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SUBMISSION TO THE HOUSE STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO BREASTFEEDING

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Summary

There is substantial evidence of the health benefits of breastfeeding to infants in the short and longer term and to breastfeeding mothers. Breastfeeding helps protect against a range of conditions, including infections in infants, asthma and allergies in children and obesity and chronic diseases in later life. Breastfeeding also provides some protection to mothers against breast and ovarian cancer and osteoporosis as well as type-2 diabetes.

The rates of initiation of breastfeeding in Australia are relatively high at 87%, however only 54% of babies aged up to 3 months are fully breastfed. Only one-third of infants aged up to 6 months are fully breastfed, compared with the recommendation by the National Health and Medical Research Council (NHMRC) to 'encourage, support and promote exclusive breastfeeding for the first six months of life'.[1]

The Australian Government has consistently demonstrated its commitment to the protection and promotion of breastfeeding through a range of successful initiatives over recent years including development of national recommendations and guidelines, ten years support for the work of the Australian Breastfeeding Association, funding research and breastfeeding projects and resources, and supporting the Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (1992) (MAIF Agreement) as the Government's response to the World Health Organization's International Code of Marketing of Breast-milk Substitutes (WHO Code).

In May 2007 the Australian Government committed $8.7 million over four years for initiatives to promote breastfeeding. This initiative will involve research, improved data collection, an information and community education campaign on the benefits of breastfeeding, and activities to support families such as access to 24-hour advice, and innovative programs for disadvantaged and young mothers. This is an ongoing initiative.

The research will explore the reasons many Australian mothers decide not to breastfeed or to stop breastfeeding before the recommended period of six months. Practical and up-to-date information will be provided to parents in take-home packs after the birth. From August 2008, a public education campaign will target messages to expecting and new parents about the importance of breastfeeding in promoting good health and reducing the risk of disease throughout life.

Additional funding has been committed to update Australia's scientific guidelines on children's nutrition. The *Dietary Guidelines for Children and Adolescents* will be updated, including the *Infant Feeding Guidelines for Health Workers.*

The Australian Government has also committed new funding of $37.4 million over four years to Health @ Home Plus, a nurse-led home visiting program for Aboriginal and Torres Strait Islander mothers and babies. Aboriginal and Torres Strait Islander children aged up to two years old and their families in specific outer regional and remote areas will benefit from dedicated, intensive home visiting services to improve child development and provide help with early learning, diet and physical health, and parenting skills.

Efforts to improve breastfeeding rates need to focus on continuing to promote breastfeeding as the best choice for babies and mothers and providing women with the ongoing support and information they need to exclusively breastfeed until around 6 months and to continue to breastfeed in conjunction with the introduction of complementary foods thereafter.

The role of the Australian Government in population health issues is to provide national leadership through, for example, the development of national policies and programs, data collection, regulatory policy, national campaigns, development and dissemination of national education resources, and development of health workforce initiatives.

1. Introduction

This submission addresses the Terms of Reference of the House Standing Committee on Health and Ageing Inquiry into Breastfeeding:

"The Committee shall inquire into and report on how the Commonwealth government can take a lead role to improve the health of the Australian population through support for breastfeeding. The Committee shall give particular consideration to:

A. the extent of the health benefits of breastfeeding;
B. evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;
C. the potential short and long term impact on the health of Australians of increasing the rate of breastfeeding;
D. initiatives to encourage breastfeeding;
E. examine the effectiveness of current measures to promote breastfeeding; and
F. the impact of breastfeeding on the long term sustainability of Australia's health system."

1.1 Roles and responsibilities

The Australian Government takes a leadership role in the development of national population health initiatives in order to: combat preventable illness and injury; contribute to the overall quality and length of life; and to prevent chronic disease and improve its management through the adoption of healthy lifestyles and best practice in care to the end of life. This includes, for example, the development of national policy, targeted population health programs, regulatory policy (e.g. food), national social marketing campaigns, national surveys, social research, development and dissemination of national information resources, support for national activities and committees, and development of health workforce initiatives.

Australian Government Funding

Over the last ten years (1997-98 to 2006-07) the Australian Government has allocated funding of over $6 million for activities with a specific focus on breastfeeding. The National Health and Medical Research Council (NHMRC) has allocated funding of nearly $3.4 million for breastfeeding-related research between 1998 and 2010. A summary of the annual Australian Government funding since 1997-98 allocated for activities with a specific focus on breastfeeding, and to the research funding allocated by the NHMRC, is provided at **Attachment A.**

The Department of Health and Ageing has supported the Government's commitment to the protection and promotion of breastfeeding through the following initiatives with a specific focus on breastfeeding, including:

- financial support for 10 years for the Australian Breastfeeding Association (ABA);
- support for the *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (1992) (MAIF Agreement)* as the Government's response to the World Health Organization's *International Code of Marketing of Breast-milk Substitutes (WHO Code)*;
- funding over 3 years to support the Baby Friendly Hospital Initiative;
- funding a range of projects under the National Breastfeeding Strategy, including the *Balancing Breastfeeding and Work* resource;
- funding a Perth Infant Feeding Study into breastfeeding initiation and duration rates, feeding patterns during the first 12 months and factors which encourage or discourage mothers from breastfeeding; and

- funding projects to support breastfeeding, as a component of the National Child Nutrition Program.

For further details of these initiatives see Section 6 of this submission.

In May 2007 the Australian Government committed $8.7 million over 4 years for initiatives to promote breastfeeding. This is an ongoing initiative. For further details see Section 8.

The Australian Government has funded other projects that focussed on a range of health issues, including breastfeeding. These projects include:

- the NHMRC *Dietary Guidelines for Children and Adolescents incorporating the Infant Feeding Guidelines for Health Workers (2003),* which includes recommendations about breastfeeding;
- data collection on national breastfeeding rates through the *National Health Survey*, *National Aboriginal and Torres Strait Islander Health Survey*, *National Children's Nutrition and Physical Activity Survey*, and the *Longitudinal Survey of Australian Children*;
- providing information on breastfeeding through the Government's Health*Insite* and HealthyActive websites;
- providing a range of holistic Indigenous projects which include support for breastfeeding; and
- developing indicators for acute care maternity services, including a breastfeeding support indicator for which data is collected on the rate that hospitals/organisations achieve *Baby Friendly Health Initiative* accreditation or achieve the WHO's 10 Steps to Successful Breastfeeding.

