- 8 MAR 2007

PUBLIC HEALTH ASSOCIATION
of Australia Inc
ABN 41 062 894 473

Submission no. 181
AUTHORISED: 28/3/07

The Hon Alexander Somlyay MP
Chairman
House Standing Committee on
Health and Ageing
House of Representatives
Parliament House
CANBERRA ACT

Dear Mr Somlyay,

House of Representatives Inquiry into Breastfeeding

The Public Health Association of Australia (PHAA) is a forum for the promotion of the health of the public as well as being a professional resource for public health personnel. The Association provides opportunities for the exchange of ideas, knowledge and information on public health and actively undertakes advocacy for public health policy, development, research and training. The PHAA is a non-party political organisation.

The PHAA welcomes this opportunity to provide a submission to the House of Representatives Standing Committee on Health and Ageing.

We believe that the public health benefits of breast-feeding are strongly supported by scientific evidence and encourage the Committee to develop recommendations that include the actions suggested by the PHAA on pages 7-9 of the attached submission.

PHAA's Women's Health Special Interest Group Co-Convenors, Dr Angela Taft and Dr Rhonda Small and others have specific expertise in this area and would be happy to discuss any issues arising from this submission with you. They can be contact through the PHAA Secretariat on (02) 62852373 or at plaut@phaa.net.au

Yours sincerely,

Pieta-Rae Laut
Pieta-Rae Laut
Executive Director
28 February 2007

20 Napier Close Deakin, ACT Australia, 2600 PO Box 319 Curtin, ACT Australia, 2605
Tel: (02) 6285 2373 Fax: (02) 6282 5438 Email: phaa@phaa.net.au www.phaa.net.au

Submission by the
Public Health Association of Australia
in response to the Federal Government Parliamentary Inquiry into Breastfeeding

Prepared by Dr Lisa Amir and Dr Debra Hector
for the Women's Health Special Interest Group, with input
from other members of the Association, and
endorsed by the Food and Nutrition Special Interest Group
and the Child Health Special Interest Group

The Public Health Association of Australia notes the following:

1) ***Breastfeeding is an extremely important public health issue***

a) Breastfeeding is the optimum method, the natural and most healthy way, of feeding infants. Breast milk is a perfectly balanced source of nutrition and contains a variety of nutrients and immunological factors that cannot be replicated [1, 2].

b) As breastfeeding is the natural way to feed infants, health professionals should refer to the risks of not breastfeeding, rather than the "benefits" of breastfeeding [3].

c) The health risks of not breastfeeding are many.

i) The evidence for the health risks of not breastfeeding is extensive and increasingly derived from good quality studies included in meta-analyses and systematic reviews [4].
ii) There is convincing evidence for increased gastrointestinal illnesses, otitis media, respiratory tract infections, and neonatal necrotizing enterocolitis in infants and children not breastfed [4]. There is evidence of a dose-response relationship, i.e. more intensive and longer breastfeeding is associated with the greatest health benefits. For example, there is strong evidence that breastfeeding is associated with a lower risk of breast cancer (premenopausal and postmenopausal) in proportion to the duration of breastfeeding in mothers [5-7]. Mothers who do not breastfeed are also at increased risk of ovarian cancer and rheumatoid arthritis [4].
iii) There is increasing evidence that feeding infants formula instead of breastmilk leads to higher incidence and prevalence of a number of chronic diseases and risk markers of chronic disease, including obesity, type 2 diabetes and atherosclerosis, in childhood and adulthood [4, 8].
iv) Exclusive breastfeeding for six months and a long duration of breastfeeding (for at least 12 months) confers optimal health protection to infants and mothers [9].

d) The poor health outcomes from not following recommended breastfeeding practices present a huge economic and social burden on individuals, families, and the health system [10, 11]. The poor health outcomes that breastfeeding protects against are among the major health problems in Australia and contribute significantly to the health burden.

e) Breastmilk contributes significantly to Gross Domestic Product in Australia, and yields a net economic benefit of a minimum of $2.2 billion each year in Australia [12, 13].

f) Breastfeeding is a human rights issue: infants have the right to human milk [14]. The Convention of the Rights of the Child requires governments to ensure that all segments of society, in particular parents, are informed about the risks of not breastfeeding [15].

