



Submission in response to Draft Determination of MAIF
22nd March 2021

PROTECT PROMOTE SUPPORT

MOTHER-BABY FRIENDLY PHILIPPINES **DOH**

World Vision

THE RISKS OF FORMULA MILK FEEDING

Children who are fed with formula milk are at higher risk of having:

- lung infections
- ear infections
- infection from contaminated formula milk
- chronic diseases
- lower intelligence
- allergies
- asthma
- heart disease
- obesity
- childhood cancers
- diarrhea
- diabetes

Mothers who do not breastfeed:

- May become pregnant sooner
- Have increased risk of anemia, ovarian cancer, endometrial cancer, and breast cancer

References:
International Labor Organization. (2015). Healthy Beginnings for a Better Society: Breastfeeding in the Workplace is Possible- A Toolkit. Makati City: ILO Country Office for the Philippines.
Department of Health. (n.d.). Gabay sa Naray sa Tamang Pagpapasuso.
INFANT Canada. (n.d.). Fourteen Risks of Formula Feeding: A Brief Annotated Bibliography by the Breastfeeding Action Group. Corner Brook, Newfoundland.

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Table of Contents

General Comments	2
Requested Background Information	2
Background on the WHO Code	3
Risks of not breastfeeding.....	6
Cross-promotion.....	16
Commercial influence.....	24
Marketing Research	29
Records of unethical marketing	33
Detailed response to individual points in the Draft Determination	36
Recommendations	46
References.....	51



REPLY TO THE DRAFT DETERMINATION

GENERAL COMMENTS

BAA congratulates the ACCC on recognising, in writing, the need for breastfeeding to be protected in Australia and the role that toddler products, cross-promotion, and industry play in this action.

Replying to the specific request in 4.88 requires the information presented to be clear and accurate. We have taken the time to examine each statement made in the draft and comment on points of disagreement and obscurity. Firstly, we include further background information as requested, prior to the detailed response. This includes:

1. Background on the WHO Code¹
2. Universally recognised and stated risks of ultra-processed powdered infant formula
3. Examples of cross-promotion beyond the infant formula/toddler drink model
4. Corporate influence in the development of potentially harmful public health guidelines
5. Published research outlining the deliberate, unethical, predatory marketing tactics, including during the COVID-19 pandemic.
6. A comprehensive list recording 25 months of documented WHO Code violations in Australia.

Full detail is provided in this reply because it was clear, when reading the draft determination, that minimal use of the reference material was made by the commissioners writing the draft, instead relying on industry rhetoric.

Terminology

Could the ACCC please clarify the appropriate term for the toddler products as required by Australian labelling guidelines?

It is noted that the ACCC has used the term “toddler milk” in nearly every instance it is mentioned in the determination. As a matter of clarity and transparency for Australian consumers, it would be helpful for our peak consumer protection body to demonstrate understanding of the significant difference in the perception when the word “milk” is used instead of “milk drink” or “toddler drink”. This critical difference in language reflects the product contents, labelling requirements and role in the toddler diet accurately.

Relevant background on the WHO Code

In 2.1, the ACCC has written “The World Health Organization (WHO) established an International Code of Marketing of Breast-Milk Substitutes (WHO Code) in 1981 **in response to concerns over a perceived decline in breastfeeding rates**”.

This statement represents a gross understatement of the facts and ignorance of the millions of infant and maternal lives lost and harmed in the pursuit of profit. Many well documented factors contributed to the development of the WHO Code, none were “perceptions”, and the concern over infant deaths related to predatory marketing and use of breastmilk substitutes was disturbing and real. Historically the process for development of the Code is presented here:

YEAR	ACTION
<p>1974 27th WHA</p>	<div data-bbox="384 779 651 1115" data-label="Image"> </div> <p data-bbox="675 813 1358 1021">Widespread recognition of declining breastfeeding rates related to promotion of breastmilk substitutes in particular the information on infant death and commerciogenic malnutrition collated into this document, “The Baby Killer” .²</p>
<p>1978 31st WHA</p>	<p data-bbox="395 1193 1369 1312">To address malnutrition breastfeeding should be promoted and supported by taking legislative and social action to regulate the inappropriate sales promotion of foods sold as breastmilk substitute.</p> <p data-bbox="395 1346 1358 1464">WHO and UNICEF, Governments, nongovernmental organizations, professional associations and scientists were all aware of the problems of infant and young child feeding and the need for action.</p> <p data-bbox="395 1498 1382 1617">WHO and UNICEF announced their intention of organizing jointly a meeting on infant and young child feeding. The meeting was convened in Geneva from 9 to 12 October 1979 and was attended by:</p> <ul data-bbox="443 1650 1114 1912" style="list-style-type: none"> • 150 representatives of governments, • organizations of the United Nations system and • other intergovernmental bodies, • nongovernmental organizations, • the infant-food industry • experts in related disciplines.



1980 33rd WHA	This meeting endorsed in their entirety the statement and recommendations agreed by consensus at this joint WHO/UNICEF meeting and made particular mention of the recommendation that <u>"there should be an international code of marketing of infant formula and other products used as breast-milk substitutes"</u> , requesting the Director-General to prepare such a code "in close consultation with Member States and with all other parties concerned".
1981 34 th WHA	On the recommendation of the Executive Board of the WHO, the fourth draft of a code which maintained a basic minimum content of the agreed points, was adopted as a resolution of the 34 th WHA.

The WHO Code is a resolution of the 34th WHA, **it includes all subsequent resolutions**.³ It does not stand alone. It is very clear, from reading the draft determination, that misperception exists with the ACCC’s understanding of the differences between the WHO Code and MAIF⁴. We provide a comprehensive description of the difference here, free from commercial influence, in order for the background information to be correct.

The misunderstanding means the situation is not evaluated fairly or subjectively by the ACCC. This puts mothers and babies at a greater risk than the current unsafe situation they find themselves in, in Australia.

We take this opportunity to remind the ACCC the WHO Code is the **BARE MINIMUM STANDARD** that all parties, including industry, agreed is required to offer protection of breastfeeding. MAIF does not even come close to meeting this least possible standard of conduct.

WHO Code	MAIF
Applies to all countries and companies as a minimum standard	Coverage is limited to only the signatories. Others are not bound to follow MAIF.
Applies to all breast milk substitutes including other milk products, foods and beverages marketed to replace breast milk, feeding bottles and teats	Applies only to infant formula. Products such as baby cereals, infant meals and drinks are not covered even if marketed for infants below 6 months of age. MAIF does not cover feeding bottles and teats.



Covers “retailers” under its definition of “Distributor”, and forbids promotion at retail level.	Distributors and retailers are not covered by MAIF.
Governments have the responsibility to ensure that objective and consistent information is provided on infant feeding.	No equivalent responsibility exists. Information materials by companies are often distributed through health care systems and usually contain conflicting messages about breastfeeding.
No point-of-sale advertising or any other promotion device such as special displays, discount coupons, premiums, special sales, loss leaders and tie-in sales at the retail level.	No equivalent provision on promotion at the retail level. Thus promotion at the retail level is not forbidden
Health authorities have the responsibility to encourage and protect breastfeeding and promote the principles of the Code.	No equivalent responsibility exists.
Free or subsidised supplies are banned in any part of the health care system (WHA resolution 47.5 [1994]).	Allows certain free supplies as it is based on 1981 Code Article 6.6 which is superseded by WHA resolution 47.5.
Information to health professionals should be restricted to scientific and factual matters, and should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding.	Requires companies to give health care professionals product information reflecting current knowledge and responsible opinion which are clearly identified with company and brand names.
Governments have overall responsibility to implement and monitor the Code. Monitoring should be carried out in a transparent and independent manner.	Advisory Panel which administers MAIF and decides on complaints is partly represented and supported by industry, giving rise to conflict of interests. This conflicts with the recommendations of the Ethics Centre