Further information about these projects is provided in Section 6.

State and Territory Governments

State and Territory governments have primary responsibility for the provision of health services. This includes provision of hospital infrastructure and services and delivery of population health programs. State and territory programs relevant to breastfeeding may include:

- provision of antenatal breastfeeding courses;
- teaching women to breastfeed whilst in hospital, and through outpatient services;
- community education and support for breastfeeding mothers;
- collection of data about breastfeeding;
- targeted support for teenage, disadvantaged, indigenous, multicultural and disabled breastfeeding mothers;
- provision of information resources;
- development of State/Territory breastfeeding strategies; and
- consumer research.

1.2 Evidence-based advice about breastfeeding

Exclusive breastfeeding for the first 6 months of life is recommended by scientific bodies in Australia and overseas, including the NHMRC, Royal Australasian College of Physicians, the World Health Organization (WHO), the American Academy of Pediatrics, and United Nations Children's Fund (UNICEF).

The NHMRC recommends that at around six months of age, complementary foods should be introduced with breastfeeding continuing to one year of age or for as long as mother and baby wish, in recognition of the continuing value of breastfeeding.

Exclusive breastfeeding to six months of age, i.e. avoiding the introduction of complementary foods or drinks, protects against infections and the development of some chronic diseases, and decreases the risk of allergy in infants with a positive family history. At six months, infants require foods in addition to breast milk to meet increasing nutritional and developmental needs. By one year of age, children can share the normal family diet and drink cow's milk, and do not require specially prepared foods or formula unless they suffer from allergies.

1.3 Medical conditions and medications affecting breastfeeding

The NHMRC Dietary Guidelines for Children and Adolescents in Australia describe the few medical conditions in either the mother or baby where breastfeeding is contraindicated, for example HIV/AIDS and breast cancer detected during pregnancy.[1] The Dietary Guidelines also provide information about the health risks to the infant of using certain drugs or compounds when breastfeeding.

Many prescription and over-the-counter medications are safe for breastfeeding when taken by the breastfeeding woman. However, pregnant or breastfeeding women should seek guidance from their doctor, pharmacist or drug information centre about their condition and/or medication and dosage when breastfeeding, including for common medications such as decongestants, and headache medications. If the mother is affected by a short term/temporary condition or taking medication which affects breastfeeding, short term milk supply can be maintained by expressing, so that breastfeeding can resume.

1.4 Maternal factors affecting breastfeeding including diet, smoking and alcohol consumption

Breastfeeding women need a healthy, nutritious, well-balanced diet with adequate intakes of all nutrients.

The *Dietary Guidelines for Children and Adolescents incorporating the Infant Feeding Guidelines for Health Workers* (2003) indicate that the consumption of moderate amounts of caffeine should be safe when breastfeeding.[1]

There are well-documented adverse effects of second-hand smoke on infants such as sudden infant death syndrome and asthma. Although the amount of nicotine in breast-milk is small, there have been cases where toxicity in the infant has been reported. Excess alcohol intake by mothers may impair neurological development of the infant and significantly reduces the milk let-down reflex. However, the benefits of breastfeeding over infant formula feeding are significant enough for breastfeeding to be the best choice if the mother smokes or drinks alcohol infrequently.

1.5 Breastfeeding barriers and enablers

Characteristics of breastfeeding women

Women are less likely to choose to breastfeed if they:

- are of low socio-economic status;
- are less educated;
- have language, literacy or cultural barriers limiting access to impartial information;
- are younger mothers (less than 25 years of age);

- smoke (which may be linked to that fact that smoking inhibits lactation capacity);
- feel that breastfeeding labels them solely as a mother and they want to re-establish their identity as an individual; or
- are depressed.

Women in these groups who do breastfeed tend to do so for a shorter duration. Women also tend to breastfeed for a shorter duration if they are obese or have insufficient breastfeeding knowledge. First-time mothers are more likely to breastfeed.

Social Factors

The main reason women give for choosing to breastfeed is the health benefits of breastfeeding for their baby. Other reasons included family influence, and that it was more convenient than formula feeding. The decision to breastfeed or formula feed is often made early in pregnancy or before conception and women who decide to breastfeed before they become pregnant tend to breastfeed for longer.

Social factors that undermine a woman's confidence or negatively influence initiation as well as duration of breastfeeding include:

- lack of support by a partner;
- perceived or genuine lack of freedom and independence;
- inconsistent advice from health professionals and peers;
- lack of role models;
- the misconception that infant formula is nutritionally equivalent to breast milk;
- embarrassment caused by negative and ill-informed community attitudes;
- lack of community support for breastfeeding in public places; and
- cultural attitudes.

Breastfeeding needs to be learned and continued in a supportive environment. The necessary support includes: emotional support, practical support (e.g. housework, helping to look after other children, flexible work hours to express), ensuring women are not socially isolated, and support from experienced breastfeeding counsellors.

Infant Formula Marketing

Overseas evidence indicates that infant formula marketing can affect breastfeeding rates and duration. This evidence led to the development of the *WHO Code* and in Australia, the *MAIF Agreement*. This issue is covered in detail in Section 5.

Return to Work

Recent studies show that returning to work is negatively associated with both the initiation and duration of breastfeeding. This can be due to unsupportive work environments or the stress of combining a career and breastfeeding. In order to maintain their milk supply, working women need to be able to express milk around twice a day and store it in a refrigerator. Work-based child care and flexible work hours can help enable breastfeeding to continue. Because breastfed infants experience fewer days of illness, breastfeeding decreases parental employee absenteeism due to decreased infant illness.

Health Sector Practices
Initiation rates and the duration of breastfeeding can be increased by hospitals that actively promote and support breastfeeding. It is considered good practice for hospitals to provide hospital materials and discharge packs that do not promote infant formula. Our understanding of current practice in Australia is that hospital materials, discharge packs and "bounty bags" are not promoting infant formula.

Because breastfeeding is a learned skill that takes time to develop, short hospital stays combined with inadequate professional support at home mean that problems can develop which can lead to early cessation. Common reasons for ceasing breastfeeding in the early weeks include: the perception of an inadequate milk supply, pain, complementary feeding which decreases breast milk supply, difficulty attaching, tiredness and fatigue and the fact that the partner is unable to share in feeding. Adequate support for breastfeeding mothers after discharge from hospital is therefore crucial for the ongoing maintenance of breastfeeding.

