hospitals and health care services caring for women and babies in Australia</td>
<td>Learning about which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Interest in Strategy</td>
<td>Interest/ role in Monitoring and Evaluation</td>
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</tr>
<tr>
<td><strong>Australian Association of Parenting and Child Health</strong></td>
<td>Represents organisations that work with parents and children from 0-5 years and provides advice on breastfeeding</td>
<td>Learning about which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td><strong>Universities and research institutes</strong></td>
<td>Undertake research on breastfeeding interventions</td>
<td>Build the evidence base on effective strategies to increase breastfeeding rates</td>
</tr>
<tr>
<td><strong>Businesses/ Workplaces</strong></td>
<td>Support women to continue breastfeeding on return to work</td>
<td>Learn which interventions/strategies are effective in supporting women returning to work to continue breastfeeding</td>
</tr>
<tr>
<td><strong>Children and family services/ child care centres</strong></td>
<td>Deliver parenting, family support, and early childhood education and care services and their role in supporting breastfeeding and improving child and maternal health</td>
<td>Learn which interventions/strategies are effective in increasing breastfeeding rates</td>
</tr>
<tr>
<td><strong>Women and their families</strong></td>
<td>Consumers of services – interest in a supportive/ enabling environment for child-rearing</td>
<td></td>
</tr>
<tr>
<td><strong>Infant Nutrition Council</strong></td>
<td>Industry body representing infant formula manufacturers</td>
<td></td>
</tr>
</tbody>
</table>

**Governance/management arrangements**

The Strategy recognises the shared aims and responsibilities for its successful implementation and the interests and role of stakeholder partners in monitoring and sharing progress and learning over time. It is proposed that the Department of Health provide national coordination of monitoring and evaluation activities in close consultation with key stakeholders, through a national breastfeeding coordination committee.

It is proposed that the national breastfeeding coordination committee will include representatives from all states and territories, health professional associations, maternal, child and family health service providers, researchers, consumers, and data experts.

**Evaluation approach**

**Overall evaluation approach**

It is proposed that an initial evaluation of the Australian National Breastfeeding Strategy: 2018 and Beyond be conducted in 20xx and every three years thereafter. Evaluation
findings will be used to assess the extent to which the intended activities and outcomes are being achieved and to inform future resource allocation and direction.

Key evaluation questions
To be finalised in June/July 2018

Key evaluation activities and schedule
To be finalised in June/July 2018

<table>
<thead>
<tr>
<th>Type of evaluation</th>
<th>Methodology</th>
<th>Internal/external</th>
<th>Budget/resources (if external)</th>
<th>Responsible person/s</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Ethical considerations
To be finalised in June/July 2018

<table>
<thead>
<tr>
<th>Ethics approval required?</th>
<th>Reason</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, document who will be responsible for obtaining ethics approval (if known). If no, document reasons why ethics approval is not required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Monitoring and Data Collection approach

Approach to monitoring

Monitoring progress of the Strategy is based on the program logic and encompasses three main elements: 1.) changes in breastfeeding practices (long-term outcomes), 2) tracking the progress of Strategy implementation, and 3) capturing the intermediate changes (short to medium-term outcomes) that connect the achievement of activities with the positive changes and influences that lead to improved breastfeeding outcomes.

The approach to monitoring and data collection will be finalised in June/July 2018.

STRATEGY IMPLEMENTATION

Monitoring implementation of the Strategy will enable stakeholders to reflect on what areas are and aren’t being progressed and what’s working well. The proposed approach is to broadly capture the development and roll out of the proposed activities considering:
1. **Engagement and participation** – the level of engagement and participation fostered by relevant stakeholders in the initial stages of activity development and then implementation over time.

2. **Resources** – the resources harnessed to initiate and progress activities.

3. **Activities** – the level of progress in developing and implementing individual activities and the quantum and quality of outputs being achieved.

Specific indicators will likely be developed at the level of individual activities and aggregated at the Strategy level to track overall progress of Strategy implementation over time.

**INTERMEDIATE OUTCOMES (SHORT TO MEDIUM-TERM)**

To be finalised in June/July 2018

**BREASTFEEDING PRACTICES (LONG TERM OUTCOMES)**

Monitoring breastfeeding practices in Australia relies on a range of existing national data collections that together enable the measurement of breastfeeding practice over time (see Data Sources below). Each component has a variety of sub-components/collections that together provide an overarching picture of breastfeeding in Australia. The proposed approach should, where possible:

- Be capable of measuring breastfeeding indicators based on a nationally agreed indicator set;
- Leverage off pre-existing data collections;
- Enable consistent and statistically reliable reporting by state and territory, region (metro, rural, remote) and socio-economic status; and
- Enable reporting of trends.