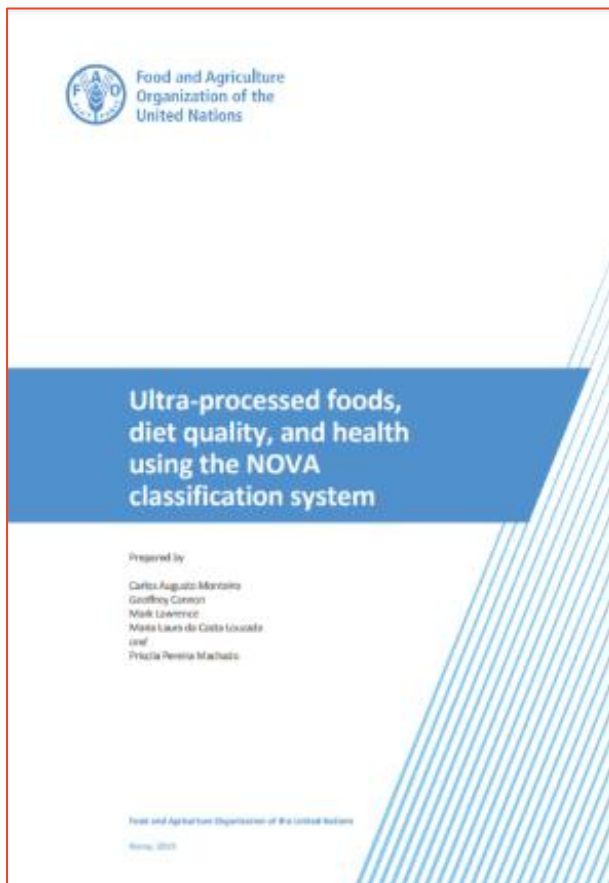


2. Universally recognised and stated risks of ultra-processed powdered infant formula

As this is written, yet another natural disaster is unfolding in Australia. Australia currently has no provision or guidance for infant and young child feeding in emergencies. (a comprehensive one exists for pets) When mothers not breastfeeding are isolated with their infant, where there is no clean water or power, this immediately plunges them into a situation where not breastfeeding is now life-threatening. Assuming these harms are only related to developing countries is to be misinformed and evidence from Australian sources will demonstrate this..

“The significance of industrial processing, and in particular techniques and ingredients developed or created by modern food science and technology, on the nature of food and on the state of human health, is generally understated.”

Ultra-processed foods, diet quality, and health using the NOVA classification system p.3



Food processing and its effects on human health can be assessed and made the basis of guidelines and thus public policies and actions only when analysis is discriminating and precise, with terms defined, and the nature, purpose, extent and effects of processing identified and distinguished.

In 2019 the UN Food and Agriculture Organisation released the NOVA ⁵ classification system to enable governments to make better informed decisions about dietary guidelines.

A simple table is provided as a guideline for this classification. Infant formula is a Class 4, the same category as lollies.



Group 1	Group 2	Group 3	Group 4
Unprocessed and minimally processed foods	Processed culinary ingredients	Processed foods	Ultra-processed foods
edible parts of plants and animals after separation from nature. fruit, leaves, stems, seeds, roots, muscle, offal, eggs, milk, fungi, algae and water	oils, butter, lard, sugar and salt	canned/bottled vegetables or legumes (pulses) preserved in brine; whole fruit preserved in syrup; tinned fish preserved in oil; ham, bacon, pastrami, smoked fish; most freshly baked breads; and simple cheeses with added salt.	soft drinks; sweet, fatty or salty packaged snacks; confectionery, mass produced packaged breads and buns, biscuits, pastries, cakes and cake mixes; margarine, other spreads; sweetened breakfast 'cereals' fruit yoghurt, 'energy' drinks; pre-prepared meat, cheese, pasta and pizza dishes; reconstituted meat products; powdered and packaged 'instant' soups, noodles and desserts; baby formula

There is no need for a plethora of articles here, the issues are simply stated at the beginning of the NHMRC Infant feeding Guidelines for Health Workers 2012⁶ and the Australian National Breastfeeding Strategy 2019 and Beyond (ANBS)⁷. This overwhelming, well documented evidence cannot be refuted or minimised.