2. The extent of the health benefits of breastfeeding (Term of Reference A)

Breast milk provides the best nutritional start to infants and has both immediate and long-term health benefits. Breast milk provides important immune properties and growth factors. Breast milk changes composition over time to suit the growing infant's needs, and also changes from morning to night and from the beginning to the end of a feed. Colostrum, the substance produced in the first few days after the infant's birth, transfers immune properties to the infant, stabilises blood sugar in small and large-for-date infants, protects against allergy, helps prevent jaundice and helps the intestine to mature. Bodily contact between mother and infant is of great psychological benefit to both parties.

2.1 Health benefits to infants

Breastfeeding protects infants against gastrointestinal, and to a lesser extent, respiratory infection and this protective effect is enhanced with greater duration and exclusivity of breastfeeding. Breastfeeding also protects against jaundice, diarrhoea and ear infections, which are less likely to occur the more breast milk is consumed in the first six months of life. Breastfeeding reduces the risk or severity of a number of conditions including: physiological reflux, pyloric stenosis, asthma, urinary tract infections, bacteraemia-meningitis, sudden infant death syndrome, and necrotising enterocolitis. Colic and/or excessive crying has been found to be significantly less among breastfed infants.

2.2 Long Term Health Benefits

There is a significant (33%) increased risk of type 1 diabetes in infants who are not breastfed.[1] Breastfeeding protects against allergic rhinitis, wheezing, asthma, eczema, food allergy and respiratory allergy in children. Breastfeeding reduces the risk or severity of a number of conditions including: obesity, inflammatory bowel disease, some childhood cancers, and coeliac disease. Exclusive breastfeeding seems to have a protective effect against some risk factors for cardiovascular disease in later life.

2.3 Health benefits to breastfeeding mothers

Breastfeeding provides some protection against breast cancer, such that the risk drops in proportion to the length of time a woman breastfeeds. It also protects against ovarian cancer and osteoporosis. Breastfeeding hastens the return of the uterus to normal size after birth helping to prevent post-partum haemorrhage. Breastfeeding also assists the mother in

regaining her pre-pregnancy body weight and shape earlier provided breastfeeding continues for more than seven months.

Women with a history of gestational diabetes have an increased risk of developing type 2 diabetes, so achieving optimal weight loss from breastfeeding may reduce the risk of developing type 2 diabetes later in life. There is also some evidence that breastfeeding for over six months reduces the mother's risk of developing type 2 diabetes. This protective effect increases with each additional year of lactation accumulated during a women's lifetime and is stronger for periods of exclusive breastfeeding.

3. Potential short and long term impact on the health of Australians of increasing the rate of breastfeeding (Term of Reference C)

While it is not possible to quantify the overall impact of breastfeeding on health, the short term and long term health benefits to infants and mothers as outlined in Section 2 suggest that the impact would be significant.

3.1 Breastfeeding rates in Australia

In Australia, rates of initiation of breastfeeding are relatively high, however breastfeeding rates decline substantially by 3 months of age and continue to decline thereafter. The NHMRC recommends the encouragement, support and promotion of exclusive breastfeeding for the first six months of life[1], however just 32% of infants aged up to 6 months are fully breastfed[2] compared with a goal of at least 80% considered achievable by the NHMRC.

The *2001 National Health Survey* showed that 87% of Australian women initiated breastfeeding in hospital, 54% of infants aged up to 3 months were being fully breastfed, and 32% of infants aged up to 6 months were being fully breastfed. At 6 months of age 48% were receiving some breast milk, at 12 months this figure dropped to 23% and at 2 years of age the figure was 1%. These rates are of concern because the health benefits of breastfeeding often depend on or increase with the duration.

In Australia there is some evidence that migrant and Aboriginal women initiate breastfeeding at the same rate as the overall population but that they do not breastfeed for as long. This could be partly a reflection of socioeconomic status. The *1995 National Health Survey* showed considerable variations between states and territories e.g. 90.1% breastfeeding at discharge in the ACT compared with 78.1% in Tasmania. Other studies have shown differences between different socio-economic groups within states and territories[3].

3.2 Impact on key health issues of increasing breastfeeding rates

Infant Illness

The major acute illnesses associated with morbidity in infants and children for which breastfeeding is known to be protective are: gastrointestinal illness; otitis media; and necrotising enterocolitis (NEC). An increase in breastfeeding rates could reduce the risk for infants of developing these illnesses, as follows:

- The risk of diarrheal illnesses in formula fed infants has been shown to be twice that for breastfed infants during the first year of life[4], predisposing these infants to dehydration and malnutrition;
- Infants breastfed two months or less have an incidence of otitis media that is 3.3 times greater than infants breastfed for six months[5]; and

- NEC, characterised by inflammation of the intestine and fatal in 9-28% of cases, has been shown to be 6.5 times more common in formula fed infants than breastfed infants.[6]

An Australian economic analysis conducted in 1997 estimated the impact if the nationwide prevalence of exclusive breastfeeding at three months was increased from 60% to 80%.[7] It estimated that achieving this increase would avert 223 cases of NEC, 3,072 cases of gastrointestinal illness and 6,404 cases of eczema in babies each year.

Obesity

Breastfeeding has been shown to protect against obesity, and the use of infant formula has been found to be a risk factor for overweight and obesity at six years of age. One study of 8,186 girls and 7,155 boys aged 9 to 14 years examined their breastfeeding status up to 9 months of age and showed that breastfed infants were less likely to be overweight or obese adolescents.[8] Children who had been breastfed for at least seven months had a lower risk of becoming overweight or obese than those who were breastfed for three months or less. For every 3 months an infant was breastfed, there was an 8% reduction in the risk of the being overweight as an adolescent. The risk of obesity attributable to formula feeding is estimated to be about 15-20%.[9]

Atopic Disease (eczema, food allergy and respiratory allergy)

A long-term study on the relationship between infant feeding and atopic disease found that the prevalence of atopic disease for ages 1-3 was highest for those never breastfed or exclusively breastfed for less than a month.[10] At age 17, those who had been breastfed for less than a month had a higher prevalence of atopy. The prevalence of atopy was 8% in those exclusively breastfed for more than 6 months, 23% for those exclusively breastfed 1-6 months and 54% for those not breastfed or breastfed for less than 1 month.