The strategic priorities for monitoring and evaluation are based on the breastfeeding continuum, beginning from the antenatal period (intention to breastfeed), the birth (initiation of breastfeeding), and the period from around 6 months when solids are introduced to around 12 months to 2 years and beyond (duration of breastfeeding). Potential data sources for each stage are nominated below:

<table>
<thead>
<tr>
<th>Stage of the breastfeeding continuum</th>
<th>Potential data source</th>
</tr>
</thead>
</table>
| Intention                           | National Perinatal Data Collection  
                                        Australian Immunisation Register  
                                        Digital Child Health Record        |
| Initiation                          | National Perinatal Data Collection  
                                        Digital Child Health Record        |
| Duration                            | Australian Immunisation Register  
                                        Digital Child Health Record  
                                        National Health Survey  
                                        Australian National Infant Feeding Survey |
A Data Matrix at Attachment A defines relevant indicators, measuring and potential data sources.

**Data Sources**

Changes in breastfeeding practices will be analysed drawing on a number of existing data sources:

1. A national reporting system
   - The National Perinatal Data Collection
   - The Australian Immunisation Register
   - The National Health Survey
   - The Australian National Infant Feeding Survey
   - The Digital Child Health Record

2. National longitudinal studies
   - The Longitudinal Study of Australian Children
   - The Australian Longitudinal Study on Women’s Health

3. State and territory data collections
   - State and territory based surveys
   - State and territory based administrative data collections

**Utilisation and dissemination**

Use of data and findings

*How and when data and findings will be used – to be finalised in June/July 2018.*

**Reporting requirements**

<table>
<thead>
<tr>
<th>Report</th>
<th>Content</th>
<th>Frequency</th>
<th>Responsible person/s</th>
<th>Recipients</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Dissemination**

How evaluation findings and reports will be communicated to stakeholders and interested parties

<table>
<thead>
<tr>
<th>Communication Type</th>
<th>Content</th>
<th>Frequency</th>
<th>Responsible person/s</th>
<th>Recipients</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Research**

In addition to these core attributes, the approach should support research that provides a greater understanding of the barriers and enablers for breastfeeding and the efficacy and feasibility of new and innovative approaches.

**Budget and resources**
To be finalised in June/July 2018
## ATTACHMENT A: PROPOSED LIST OF INDICATORS – LONG-TERM OUTCOMES

<table>
<thead>
<tr>
<th>Outputs/Outcomes</th>
<th>Measures/indicators</th>
<th>Data sources/methods</th>
<th>When/how reported</th>
<th>Responsible person/s (data collection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased proportion of mothers who intend to breastfeed</td>
<td>Mother’s Intention to breastfeed</td>
<td>National Perinatal Data Collection</td>
<td>Collected at birth</td>
<td>Midwives/ other staff</td>
</tr>
<tr>
<td></td>
<td>Mother’s intention to breastfeed</td>
<td>Australian Immunisation Register</td>
<td>Women in their third trimester receiving vaccination for Whooping Cough/Pertussis</td>
<td>Nurses at General practices or Community health clinics</td>
</tr>
<tr>
<td>Increased proportion of children who were put to the breast within one hour of birth</td>
<td>Early initiation of breastfeeding</td>
<td>National Perinatal Data Collection</td>
<td>Collected at birth</td>
<td>Midwives/ other staff</td>
</tr>
<tr>
<td>Increased proportion of children who were ever breastfed</td>
<td>Breastfeeding status: nil, partial, full</td>
<td>Australian Immunisation Register</td>
<td>Infants receiving vaccinations at 2, 4, 6, 12 and 18 months of age</td>
<td>Nurses at General practices or Community health clinics</td>
</tr>
<tr>
<td></td>
<td>Ever received breastmilk</td>
<td>National Health Survey</td>
<td>Every 3 years Reports on children aged 0-24 months</td>
<td>ABS</td>
</tr>
</tbody>
</table>

Australian National Breastfeeding Strategy: 2018 and Beyond – Draft for public consultation
<table>
<thead>
<tr>
<th>Outputs/Outcomes</th>
<th>Measures/indicators</th>
<th>Data sources/methods</th>
<th>When/how reported</th>
<th>Responsible person/s (data collection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>proportion of children who are exclusively breastfed</td>
<td>6 months who are fed only breast milk</td>
<td>Immunisation Register</td>
<td>Receiving vaccinations at 2, 4, 6, 12 and 18 months of age</td>
<td>General practices or Community health clinics</td>
</tr>
<tr>
<td></td>
<td>Children aged 0-6 months who are fed only breast milk</td>
<td>National Infant Feeding Survey</td>
<td>Every 5 years</td>
<td>AIHW</td>
</tr>
<tr>
<td>Babies receive solid foods from 6 months</td>
<td>Age at which child first ate soft, semi-solid or solid food (4 months or less, more than 4 months to 6 months etc.)</td>
<td>National Health Survey</td>
<td>Every 3 years Reports on children aged 0-24 months</td>
<td>ABS</td>
</tr>
</tbody>
</table>
REFERENCES


United Nations. (2016). *Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to health, the Working Group on Discrimination Against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support*.


http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/