Breastfeeding is the **normal** way to nourish an infant after birth, it is disappointing that proof is needed to support a biological function. There would be no argument that a kidney works better than dialysis and even in severe kidney failure dialysis is used until a kidney can be transplanted. It does the job but does not provide the extraordinary nuance needed that can only be provided by a kidney. The NHMRC and ANBS pages are provided without interpretation for the commissioners.

If this evidence is to be dismissed by the commissioners, an explanation and rationale would be welcome for the public record and the Department of Health.

NHMRC Infant Feeding Guidelines for Health Workers page 13

1.2.1 Benefits to the infant

Breastfeeding has positive effects on the nutritional, physical and psychological wellbeing of the infant.

Nutritional benefits

The composition of breast milk is uniquely suited to the newborn infant, at a time when growth and development are occurring rapidly while many of the infant's systems – such as the digestive, hepatic, neural, renal, vascular and immune systems – are functionally immature. Many of the nutrients contained in breast milk are in forms that are readily absorbed and bioavailable.²⁶

Breast milk contains many valuable components including bile salt-stimulated lipase, glutamate, certain polyunsaturated long-chain fatty acids, oligosaccharides, lysozyme, immunoglobulin A, growth factors and numerous other bioactive factors. These components facilitate optimal function of the infant's immature systems and confer both active and passive immunity.²⁷ The living cells found in breast milk are also important functionally.²⁸

Health benefits

Breastfeeding confers a range of benefits to the developing infant, including improved visual acuity, psychomotor development¹⁷ and cognitive development,²⁹ and reduced malocclusion as a result of better jaw shape and development.³⁰

Globally, suboptimal infant feeding is responsible for 45% of neonatal infectious deaths, 30% of diarrhoeal deaths and 18% of acute respiratory deaths in children under five years.³¹ Numerous studies have shown that breastfeeding reduces the risk or severity of a number of conditions in infancy and later life, including:

- physiological reflux³²
- pyloric stenosis^{33,34}
- gastrointestinal infections (Evidence Grade B)^{18,35,36}
- respiratory illness¹⁸
- otitis media^{18,37}
- urinary tract infections^{38,39}
- bacteraemia-meningitis^{40,41}
- sudden infant death syndrome (SIDS) (Evidence Grade C)^{18,42}
- necrotising enterocolitis in preterm infants¹⁸
- atopic disease (Evidence Grade C)¹⁸
- asthma (Evidence Grade C)^{17,18}
- some childhood cancers¹⁸
- type 1¹⁸ and type 2 diabetes^{17,18}
- coeliac disease (Evidence Grade C)⁴³
- inflammatory bowel disease (Evidence Grade C)⁴⁴
- cardiovascular disease risk factors including blood pressure (Evidence Grade B)^{17,18,45,46} and total and low-density lipoprotein (LDL) cholesterol (Evidence Grade C)^{17,18}
- obesity in childhood and in later life (Evidence Grade A).^{17,18,47,48}

Reviews of the benefits of breastfeeding and risks of not breastfeeding are available elsewhere.^{17,18,49,50}

NHMRC Infant Feeding Guidelines for Health Workers page 14

Table 1.1 is an alternative way of presenting these data.

Table 1.1: Excess health risks associated with not breastfeeding

Outcome	Excess risk* (%)
Among full-term infants	
Acute ear infection (otitis media)	100
Eczema (atopic dermatitis)	47
Diarrhoea and vomiting (gastrointestinal infection)	178
Hospitalisation for lower respiratory tract diseases in the first year	257
Asthma, with family history	67
Asthma, no family history	35
Childhood obesity	32
Type 2 diabetes mellitus	64
Acute lymphocytic leukaemia	23
Acute myelogenous leukaemia	18
SIDS	56
Among preterm infants	
Necrotising enterocolitis	138
Among mothers	
Breast cancer	4
Ovarian cancer	27

*The excess risk is approximated using odds ratios.