Asthma

Asthma is the leading cause of hospitalisation in Australian children. In 2001-02 asthma accounted for 41,000 hospital separations, 51% were children aged 0-14 years.[11] The Western Australian Pregnancy Cohort Study of 2,187 children showed that the introduction of infant formula before 4 months of age was significantly associated with an increased risk of asthma and that a child is more likely to be hospitalised in the first 5 years of life if infant formula is introduced before 4 months of age.[12]

Type 2 Diabetes

Breastfeeding has a protective effect on the risk of developing type 2 diabetes in adult life. A review of studies relating infant feeding and risk of diabetes showed that breastfeeding was consistently associated with a lower risk of type 2 diabetes in later life compared with those that were formula fed.[13]

3.3 Impact of increasing breastfeeding rates on Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have worse health status and lower life expectancy than non-Indigenous Australians. Babies of Aboriginal and Torres Strait Islander mothers have higher rates of infant mortality. Aboriginal and Torres Strait Islander babies are also more likely to experience poorer physical development and disproportionately high prevalence of illness and conditions such as poor dental health. They also have higher death rates from sudden infant death syndrome. The NHMRC guidelines recognise the protection that breastfeeding can provide against poor health outcomes in early childhood.

The reported rates of breastfeeding among Australian Indigenous women are variable. They are commonly regarded as roughly comparable with those for non-Indigenous Australian women although it has been argued that many Indigenous women cease breastfeeding prematurely. The Australian Bureau of Statistics *2004-05 National Aboriginal and Torres Strait Islander Health Survey* found that approximately 79% of Aboriginal and Torres Strait Islander infants aged 0 – 3 years in non-remote areas had been breastfed compared with 88% of non-Indigenous infants.

Breastfeeding varies by remoteness, with a higher proportion of Indigenous mothers in remote areas breastfeeding their children than in non-remote areas. At the time of the *Survey*, approximately 42% of Indigenous children in remote areas aged 0-3 years were currently being breastfed, 43% had previously been breastfed and 14% had never been breastfed. This compares with 13%, 65% and 21% respectively for Indigenous children and infants in non-remote areas. Other figures available only for non-remote areas indicate that a higher proportion of Aboriginal and Torres Strait Islander infants (18%) were first given solid food within their first 3 months compared with 10% of non-Indigenous infants.

Increasing the rate and the duration of breastfeeding is likely to have a positive impact on the health of Indigenous children. However factors contributing to the continued health inequalities between Aboriginal and Torres Strait Islander people and other Australians are multiple and interlinked. The rate and duration of breastfeeding is but one factor in a complex situation. Long term health improvements are more likely if breastfeeding programs are part of comprehensive primary health care services which address a range of issues relevant to mothers and their children. The Department of Health and Ageing is continuing to pursue improvements to primary health care services for Indigenous mothers and children, including through the new *Health @ Home Plus* measure in the 2007 Budget.

4. Impact of breastfeeding on the long term sustainability of Australia's health system (Term of Reference F)

The economic value of breastfeeding lies in the health benefits to the population and subsequent decrease in health costs. There are no comprehensive studies on the cost savings to Australia's health system of increasing breastfeeding rates. Health and illness later in life are a consequence of accumulated exposure to risk and protective factors throughout life, so interventions to prevent ill health that focus on women of child-bearing age and infants can be very beneficial in the long term. Existing studies indicate that cost savings from breastfeeding could be considerable, but there is a need for more comprehensive research.

Existing Australian studies provide the following estimates:

- Cost savings to the Australian hospital system from women not weaning within the first 3 months, and based on five common illnesses associated with early cessation of breastfeeding (gastrointestinal illness, respiratory illness, otitis media, eczema and necrotising enterocolitis), have been estimated to be $60-120 million annually.[14]
- It has been estimated that $11.5 million could be saved each year in Australia if the prevalence of exclusive breastfeeding at 3 months was increased from 60% to 80%. This assessment was based on costs of hospitalisation for four illnesses only (gastrointestinal illness, necrotising enterocolitis, eczema and type 1 diabetes).

- The costs of not breastfeeding or short duration of exclusive breastfeeding were estimated in 2004 to be $20-40 million a year in NSW for five illnesses alone (gastrointestinal illness, lower respiratory infection, otitis media, eczema and necrotising enterocolitis).[15]

It is difficult to draw international comparisons due to differing breastfeeding rates and differences between health systems, however there are estimates from other countries that also show potential economic benefits from breastfeeding:

- The National Health Service spends £35 million a year in England and Wales treating gastroenteritis alone in formula-fed infants and it has been estimated that for each 1% increase in breastfeeding at 13 weeks, a saving of UK£500,000 could be made.[16]
- In the United States of America it has been estimated that a minimum of $3.6 billion could be saved annually if the prevalence of exclusive breastfeeding increased to the rates recommended by the US Surgeon General.[17] Estimated savings were based on an increase from 64 to 75% breastfeeding initiation rate and 29 to 50% breastfeeding rate at 6 months. Direct health care costs accounted for $3.1 billion and indirect costs $0.5 billion for wages lost etc for 3 infant illnesses (necrotising enterocolitis, gastrointestinal illness and otitis media).

5. Impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities (Term of Reference B)

The Department of Health and Ageing is not aware of any research on the impact of marketing of breast milk substitutes on the breastfeeding rates of the Australian population, or on disadvantaged, Indigenous, or remote communities within Australia. There is, however, overseas evidence that infant formula marketing decreases breastfeeding rates.

5.1 WHO International Code of Marketing of Breast-milk Substitutes (WHO Code)

In May 1981, Australia was one of 118 countries that voted in favour of adopting the *WHO International Code of Marketing of Breast-milk Substitutes*. The aim of the *WHO Code* is to contribute to the provision of safe and adequate nutrition for infants, through the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The *WHO Code* is designed to protect mothers from misinformation and undermining practices, and protect health professionals from infant formula company inducements. Compliance with the *WHO Code* is monitored by the WHO and the International Baby Food Action Network (IBFAN).