g) When maternal milk isn't available, the use of banked human donor milk may significantly improve health outcomes and reduce health care costs in the neonatal intensive care unit [16-18]. Currently two milk banks are operating in Australia (one in Perth and one on the Gold Coast in Queensland); neither is supported by government funds. Support from governments, as well as from health professionals, is vital for the establishment of human milk bank facilities throughout Australia [19].

h) Although virtually all women are physically capable of breastfeeding, infant formula is necessary for infants under 12 months when human milk is not available. Infant formula is based on cow's milk or, in special circumstances, soy beans, modified to be suitable for young children. As a manufactured food it is at risk of errors in manufacture, and contamination during manufacture or in the home [20-23]. The World Health Assembly, in 2005, recognised "the need for parents and caregivers to be fully informed of evidence-based public-health risks of intrinsic contamination of powdered infant formula and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula" [24]. The so-called "follow-up milks" for infants over 12 months are not necessary as children can receive adequate nutrients from a mixed diet [25]. The use of infant formula incurs substantial environmental costs. These costs include deforestation, soil erosion, pollution and wasted resources [26].

i) The *International Code of Marketing of Breastmilk Substitutes* (the International Code) was adopted by the World Health Organization in 1981 as WHA resolution 32.22 by 118 member states; Australia voted in favour of the resolution (the USA alone voted against) [27]. The aim of the Code is to protect and promote breastfeeding and ensure proper use of breastmilk substitutes, when these are necessary. The Code prohibits all advertising and promotion of products to the general public, prohibits the use of the health care system to promote breastmilk substitutes, demands that product information be factual and scientific, and allows health professionals to receive samples but only for research purposes.

   Since 1981, there have been a number of World Health Assembly resolutions related to infant and young child feeding. In 1996, the World Health Assembly expressed concern that "health institutions and ministries may be subject to subtle pressure to accept, inappropriately, financial or other support for professional training in infant and child health" and urged countries "to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest . . . " [28] In 2002, the World Health Assembly endorsed the Global Strategy for Infant and Young Child Feeding [9] which called for renewed commitment by governments to implement the International Code [29].

j) The *Innocenti Declaration* was adopted by participants at the WHO/UNICEF policy makers meeting in Florence, Italy, in 1990, and endorsed by Resolution WHA 45.34. All governments were urged to develop national breastfeeding policies, set national targets, monitor prevalence of breastfeeding, appoint a national breastfeeding coordinator or appropriate authority and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-government organisations and health professional associations, ensure all maternity facilities fully practise the Ten Steps to Successful Breastfeeding take action to give effect to the principles and aim of the International Code, and protect the breastfeeding rights of working women [30]. Since then, the *Innocenti Declaration* has been re-issued and re-affirmed [31].

k) The *Baby Friendly Hospital Initiative* (BFHI) is a global program of WHO and UNICEF to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practice in accordance with the International Code [32]. In 1992, the World Health Assembly urged all countries to "encourage and support all public and private health facilities providing maternity services so that they become Baby Friendly" [33]. The 2005 *Innocenti Declaration* called for all governments to revitalise the BFHI and to expand the Initiative to include maternity, neonatal and child health services and community based support for lactating women and caregivers of young children [31]. The UK and USA are working towards making their community health services and paediatric units "Baby Friendly" [34, 35].

2) *Most mothers in Australia initiate breastfeeding but the majority of mothers cease breastfeeding early*

a) The NHMRC recommends that all babies are exclusively breastfed for the first six months of life, and, together with complementary food, continue to be breastfed until 12 months of age – and beyond if both mother and infant wish. [36]. The World Health Organization also recommends exclusive breastfeeding for the first six months of life, but extends the recommendation of continued breastfeeding with complementary foods for up to two years and beyond [1].

b) National data from the 2001 National Health Survey show that although most mothers in Australia (around 90%) initiate breastfeeding, the rate rapidly declines to less than half of all mothers breastfeeding at six months and less than a fifth breastfeeding for the recommended 12 months [37]. Rates of full breastfeeding to six months are also low. There are no national data on rates of exclusive breastfeeding to six months.