Source: Adapted from US Department of Human Services 2011.⁵⁰

In the United States (US) National Maternal and Infant Health Survey (n=7,092), predominant breastfeeding was associated with the lowest illness rates in the first 6 months of life.⁵¹ Minimal breastfeeding (defined as infants receiving more foods and liquids compared to breast milk) was not as protective.⁵¹ Breastfeeding conferred health benefits in infants from all socioeconomic groups. More recent evidence from the United Kingdom (UK) Millennium Cohort Study suggests that each month an estimated 53% of hospitalisations for diarrhoea and 27% for lower respiratory tract infections could have been prevented by exclusive breastfeeding and 31% of hospitalisations for diarrhoea and 25% for lower respiratory tract infection by partial breastfeeding.⁵²

Two comprehensive systematic reviews provide detailed summaries and meta-analyses of relevant studies for a variety of health outcomes for infants and mothers.^{17,18}

Immunoprotection

Breastfeeding is particularly valuable while the infant’s immune system is immature but continues to offer significant protection throughout lactation.^{53,54}

Factors present in breast milk that offer active or passive immunoprotection include:⁵⁵

- immunoglobulin A – the most abundant antibody in breast milk, which is manufactured and excreted by the breast in response to maternal exposure to specific bacteria and viruses, and provides protection against pathogens in the infant’s local environment
- immunoglobulin G and immunoglobulin M – offer further protection against specific pathogens.

Breast milk has factors that are not present in infant formula and have an important role in antigen recognition as a host defence mechanism.⁵⁶ Bacterial recognition by mucosal receptors, an important component of the non-

NHMRC Infant Feeding Guidelines for Health Workers page 15

specific innate immune system, is enhanced by components of breast milk in the first 5 days of life, facilitating the ability of the newborn infant to deal with pathogenic bacteria.

Breast milk also contains a range of non-specific and pattern-specific protective factors, including:⁵⁷

- *proteins* – lactoferrin makes iron unavailable to micro-organisms that require iron for growth (e.g. *Escherichia coli*, *Candida albicans*) and releases a peptide with bactericidal properties²⁷ and vitamin B₁₂-binding proteins make vitamin B₁₂ unavailable to micro-organisms (other proteins with anti-microbiological functions have been described by Lopez-Alvarez⁶⁰)
- *lysozyme* – bactericidal against certain gram-negative rods and gram-positive bacteria
- *prolactin* – enhances the development of B- and T-lymphocytes and affects differentiation of intestinal lymphoid tissue
- *cortisol, thyroxine, insulin and growth factors* – promote maturation of the newborn infant's intestine and development of intestinal host defences
- *macrophages, monocytes, neutrophils and B- and T-lymphocytes* – inhibit and/or destroy micro-organisms such as bacteria and viruses²⁷
- *oligosaccharides* – (12–24 g/L; over 130 different types⁵⁹ mostly resistant to digestion in the small intestine⁶⁰) promote bifidus bacteria in the large intestine, inhibit attachment of pathogenic bacteria to intestinal and urinary tract mucosa, may provide important precursors for early brain development, and may be essential to reducing incidence of necrotising enterocolitis⁶⁰
- *some free fatty acids* – several have antimicrobial actions^{61,62}
- *nucleotides* – thought to be required for rapid expansion of the immune system in the immediate postpartum period resulting from microbial exposure during birth.⁵⁵

The concentration of most of these protective factors is highest in colostrum, decreasing as lactation is established and increasing again during gradual weaning.

Diabetes

Breastfeeding for at least 3 months has been shown to be associated with a reduced risk of childhood type 1 diabetes.¹⁶ Evidence from the large Eurodiab study⁶³ indicates that the risk of type 1 diabetes is unrelated to the introduction of either cow's milk or infant formula before 3 months of age.⁶⁴

An analysis of studies evaluating the association between breastfeeding and type 2 diabetes reported a protective effect (odds ratio [OR] 0.63; 95% confidence interval [CI] 0.45–0.89),¹⁷ although further studies are needed to confirm this conclusion. Another review¹⁸ came to a similar conclusion, but noted that the association was present in retrospective case-control studies relying on long-term recall but not in studies that used existing infant records to determine breastfeeding initiation and duration. There is inconclusive evidence linking the method of feeding infants and type 2 diabetes, but there is an indirect relationship through infant growth, particularly the velocity of growth.⁶⁵⁻⁶⁷