5.2 The Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement

Supporting the 1992 *MAIF Agreement* is the Australian Government's main response to the WHO Code. The MAIF Agreement is a voluntary, self-regulated industry code of practice which aims to protect breastfeeding by restricting infant formula manufacturers and importers from promoting infant formula directly to the public. However, the marketing activities of retailers such as supermarkets, chemist chains and pharmacies are not covered by the *MAIF Agreement*.

The Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) is a non-statutory body appointed by the Australian Government to monitor compliance with the *MAIF Agreement*.

The APMAIF's terms of reference are to:

- receive and investigate complaints regarding the marketing in Australia of infant formulas;
- act as liaison point for issues relating to the marketing in Australia of infant formulas;
- develop guidelines on the interpretation and application of the *MAIF Agreement*; and
- provide advice on the operation of the *MAIF Agreement* to the Australian Government Minister for Health and Ageing.

The APMAIF considers complaints from the public regarding marketing of infant formulas and determines whether these complaints constitute breaches of the *MAIF Agreement*. Breaches are recorded in the APMAIF annual report.

The Department provides the Secretariat to APMAIF and is also an observer on APMAIF. APMAIF is preparing a separate submission to the Inquiry.

6. Initiatives to encourage breastfeeding (Term of Reference D)

Even though breastfeeding is a natural act, it is also a learned behaviour. It is possible for most mothers to breastfeed provided they have accurate information, and support from their families, communities and the health care system.

The focus of initiatives to encourage breastfeeding needs to be on maintaining high initiation rates, increasing overall duration of breastfeeding and promoting exclusive breastfeeding to around 6 months of age, in order to have an impact on population health. In addition, any new programs or services need to undergo a high quality evaluation in order to add to the currently limited knowledge base on the best ways to improve breastfeeding rates and duration.

6.1 Workplace measures

Returning to work has been cited as the most common reason for ceasing to breastfeed when the infant is between 3 and 6 months of age.[18] There is evidence that some women do not initiate breastfeeding because of anticipated return to work. Duration of leave from work affects duration of breastfeeding, i.e. longer leave is associated with longer duration of breastfeeding, however women do not tend to take more leave because they want to breastfeed for longer.

Formula fed infants suffer from more illness and parental absence from work is expensive to employers and employees. A lactation program introduced to support employees to breastfeed saved an American company approximately $1435 in medical claims and three days of employee sick leave per breastfed infant in the first year of the program.[19] This resulted in a return on investment of almost 3 to 1.

In Norway, a number of initiatives have been introduced that have significantly enhanced breastfeeding rates. In 1970, Norwegian breastfeeding rates were as low as in the United Kingdom today (69% initiation; 42% at 6 weeks; 28% at 4 months; 21% at 6 months; and 13% at 9 months[20]). Norway subsequently adopted a number of strategies to increase

breastfeeding rates, including provision of time for women to breastfeed or express milk at work. Today Norway has one of the highest breastfeeding rates in the developed world with 98% initiation and 90% still breastfeeding at 4 months.[18] It has been observed that the rate of increase in obesity in Norway over the last two decades has been significantly lower than in many other OECD nations, however a causal link between rates of obesity and breastfeeding cannot be made in this case as a number of other strategies and demographic factors may have contributed to this outcome.[21,22,23]

Conditions which have been shown to facilitate the continuation of breastfeeding include: paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding or expressing breaks.

As part of the *National Breastfeeding Strategy (1996-2001)*, the Australian Government funded the development and distribution of a booklet, pamphlet and poster for workplaces titled *Balancing Breastfeeding and Work.*

6.2 Community education and awareness raising

Women usually decide whether or not to initiate breastfeeding before or during pregnancy. An Australian review noted that the factors associated with the decision to breastfeed are not necessarily the same as those that predict duration of breastfeeding.[24] For example, if the decision has been made by the mother to breastfeed, then hospital practices are not likely to affect initiation rates but can affect duration.

Breastfeeding initiatives aiming to increase initiation rates need to target the general population, not just pregnant women. This is important to address the barriers to breastfeeding which include, lack of support by a partner, lack of role models, the misconception that infant formula is nutritionally equivalent to breast milk, embarrassment caused by negative and ill-informed community attitudes, and lack of community support for breastfeeding in public places.

Community Awareness Campaigns

The National Breastfeeding Strategy (1996-2001) was an Australian Government initiative announced in the 1996-97 Budget. It had a specific focus on the promotion and support of breastfeeding. The Australian Government provided $2 million over four years for nine projects which produced a range of resources for ongoing use. Projects were funded in a number of different areas including: family education, national accreditation standards for maternal and infant care services, employer support, health professional education, indigenous health, data collection, and antenatal educators.

The 2007 Budget breastfeeding initiative described in Section 8 will further build on this work.

Community awareness campaigns can potentially reach a wide audience and change attitudes and perceptions towards breastfeeding affecting overall acceptance by the community and mothers in particular. These campaigns, however, must be combined with other strategies to effect sustained behavioural change. One study showed that 90% of women reported that books, magazines and television positively influenced their decision to breastfeed.[25]

The development of consistent and objective information resources on topics such as correct attachment, how to tell whether you are producing enough milk, common problems and

solutions, introducing solids and where to find help, may provide support to address common reasons for ceasing breastfeeding.

The Commonwealth and States each have a role to play in community education, which includes social marketing campaigns, education in schools, education in child care facilities, and antenatal breastfeeding courses.

6.3 Health professionals

Training for health professionals in the provision of breastfeeding support to women is crucial. In 2001, the *National Breastfeeding Strategy* delivered the following initiatives for health professionals:

- Audit of training and breastfeeding support and infant nutrition in Indigenous health services;
- Review of interventions and identification of best practice used in Indigenous health services;
- A companion document to the *NHMRC Infant feeding Guidelines for Health Workers (2003)* to assist health workers and general practitioners (GPs) in providing consistent and practical breastfeeding advice to the public;
- National accreditation standards for maternal and child health services;
- Health professional education kit for GPs, paediatricians, infant health nurses and pharmacists; and
- Breastfeeding antenatal education package.

There is a need to assess the currency and value of these resources with jurisdictions and stakeholders to work out what needs to be updated, and then implement those updates.

The Australian Government funded the development and dissemination of the *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers (2003)*. This resource, designed for health professionals, was produced by the NHMRC and provides information on initiating, establishing and maintaining breastfeeding, common problems and their management, storage information, contraindications, allergies and more.