3) *There is no national monitoring of breastfeeding in Australia, and a lack of consistency in survey methods, analysis and reporting of breastfeeding data across Australia*

a) The 2001 document 'Towards a National System for Monitoring Breastfeeding in Australia' [38] highlights the need for, and was a first step towards, standardising the monitoring and reporting of breastfeeding practices in Australia. No data have been collected nationally since this document was released (the National Health Surveys occurred in 1995 and 2001), but several states, notably NSW and QLD have conducted state-level CATI surveys. No breastfeeding questions will be included in the next national nutrition and physical activity survey in 2007.

b) Several states are working towards electronic perinatal data collection, including infant feeding data, but there is no consistent approach.

4) *There is currently no strategic approach to breastfeeding support, promotion and research in Australia*

The requirement for a national peak body to oversee the promotion, protection and support of breastfeeding was outlined in the 1990 Innocenti Declaration [30] and reaffirmed in the Global Strategy for Infant and Child Feeding in 2003 [9]. Many countries have established national committees or peak bodies to ensure a strategic approach to breastfeeding promotion and research, including the following, but Australia has yet to do so.

New Zealand: http://www.moh.govt.nz/nbac;
Canada: http://www.breastfeedingcanada.ca/html/contents.html;
USA: http://www.usbreastfeeding.org/breastfeeding/index.htm;
Ireland: http://www.healthpromotion.ie/breastfeeding/national_committee/.

Some states have produced breastfeeding policies as a step towards state-level coordination of breastfeeding initiatives. For example, NSW Health released the breastfeeding policy directive: Breastfeeding in NSW: Promotion, Protection and Support in April 2006 [26]. This policy lists five strategic areas for action for the state health department and Area Health Services: (1) Organisational support for an enhanced, coordinated NSW Health effort; (2) Workplace development and provision of breastfeeding-friendly workplaces; (3) Provision of evidence-based health services; (4) Intersectoral collaboration with organisations outside of the NSW Health system; and (5) Monitoring and reporting of breastfeeding rates.

Eat Well Australia: An Agenda for Action for Public Health Nutrition 2000-2010, identifies 'Promoting breastfeeding and improving infant nutrition' as a national priority and sets out an agenda for action listing objectives, proposed actions, target groups and potential partners [39]. Little has been done to fund and coordinate this work.

There is no coordination of breastfeeding research in Australia. As such, the small amount of research that is funded in Australia occurs in a fragmented manner; no specific funding is available.

5) *Many factors affect breastfeeding behaviours, and some women are more at risk of not breastfeeding than others. Breastfeeding requires appropriate support.*

a) It is consistently and widely reported that young mothers, mothers without a tertiary education and mothers of a socio-economically disadvantaged background are substantially less likely to breastfeed or to maintain breastfeeding [40]. Breastfeeding rates vary among mothers from different culturally and linguistically diverse backgrounds [41-43]. There is increasing evidence that mothers who are overweight or obese are less likely to breastfeed and more likely to cease breastfeeding early [44, 45], as are women who return to work early after the birth of their child [46].

b) Breastfeeding is a natural act, but also a learned behaviour that can require effort and assistance to establish. There are physically challenging aspects of early breastfeeding [47]. Nearly all women can breastfeed provided they have appropriate social, emotional, informational and structural support. Many factors that are beyond the control of the individual affect a mother's intention to breastfeed and for how long she breastfeeds. Successful breastfeeding requires support from the baby's father and wider family and community [48, 49]. Some women feel uncomfortable breastfeeding in public places [50, 51].

6) *Evidence for effectiveness of some breastfeeding interventions is strong, but lacking in other areas*

a) There is strong evidence for the effectiveness of interventions to promote, protect and support breastfeeding that are aimed at the individual mother – mainly education (although not written information alone, which can be detrimental) and one-to-one support [52, 53]. Evidence is also strong for the effectiveness of interventions at the hospital services level – specifically the Baby Friendly Hospital Initiative (BFHI), particularly some of the individual steps of the BFHI (rooming-in, not giving supplementary feeds, early skin-to-skin contact, not giving hospital discharge packs containing formula or advertising formula), and the BFHI as a complete strategy [54-58]. Effectiveness appears to increase with increased compliance with all of the Ten Steps and it has been shown that monitoring for compliance with BFHI is necessary to promote the full effect of the BFHI [54]. The target areas for improvement in Australia are BFHI Steps 1b, 2, 7 and 10 [59]. Full

implementation of the BF Hospital Initiative, alone, is unlikely to be sufficient to ensure an adequate duration of breastfeeding [60, 61].