The Guidelines are used as a basis for the development of many private sector and government brochures for use with the general public. The Australian Government has provided funding for the development of a number of brochures, including several by the Australian Breastfeeding Association. These brochures are distributed through government mail outs and by health professionals, dietitians, nutritionists, sporting organisations, corporations, non-government organisations and others.

6.4 Initiatives targeting Aboriginal and Torres Strait Islanders

Research emphasises the need for culturally appropriate breastfeeding support and advice in the early weeks and months of breastfeeding.[26] Effective strategies include combinations of group sessions, individual sessions and home visits.

There is scope for promoting breastfeeding within health services to encourage the view that breastfeeding is a priority and to ensure that advice given by health professionals is consistent and accurate. This reflects the recommendations of an earlier Departmental review of breastfeeding interventions and best practice in community-based Aboriginal and Torres Strait Islander health services.[27]

The Office for Aboriginal and Torres Strait Islander Health has identified a number of common factors in Aboriginal and Torres Strait Islander maternal and child health programs which have reported improved health impacts or outcomes. These are:

- community-based and/or community controlled services
- a specific service location intended for women and children
- provision of continuity of care and a broad spectrum of services
- integration with other services e.g. hospital liaison
- outreach activities
- home visiting
- a welcoming and safe service environment
- flexibility in service delivery and appointment times
- a focus on communication, relationship building and development of trust
- respect for Aboriginal and Torres Strait Islander people and their culture
- respect for family involvement in health issues and child care
- an appropriately trained workforce
- valuing Aboriginal and Torres Strait Islander staff and female staff
- provision of transport
- provision of childcare or playgroups.

These factors should be considered in the development of new breastfeeding programs or the enhancement of existing programs.

Current Australian Government measures relating to Indigenous Health are:

Health @ Home Plus

The Australian Government has committed new funding of $37.4 million over four years to *Health @ Home Plus*, a nurse-led home visiting program for Aboriginal and Torres Strait Islander mothers and babies. Aboriginal and Torres Strait Islander children aged up to 2 years old and their families in specific outer regional and remote areas will benefit from dedicated, intensive home visiting services to improve child development and provide help with early learning, diet and physical health, and parenting skills. Those children most in need will also be supported until they are eight years old to help them make a successful transition to school.

Extensive international and local evidence has established that nurse-led home visiting programs for mothers and babies are an effective way to improve outcomes for vulnerable and disadvantaged children. More than 60 health professionals, including nurses and Aboriginal Health Workers, will be engaged by the fourth year of the measure. This is an ongoing initiative.

Healthy for Life Program

The Department of Health and Ageing is currently implementing the *Healthy for Life* program. The program was announced in May 2005 and aims to enhance the capacity of primary health care services to improve the quality of Aboriginal and Torres Strait Islander child and maternal health services and chronic disease care, and to improve the capacity of the Indigenous health workforce.

Healthy for Life is designed to allow health services to step back and review their current service delivery in child and maternal health and chronic disease, to identify priority areas for improvement, and to develop further the child and maternal health and chronic disease care

provided in their community. Under this program, $102.4 million is being provided over 4 years. Breastfeeding support activities are one of many aspects on which the *Healthy for Life* program may focus, depending on local circumstances. Eighty primary health care services are now participating in the program through 53 sites. An evaluation of the *Healthy for Life* program will commence in 2007.

Aboriginal and Torres Strait Islander Primary Health Care Services
A review of the Australian Government's Aboriginal and Torres Strait Islander primary health care program was completed in 2003-04. The Review found that access to comprehensive primary health care (which includes breastfeeding and infant nutrition care) is an essential component of action to improve health status and that the Australian Government has made significant progress in increasing the provision of such services.

The Australian Government has substantially increased the coverage and capacity of Indigenous-specific health services across Australia in urban, rural and remote areas since 1995-96. In that time, program funding for Indigenous health has increased by over $270 million to $384.92 million allocated in 2006-07 through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), a real increase of 170 per cent.

The most recent statistics show that 73% of the Aboriginal and Torres Strait Islander primary health care services funded by the Department provide dietary and nutrition programs and 71% provide an infant/child growth monitoring program. Both types of program may include breastfeeding and infant nutrition care. However it is not possible to extrapolate the portion of primary health care funding which supports these activities.

In addition, other funding measures may have an impact, albeit unquantifiable, on the provision of breastfeeding and infant nutrition care. One example is the establishment of five brokerage services in urban and rural areas which aim to link up to 15,000 Indigenous people to general practitioners and other health professionals in mainstream health services. This is part of a $39.5 million initiative which was announced in the 2006-07 Federal Budget.

Aboriginal and Torres Strait Islander Health Worker Competencies
An earlier Departmental review of training in breastfeeding support and infant nutrition noted that, as the existing Aboriginal Health Worker units relating to maternal and child health and nutrition were all optional, the qualifications did not result in a minimum level of expertise in this area. The new *Aboriginal and Torres Strait Islander Health Worker Competencies* and qualifications form part of the recently revised Health Training Package. The package was endorsed by the National Quality Council in February 2007. The updated qualifications will contain opportunities for Aboriginal Health Workers to study breastfeeding and related topics but still in the form of elective units.

6.5 National breastfeeding policy
The Australian Government provides leadership in promoting breastfeeding. To avoid duplication of effort between jurisdictions, and to gain the maximum impact from interventions, a national breastfeeding policy could be developed to provide overarching guidance and form the basis for development of initiatives.

Development of such a policy could involve: a literature review of interventions, reviews of breastfeeding interventions implemented in jurisdictions including their cost-effectiveness, options for new initiatives based on this information, information on current Australian

Government breastfeeding and related initiatives, information on current State and Territory breastfeeding and related initiatives. Both Victoria and New South Wales have funded reviews into breastfeeding interventions in recent years with New South Wales releasing a breastfeeding policy in April 2006 aiming to increase breastfeeding rates.

In the United States of America, objectives have been set for increasing breastfeeding rates as part of *Healthy People 2010*, a national policy initiative developed with a range of stakeholders.[28]

6.6 National monitoring and surveillance of breastfeeding

National Health Survey and National Aboriginal and Torres Strait Islander Survey
National data on breastfeeding rates is collected by the Australian Government through the *National Health Survey* and the *National Aboriginal and Torres Strait Islander Survey,* which are undertaken by the Australian Bureau of Statistics (ABS).

The Surveys are funded by the Australian Bureau of Statistics (ABS) and the Department of Health and Ageing, with the Department providing about $1.3 million each year. The *National Health Survey* is conducted 3-yearly, and the *National Aboriginal and Torres Strait Islander Survey* coincides with every second *National Health Survey*. The complete questionnaires are available at the ABS website (www.abs.gov.au).

National data on breastfeeding is next due to be collected in the *2010-11 National Health Survey*. The *2010-11 National Health Survey* will coincide with the next *National Aboriginal and Torres Strait Islander Health Survey*. Recommendations for a national system for monitoring breastfeeding in Australia, which were published by the Australian Government in 2001,[29] will be considered as part of the process for developing the breastfeeding questions for the *2010-11 National Health Survey*.

Other Surveys
The 2006-07 National Children's Nutrition and Physical Activity Survey ('Kids Eat Kids Play') is jointly funded by the Department of Health and Ageing, the Department of Agriculture, Fisheries and Forestry and the Australian Food and Grocery Council. This survey is currently collecting data and includes questions about breastfeeding. Information about the survey, including the methodology and a calendar of events, is available at the Kids Eat Kids Play website (www.kidseatkidsplay.com.au).

The Longitudinal Study of Australian Children (LSAC) is funded by the Australian Government Department of Families, Community Services and Indigenous Affairs and was launched in 2004. The complete questionnaires and information about data access are available at the LSAC website (www.aifs.gov.au/growingup). Some breastfeeding questions are included.

Improvements that could be made to breastfeeding data collection (subject to the availability of resources) include: changes to the breastfeeding survey questions in order to align them better with NHMRC recommendations to breastfeed exclusively until around 6 months; expanding the *National Health Survey* to collect samples large enough to enable reporting by State/Territory; and utilising definitions consistent with the WHO definitions so the data can contribute to global reporting.

It would also be beneficial to monitor the factors influencing women's decisions about whether to breastfeed or not to breastfeed and how long to breastfeed, and whether there are differences between different groups within the population. This data would enable the development of evidence-based initiatives to promote breastfeeding which address barriers and target vulnerable groups.

6.7 The Marketing in Australia of Infant Formula (MAIF) Agreement

The World Health Organization's *International Code of Marketing of Breast-milk Substitutes* (WHO Code) covers marketing and practices related to:

- breastmilk substitutes including infant formula;
- other milk products;
- foods and beverages including bottle-fed complementary foods when marketed or represented as suitable for use as a partial or total replacement for breast milk; and
- feeding bottles and teats.

The *WHO Code* also applies to wholesale and retail distributors, the health care system, health workers and marketing personnel involved in marketing and promotion.

Toddler milk products were not on the market when the WHO Code was developed. The WHO now recommends exclusive breastfeeding for 6 months as the optimal way of feeding infants, with the subsequent introduction of complementary foods with continued breastfeeding up to 2 years of age or beyond. We are not aware of any clarifying documentation from the WHO and consequently there is a question of interpretation as to whether the WHO Code would consider toddler milk products as a breastmilk substitute or a bottle-fed complementary food. However, we understand that the industry view is that the WHO Code does not apply to toddler milk products.

Supporting the 1992 MAIF Agreement is the Government's main response to the WHO Code. The *MAIF Agreement* is a voluntary, self-regulated industry code of practice which aims to protect breastfeeding by restricting infant formula marketing by manufacturers and importers directly to the public. The Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) is a non-statutory body, appointed by the Australian Government to monitor industry compliance with the *MAIF Agreement.* The *MAIF Agreement* applies only to the Australian manufacturers and importers (including marketing personnel) of infant formula and follow-on formula who are signatories to the *MAIF Agreement.*

The existing MAIF Agreement was authorised by the then Trade Practices Commission in 1992, in the context of a 1988 feasibility study by the Trade Practices Commission. In 1988 the Trade Practices Commission had concluded that "the voluntary implementation of a self-regulatory scheme, based on the full WHO Code, was not feasible. The pricing restrictions contained in the WHO Code amounted to per se breaches of the Act and could not be authorised in any circumstances."

A significant number of complaints received by APMAIF fall outside the scope of the *MAIF Agreement* because they relate to: retailer activity; toddler milk products for children aged over 12 months; marketing of feeding bottles, teats or dummies; or manufacturers and importers who are not parties to the *MAIF Agreement.* Concerns have been expressed by consumers and stakeholders that the *MAIF Agreement* may not be adequately protecting breastfeeding because it does not encompass the full scope of the *WHO Code.* The infant formula marketing environment has also changed since 1992, for example in 1992 toddler

milk products were not on the market, there were no retail distributors of own-brand infant formula and internet marketing was not a consideration.

6.8 Food standards

Standard 2.9.1 - Infant Formula Products

Another aspect of Australia's response to the WHO Code is the implementation of labelling requirements through the *Australia New Zealand Food Standards Code (Food Standards Code)*. Infant formula products are regulated as special purpose foods under Standard 2.9.1 of the *Food Standards Code*. Under this Standard any representation made in relation to the nutritional composition of infant formula is prohibited unless expressly permitted in the standard.

The labelling requirements in Standard 2.9.1 are consistent with Article 9 of the WHO Code. Standard 2.9.1 describes the required warnings, directions and statements on the label of infant formula product packaging. For example, the Standard requires the statement: 'Breast milk is best for babies. Before you decide to use this product, consult your doctor or health worker for advice' to appear as an important notice on the label of infant formula products. This requirement does not apply to infant formula products for some specific medical conditions. The label on a package of infant formula product must not contain a picture of an infant, or a picture that idealises the use of infant formula product. Further information about this standard is available at: www.foodstandards.gov.au

Standard 2.9.2 - Minimum age labelling requirements for infant foods

Currently infant food is required to be labelled as suitable for children from 4 months. In 2003, Food Standards Australia New Zealand (FSANZ) was asked to review this requirement to bring the advice into line with the revised NHMRC *Dietary Guidelines for Children and Adolescents incorporating the Infant Feeding Guidelines for Health Workers (2003)* which now recommend exclusive breastfeeding until around 6 months of age. It is expected that the FSANZ Board will consider the Final Assessment Report for this proposal in September 2007 and if a decision is made this will be notified to the Australia and New Zealand Food Regulation Ministerial Council shortly thereafter.