b) There is a lack of evidence internationally and in Australia surrounding the effectiveness of interventions to address the home, community, societal and environmental level determinants of breastfeeding behaviours (i.e. those interventions that provide support for the breastfeeding mother once she has left the hospital).

c) Significant numbers of women now combine early mothering with paid work – most often part-time – in the first year of their baby's life. The ILO Maternity Protection Convention 2000 (No. 183) entitles women to 14 weeks paid maternity leave and lactating women to one or two paid breastfeeding breaks per working day. However, not all working women receive maternity leave – paid or unpaid. The Australian Government Department of Health and Ageing has produced and disseminated resources which support *Balancing Breastfeeding and Work* [62, 63]; but the degree of implementation of this approach is unknown in Australia. Reports of success in workplace breastfeeding initiatives are gathering from the USA in particular, and other countries including the UK [46, 64-69].

7) *The Baby Friendly Health Initiative has limited momentum in Australia*

a) The number of hospitals in Australia now accredited (as of 18 November 2006) is 58: 23 in VIC; 11 in SA, 8 in QLD; 6 in TAS; 3 in the NT; and 2 each in NSW, WA and the ACT.

b) In Australia, the BFHI has been expanded to encompass the 'Seven point plan for the protection, promotion and support of breastfeeding in community health care settings' and has hence become the "Baby Friendly Health Initiative" to acknowledge this broader scope. The need for guidelines for good practice in paediatric units is not widely acknowledged.

8) *The WHO International Code has no authority in Australia, and monitoring of compliance is limited*

a) Although Australia was one of the original countries that voted to adopt the International Code, it has largely failed to implement resolution WHA34.22 which indicates that member states should 'translate the Code into national legislation, regulations or other suitable measures' and 'to monitor compliance with the Code'.

b) The Marketing in Australia of Infant Formula (MAIF) agreement is a voluntary agreement between the Australian Government and companies that import and/or manufacture breastmilk substitutes. Not all infant formula companies have signed the agreement and it only covers formulas for use in infants up to the age of 12 months. The agreement does not cover several aspects of the Code relating to, for example, the cessation of free and subsidised supplies of breast milk substitutes in the health care system, guidelines for the marketing of bottles and teats, and a code of marketing for retailers.

c) In 1992, the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) was established to monitor compliance with and advise the Government on the MAIF Agreement. The APMAIF brochure sets out the differences between the International Code of Marketing of Breast-milk Substitutes (International Code) and the MAIF Agreement. The brochure also contains guidelines for lodging complaints about alleged breaches of the MAIF Agreement and information about the Panel, including its terms of reference [70].

Limitations of the MAIF agreement include: the sales of formula not included in the agreement (e.g. pharmacy company brands); the promotion of follow-on formulas for infants over 12 months to the general public which keeps the brand name in the public arena; and the sale of teats and feeding bottles.

9) *New growth charts based on breastfed children are available*

In 2006, the World Health Organization launched new growth charts based on data collected from healthy breastfed infants in several continents [3, 71]. Previous growth charts have included infants fed infant formula. The new growth charts *may* be more appropriate for use in Australia than the current ones, although reservations have been expressed [72].

10) *Health professionals and consumers need accurate information about safe use of medicines for breastfeeding women*

There are very few medicines which are unsafe for breastfeeding women [36, 73]. The amount of maternal medicine an infant would receive is less than 1% of an infant dose for the vast majority of medications [74]. However, it is important that health professionals have access to up-to-date information on medications and breastfeeding.

The Public Health Association of Australia recommends that the following actions be undertaken:

11) A **peak body,** funded by the Federal Government, should be established at the national level to devise and co-ordinate a strategic approach to promoting, protecting and supporting breastfeeding in Australia and to support for Australian breastfeeding research. A broad range of stakeholders should be approached to provide input to this committee.

12) **State and local health services should establish broad coalitions** (including non-health and community partners) to support coordination of breastfeeding promotion, protection and support efforts. Such coalitions could be ultimately under the co-ordination of the national body.

13) Consensus and consistency in **monitoring breastfeeding** should be reached:
    a) A national working group with state and territory representatives should be established to reach consensus on the optimal monitoring and reporting of breastfeeding at the national, state and local levels.
    b) All State and Territory Government health departments should collect standardised data on population breastfeeding rates, using the agreed definitions and indicators of breastfeeding.
    c) A separate, facilities-based monitoring system in which breastfeeding rates at hospital discharge, along with other indicators, are measured over time with a view to improving health facility policies and practices should be coordinated to achieve consistency at the state and national level.
    d) Appropriate breastfeeding questions must be included in national health surveys.

14) Ongoing funding should be provided for **breastfeeding research** in Australia, particularly for evaluation of independent and cumulative effects of breastfeeding interventions aimed at individual, group (health services, home, work, and community, environments) and societal levels.

15) There should be policy and national funding support for routine implementation of the **Baby Friendly Health Initiatives**:
    a) Every maternity hospital in Australia should be required to be accredited as a Baby Friendly Hospital, to encourage breastfeeding as the norm.
    b) Ongoing monitoring of compliance with the Ten Steps should be implemented.
    c) The community section of the Baby Friendly Initiative needs to be implemented nationally.
    d) Baby Friendly guidelines for Australian paediatric units need to be developed and implemented.

16) **Training of all health professionals involved in mother and child health**, including midwives, community nurses, paediatricians, obstetricians, general practitioners, and others working with new parents (including education component of undergraduate and postgraduate medical degrees), needs to be nationally coordinated so that all relevant **health professionals are competent in supporting** women to establish and maintain breastfeeding:
    a) Nationally-consistent training materials need to be developed and regularly reviewed so that health professionals working with pregnant women and mothers provide consistent, up-to-date information on the risks of not breastfeeding, can provide clinical support for breastfeeding (including prevention and management of breastfeeding problems such as nipple pain, mastitis, etc), and understand the need for community support for breastfeeding.

b) Breastfeeding knowledge, clinical competence and attitudes of relevant health professionals need to be regularly audited and updated.

17) **Antenatal and postnatal breastfeeding education** should be provided as part of normal clinical care, including:
   a) Funding should be provided for the production and dissemination of nationally consistent, accessible information on breast and artificial feeding for parents and parents-to-be. Parents need to be aware of the risks of not breastfeeding and how to formula feed in a safe manner. Breastfeeding women need easy access to breastfeeding support and advice.
   b) Breastfeeding education and support, including evidence of continuity throughout the perinatal and postnatal periods, should be included in clinical governance and audit mechanisms.

18) There should be **legislative support** for breastfeeding at the environmental and societal level:
   a) All businesses and employers should provide flexible work practices, work breaks and facilities to allow employees to combine breastfeeding and work.
   b) Large organisations should be encouraged to provide on-site child care.
   c) Paid maternity leave to at least six months, and preferably 12 months, should be adopted nationally.
   d) Provision of parenting facilities (to enable breastfeeding) in public places, should be included in local government planning requirements for all large public amenities, such as shopping centres.

19) **Public education** is necessary to confirm women's right to breastfeed whenever and wherever a mother happens to be.

20) The Commonwealth, State and Territory health departments should move towards **mandating the International Code**, including:
   a) Mandate that free or subsidised supplies of breast milk substitutes and other products covered by the Code are not provided in any part of the health care system.
   b) Develop a code of practice or agreement in alignment with the Code for:
      i) manufacturers and importers of bottles and teats;
      ii) retailers and advertisers of breast milk substitutes; and,
      iii) manufacturers, retailers and advertisers of follow-on (toddler) formulas.
   c) Widely disseminate to health professionals information about their obligations under the Code.
   d) Encourage health professionals and other relevant professionals to report breaches of the MAIF agreement/ International Code.

21) **Sponsorship and conflict of interest** issues need to be addressed. Advocacy towards ensuring the following is recommended:
   a) Government departments and health professional organisations should not accept any funding or other support from infant formula manufacturers for health professionals' education, including conference sponsorship and exhibition.
   b) Editors and publishers of journals and magazines for health professionals should not accept infant formula advertisements [75].
   c) Editors and publishers of journals for health professionals should not accept manuscripts submitted by authors who have received funding or support from infant formula manufacturers.

22) Government should explore the best way to provide easily accessible evidence-based accurate information on **medicines for breastfeeding women** for health professionals and consumers.

23) Government should support, financially, the development and ongoing operation of **human milk banks** in all states and territories. Volunteer donor milk should be available free of charge to infants who require human milk.

24) Application of the new WHO **growth charts** in Australia should be explored.