Nutrition, Health and Related Claims

The *Food Standards Code* currently precludes health claims on infant formula, and this remains the case in the current draft of the Nutrition, Health and Related Claims Standard.

6.9 Support for the Australian Breastfeeding Association

The Australian Government is providing funding of $910,000 from 1998-2008 to the Australian Breastfeeding Association (ABA) to train breastfeeding counsellors, update breastfeeding training manuals, and develop a breastfeeding case history database.

The current three year funding agreement with the ABA (2005-06 to 2007-08) is for:

- Development and distribution of a range of educational resources to existing and trainee breastfeeding counsellors and community educators; and
- Coordination, promotion and publicising of the Lactation Resource Centre's resources to provide the latest research to health professionals and the wider community.

The ABA is also funded by State and Territory governments.

The ABA provides effective voluntary, trained lay support for women in the form of

information, breastfeeding courses, the lactation resource centre, help-line and mother's groups.

In May 2007 the Australian Government committed $8.7 million over four years for initiatives to promote breastfeeding. Along with other organisations, the ABA will be welcome to tender for elements of this work.

6.10 Acute care maternity services

The Australian Government is participating in the AHMAC *National Collaboration on Maternity Services ('the Collaboration')* which undertakes a range of projects. It is considering the opportunities for the development of a set of indicators of maternity care practice and outcomes for maternity services and is taking into account the key standards of the *Breastfeeding Friendly Health Initiative* accreditation and the WHO's 10 Steps to Successful Breastfeeding.

6.11 Australian Government web sites

Health*Insite* is an Australian Government initiative, funded by the Department of Health and Ageing. It aims to improve the health of Australians by providing easy access to quality information about human health and includes information on breastfeeding and infant health. The website is located at the following address: http://www.healthinsite.gov.au

The HealthyActive website provides information for breastfeeding women on healthy eating. The website provides a sample healthy meal plan as a guide as to how to achieve a healthy diet at: www.healthyactive.gov.au/internet/healthyactive/Publishing.nsf/Content/breast-feeding-women

Other breastfeeding information, including the publications developed under the *National Breastfeeding Strategy (1996-2001)*, is available at the Department of Health and Ageing website: www.health.gov.au

7. Effectiveness of current measures to promote breastfeeding (Term of Reference E)

There is a lack of quality Australian data on the effectiveness of measures to promote breastfeeding and improve initiation and duration of breastfeeding. Research and program evaluation components of the May 2007 Australian Government breastfeeding promotion budget initiative will provide additional Australian data on the effectiveness of breastfeeding promotion measures.

8. Future Australian Government activity to support breastfeeding

The role of the Australian Government in population health issues is to provide national leadership through, for example, the development of national policies and programs, data collection, regulatory policy, national campaigns, development and dissemination of national resources, support for national activities and committees, and development of health workforce initiatives.

In May 2007 the Australian Government committed $8.7 million over four years for initiatives to promote breastfeeding. This initiative will involve research, improved data collection, an information and community education campaign on the benefits of breastfeeding, and activities to support families such as access to 24-hour advice, and innovative programs for disadvantaged and young mothers. This is an ongoing initiative.

The research will explore the reasons many Australian mothers decide not to breastfeed or to stop breastfeeding before the recommended period of six months. Practical and up-to-date information will be provided to parents in take-home packs after the birth. From August 2008, a public education campaign will target messages to expecting and new parents about the importance of breastfeeding in promoting good health and reducing the risk of disease throughout life.

Additional funding has been committed to update Australia's scientific guidelines on children's nutrition. The *Dietary Guidelines for Children and Adolescents* will be updated, including the *Infant Feeding Guidelines for Health Workers.*

The Australian Government has also committed new funding of $37.4 million over four years to Health @ Home Plus, a nurse-led home visiting program for Aboriginal and Torres Strait Islander mothers and babies. Aboriginal and Torres Strait Islander children aged up to two years old and their families in specific outer regional and remote areas will benefit from dedicated, intensive home visiting services to improve child development and provide help with early learning, diet and physical health, and parenting skills. Efforts to improve breastfeeding rates need to focus on continuing to promote breastfeeding as the best choice for babies and mothers and providing women with the ongoing support and information they need to exclusively breastfeed until around 6 months and to continue to breastfeed in conjunction with the introduction of complementary foods thereafter.

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ATTACHMENT A

Australian Government Funding Allocated for Breastfeeding-Related Activities

Table 1: Department of Health and Ageing funding allocated to activities with a specific focus on breastfeeding (1997-98 to 2006-07)

Financial Year	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	Total
Funding Allocated ($)	**592,538**	**607,685**	**372,292**	**1,028,822**	**850,900**	**872,753**	**843,274**	**313,482**	**264,190**	**292,000**	**$6,037,938**

N.B.

1) The figures in Table 1 are for the activities with a specific focus on breastfeeding, as listed in Sub-section 1.1 of the submission. The figures do not include some other projects funded by the Australian Government that have broader public health focus that includes a breastfeeding aspect. These other projects are also listed in Sub-section 1.1 of the submission and are described in more detail in Section 6.
2) For projects funded over more than one financial year, the figure attributed to each financial year is an average of the total funding for the project.
3) Expenditure for the current financial year has not yet been finalised, therefore the figure provided for 2006-07 is an estimate.
4) A further $90,000 has been allocated for 2007-08 as part of the 2005-08 funding agreement with the Australian Breastfeeding Association. Funding in the amount of $8.7 million for a new budget initiative to promote breastfeeding has been announced in the 2007-08 Federal Budget.

Table 2: National Health and Medical Research Council funding allocated for breastfeeding research (1998 – 2007)

Calendar Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Funding Allocated ($)	77,313	85,309	223,399	146,540	217,733	268,050	396,503	396,303	464,573	486,894	**$2,762,617**

N.B. A further $624,720 has been allocated from 2008 to 2010, which is subject to change as new funding is allocated. This brings the total allocation from 1998 to 2010 to $3,387,337 as reported in the NHMRC submission to the Inquiry into Breastfeeding (submission no. 35).