The Public Health Association of Australia thanks the Federal Government for this opportunity to highlight the importance of breastfeeding to the health and well-being of all Australians; and to indicate what we consider to be the primary actions, based on the evidence and expert opinion, that the government might take to cost-effectively increase the number of infants breastfed according to recommended practice for optimal health in Australia.

References

1. World Health Organization. *Expert consultation on the optimal duration of exclusive breastfeeding. Conclusions and recommendations.* 2001 [cited; Available from: http://www.who.int/inf-pr-2001/en/note2001-07.html.
2. American Academy of Pediatrics Section on Breastfeeding, et al., *Breastfeeding and the use of human milk.* Pediatrics, 2005. **115**(2): p. 496-506.
3. Berry, N.J. and K.D. Gribble, *Breast is no longer best: the World Health Organization, the Multi-centre Growth Reference Study and normal infant feeding.* Aust N Z J Public Health, 2006. **30**(4): p. 387-89.
4. Allen, J. and D. Hector, *Benefits of breastfeeding.* NSW Public Health Bulletin 2005. **16**(3-4): p. 42-46.
5. Collaborative Group on Hormonal Factors in Breast Cancer, *Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50, 302 women with breast cancer and 96, 973 women without the disease.* Lancet, 2002. **360**: p. 187-195.
6. Shantakumar, S., et al., *Reproductive factors and breast cancer among older women.* Breast Cancer Res Treat, 2006: p. Oct 11 Epub ahead of print.
7. Kim, Y., et al., *Dose-dependent protective effect of breast-feeding against breast cancer among ever-lactated women in Korea.* Eur J Cancer Prev, 2007. **16**(2): p. 124-29.
8. Owen, C.G., et al., *Does breastfeeding influence risk of type 2 diabetes in later life? A quantitative analysis of published evidence* Am J Clin Nutr 2006. **85**(5): p. 1043-54.
9. World Health Organization. *Global strategy for infant and young child feeding.* 2003 [cited; Available from: http://www.who.int/gb/EB_WHA/PDF/WHA55/ea5515.pdf.
10. Drane, D., *Breastfeeding and formula feeding: a preliminary economic analysis.* Breastfeed Rev, 1997. **5**(10): p. 7-15.
11. Smith, J.P., J.F. Thompson, and D.A. Ellwood, *Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory.* Aust N Z J Public Health, 2002. **26**(6): p. 543-51.
12. Smith, J.P., *Human milk in Australia.*. Food Policy, 1999. **24**(1): p. 71-91.

13. Smith, J.P. and L.H. Ingham, *Breastfeeding and the measurement of economic progress.* Journal of Australian Political Economy 2001. **47**: p. 51-72.
14. Kent, G., *Child feeding and human rights.* Int Breastfeed J, 2006. **1**: p. 27.
15. General Assembly Resolution 44/25. *Convention on the Rights of the Child.* 1990 [Available from: http://www.ohchr.org/english/law/pdf/crc.pdf
16. Simmer, K., *Human milk banks and evidence-based medicine.* J Paediatr Child Health, 2000. **36**: p. 182-183.
17. McGuire, W. and M.Y. Anthony, *Donor human milk versus formula for preventing necrotising enterocolitis in preterm infants: systematic review.* Arch Dis Child Fetal Neonatal Ed, 2003. **21**(4): p. 249-54.
18. Schanler, R.J., *The use of human milk for premature infants.* J Perinatol 2001. **21**(4): p. 207-19.
19. Lording, R.J., *A review of human milk banking and public health policy in Australia* Breastfeed Rev, 2006. **14**(3): p. 21-30.
20. FAO/WHO Expert meeting, *Enterobacter sakazakii and other microorganisms in powdered infant formula: Meeting report*, in *Microbiological Risk Assessment Series 10.* 2006.
21. Fattal-Valevski, A., et al., *Outbreak of life-threatening thiamine deficiency in infants in Israel caused by a defective soy-based formula.* Pediatrics, 2005. **115**(2): p. e233-38.
22. Forsyth, J.R.L., et al., *The year of the Salmonella seekers - 1997.* Aust N Z J Public Health, 2003. **27**(4): p. 385-89.
23. Koletzko, B. and R. Shamir, *Standards for infant formula milk (Editorial).* Br Med J, 2006. **332**: p. 621-22.
24. Fifty-eighth World Health Assembly, *WHA58.32.* 2005.
25. Thirty-ninth World Health Assembly, *WHA39.28.* 1986.
26. NSW Health. *Breastfeeding in NSW: Promotion, Protection and Support.* 2006 [PD 2006_012]. Available from: http://www.health.nsw.gov.au/policies/pd/2006/PD2006_012.html.
27. World Health Organization, *International Code of Marketing of Breastmilk Substitutes.* 1981, World Health Organization: Geneva.
28. Forty-ninth World Health Assembly, *WHA49.15.* 1996.
29. Fifty-fifth World Health Assembly, *WHA55.25.* 2002.
30. *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.* 1990, WHO/ UNICEF policymakers' meeting: Florence, Italy.
31. *Innocenti Declaration 2005 On Infant and Young Child Feeding.* 2005 [Available from: http://innocenti15.net/declaration.htm.
32. *Baby Friendly Hospital Initiative Australia http://www.bfhi.org.au/.* [Available from: http://www.bfhi.org.au/.
33. Forty-fifth World Health Assembly, *WHA45.34.* 1992.
34. UNICEF UK Baby Friendly Initiative, *Best practice in community health care services - the Seven Point Plan.*
35. Massachusetts Breastfeeding Coalition. *10 Steps to a breastfeeding-friendly pediatric practice.* 2002 [Available from: http://www.massbfc.org/providers/10stepsped.html.
36. National Health and Medical Research Council, *The Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers.* 2003, Commonwealth of Australia: Canberra.
37. Australian Bureau of Statistics. *4810.0.55.001 Breastfeeding in Australia.* 2003 [Available from: http://www.abs.gov.au/Ausstats/abs@.nsf/0/8e65d6253e10f802ca256da40003a07c?OpenDocument.

38. Webb, K., et al., *Towards a National System for Monitoring Breastfeeding in Australia: Recommendations for Population Indicators, Definitions and Next Steps*. 2001, Australian Food and Nutrition Monitoring Unit, University of Queensland: AusInfo, Canberra.
39. Strategic Inter-Governmental Nutrition Alliance, *Eat Well Australia: An agenda for action for public health nutrition 2000-2010*. 2001.
40. Scott, J.A. and C.W. Binns, *Factors associated with the initiation and duration of breastfeeding: a review of the literature.* Australian Journal of Nutrition and Dietetics, 1998. **55**(2): p. 51-61.
41. Li, L., et al., *Factors associated with the initiation and duration of breastfeeding by Chinese mothers in Perth, Western Australia.* J Hum Lact, 2004. **20**(2): p. 188-95.
42. McLachlan, H.L. and D.A. Forster, *Initial breastfeeding attitudes and practices of women born in Turkey, Vietnam and Australia after giving birth in Australia.* Int Breastfeed J, 2006. **1**: p. 7.
43. Homer, C.S.E., A. Sheehan, and M. Cooke, *Initial infant feeding decisions and duration of breastfeeding in women from English, Arabic and Chinese-speaking backgrounds in Australia.* Breastfeed Rev, 2002. **10**(2): p. 27-32.
44. Oddy, W.H., et al., *The association of maternal overweight and obesity with breastfeeding duration.* J Pediatr, 2006. **149**: p. 185-91.
45. Donath, S.M. and L.H. Amir, *Does maternal obesity adversely affect breastfeeding initiation and duration?* J Paediatr Child Health, 2000. **36**: p. 482-86.
46. Ryan, A.S., W. Zhou, and M.B. Arensberg, *The effect of employment status on breastfeeding in the United States.* Women's Health Issues, 2006. **16**(5): p. 243-51.
47. Kelleher, C.M., *The physical challenges of early breastfeeding.* Soc Sci Med, 2006. **63**(11): p. 2727-38.
48. Scott, J.A., C.W. Binns, and R.A. Aroni, *The influence of reported paternal attitudes on the decision to breast-feed.* J Paediatr Child Health, 1997. **33**: p. 305-07.
49. Bar-Yam, N.B. and L. Darby, *Fathers and breastfeeding: a review of the literature.* J Hum Lact, 1997. **13**(1): p. 45-50.
50. Hauck, Y.L., *Factors influencing mothers' decision to breastfeed in public.* Breastfeed Rev, 2004. **12**(1): p. 15-23.
51. McIntyre, E., J.E. Hiller, and D. Turnbull, *Determinants of infant feeding practices in a low socio-economic area: identifying environmental barriers to breastfeeding.* Aust N Z J Public Health, 1999. **23**(2): p. 207-209.
52. Fairbank, L., et al., *A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding.* Health Technology Assessment, 2000. **4**(25): p. 1-171.
53. Sikorski, J., et al., *Support for breastfeeding mothers.* The Cochrane Library, 2002(2).
54. Merten, S., J. Dravta, and U. Ackermann-Liebrich, *Do baby-friendly hospitals influence duration on a national level.* Pediatrics, 2005. **116**(5): p. e702-8.
55. Merewood, A., et al., *Breastfeeding rates in US Baby-Friendly Hospitals: results of a national survey.* Pediatrics, 2005. **116**(3): p. 628-634.
56. Hofvander, Y., *Breastfeeding and the Baby Friendly Hospitals Initiative (BFHI): organization, response and outcome in Sweden and other countries.* Acta Paediatr, 2005. **94**: p. 1012-16.
57. Broadfoot, M., et al., *The Baby Friendly Hospital Initiative and breast feeding rates in Scotland.* Arch Dis Child Fetal Neonatal Ed, 2005. **90**(February): p. F114-F116.
58. Kramer, M.S., et al., *Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the Republic of Belarus.* JAMA, 2001. **285**(4): p. 413-20.
59. Walsh, A.D., J. Pincombe, and G.E. Stamp, *The ten steps to successful breastfeeding in Australian hospitals.* Breastfeed Rev, 2006. **14**(1): p. 25-31.

60. Bartington, S., et al., *Are breastfeeding rates higher among mothers delivering in Baby Friendly accredited maternity units in the UK? , 2006. 35(5):1178-1186.* Int J Epidemiol, 2006. **35**(5): p. 1178-86
61. Pincombe, J., et al., *Baby Friendly Hospital Initiative practices and breast feeding duration in a cohort of first-time mothers in Adelaide, Australia.* Midwifery, 2006(Dec 29 Epub ahead of print).
62. Department of Health and Aged Care. *Balancing Breastfeeding and Work.* 2000 [Available from: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-brfeed-strategy.htm.
63. McIntyre, E., et al., *Balancing breastfeeding and paid employment: a project targeting employers, women and workplaces.* Health Promot Int, 2002. **17**(3): p. 215-22.
64. Cohen, R. and M.B. Mrtek, *The impact of two corporate lactation programs on the incidence and duration of breast-feeding by employed mothers.* Am J Health Promot, 1994. **8**(6): p. 436-41.
65. CIGNA. *Working Well Moms Program.* 2000 [Available from: http://healthproject.stanford.edu/koop/CIGNA2000/documentation.html.
66. Ortiz, J., K. McGilligan, and P. Kelly, *Duration of breast milk expression among working mothers enrolled in an employer-sponsored lactation program.* Pediatr Nurs, 2004. **30**(2): p. 111-19.
67. US Department of Health and Human Services. *Health plans, as employers, supporting breastfeeding mothers who return to work.* 2001 [Available from: http://www.4woman.gov/owh/pub/breastfeeding/return2work.htm.
68. Kosmala-Anderson, J. and L.M. Wallace, *Breastfeeding works: the role of employers in supporting women who wish to breastfeed and work in four organisations in England.* J Pub Health 2006. **28**(3): p. 183-91.
69. Kimbro, R.T., *On-the-job moms: work and breastfeeding initiation and duration for a sample of low-income women.* Matern Child Health, 2006. **10**(1): p. 19-26.
70. *Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF).* 2007 [Available from: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm.
71. World Health Organization. *Launch of the WHO child growth standards.* 2006 [Available from: http://www.who.int/nutrition/media_page/en/.
72. Binns, C. and M. Lee, *Will the new WHO growth references do more harm than good? (Letter).* Lancet 2006. **368**(9550): p. 1868-69.
73. Briggs, G.G., *Drug effects on the fetus and breast-fed infant.* Clin Obstet Gynecol, 2002. **45**(1): p. 6-21.
74. Hale, T., *Medication and Mother's Milk.* 11th ed. 2004, Texas: Pharmasoft Medical Publishing.
75. Sachs, M., *Debate: Milk advertising should not be allowed in journals.* Br J Midwifery, 2005. **13**(11): p. 714-15.