Bowel disease

A meta-analysis showed that the risk of coeliac disease was significantly reduced in infants who were breastfeeding at the time when gluten was introduced (pooled OR 0.48; 95% CI 0.40–0.59) compared with infants who were not breastfed at this time (Evidence Grade C).⁴³ A recent meta-analysis indicated that breast milk exposure had a significant protective effect (OR 0.69; 95% CI 0.51–0.94) against developing early-onset inflammatory bowel disease, although a non-significant difference was shown for ulcerative colitis and Crohn's disease individually.⁴⁴ Overall the evidence suggests a relationship between breastfeeding and lower rates of inflammatory bowel disease (Evidence Grade C),⁴⁴ but further well-designed prospective studies are required.

Allergy and asthma

In Australia, 11–13% of children and 9–11% of adults have asthma.⁶⁸ As many as four in ten children have evidence of allergic sensitisation and many will go on to develop allergic diseases such as eczema and allergic rhinitis.⁶⁹ The prevalence of asthma and allergic disease has increased markedly since the 1970s, but the prevalence of asthma may be levelling.⁷⁰

NHMRC Infant Feeding Guidelines for Health Workers page 16

Breastfeeding exclusively to around 6 months is compatible with achieving the lowest rates of allergic disease:

- in the general population and families with a history of allergic disease, exclusive breastfeeding for around 6 months can protect against allergic rhinitis, wheezing, asthma and atopy in children^{71,72}
- introduction of milk other than breast milk before 6 months increases rates of asthma (OR 1.25; 95% CI 1.02–1.52) and atopic disease (OR 1.30; 95% CI 1.04–1.61) at 6 years of age⁷²
- breastfeeding reduces the risk of developing asthma – the protective association occurs in the absence of a family history (OR 0.74; 95% CI 0.6–0.92) and in children younger than 10 years with a family history¹⁸
- exclusive breastfeeding for at least 3 months is associated with reduced risk of allergic dermatitis in the presence of a family history of atopy (OR 0.58; 95% CI 0.41–0.92)¹⁸
- animal and human studies suggest that breastfeeding during the period of antigen introduction facilitates the development of oral tolerance,⁷³ with transforming growth factor-beta (TGFβ) a possible critical component in this process⁷⁴ and protective against allergic asthma.⁷⁵

There is no evidence that restricting women's diets during pregnancy and breastfeeding reduces the likelihood of allergies in infants.^{76,77}

Section 8.5 discusses the use of specialised formulas if breastfeeding is discontinued in infants at risk of allergy. Section 9.3.4 provides information on food allergy and the introduction of solid foods.

Leukaemia

A history of breastfeeding for at least 6 months is associated with a reduced risk of acute lymphocytic leukaemia (OR 0.80; 95% CI 0.71–0.91).¹⁸ Further studies are needed to investigate the biological mechanisms underlying this relationship.¹⁸

Psychological and cognitive benefits

Breastfeeding can be an important factor in bonding between mother and infant. The interdependence between the breastfeeding mother and infant, regular close interaction and skin-to-skin contact during breastfeeding encourage mutual responsiveness and attachment.⁷⁸

Several studies have shown that the method of feeding in early life affects cognitive development. A recent meta-analysis indicated that children who were breastfed for at least 1 month had higher scores on intelligence tests (mean difference 4.9; 95% CI 2.97–6.92) than those who were never breastfed or breastfed for less than 1 month.¹⁷ This beneficial effect becomes more pronounced with increasing duration of breastfeeding.^{79,80} Benefits are more obvious in preterm infants, with those given breast milk for at least 1 month having enhanced cognitive development (approximately 7 IQ units) at 7–8 years of age compared with formula-fed preterm infants.^{81–84} This response may be related to the higher concentration in breast milk of the polyunsaturated long-chain fatty acid docosahexaenoic acid (DHA).⁸⁵

Benefits later in life

Breastfeeding confers health advantages that persist into later life.^{17,18} This is a difficult area for study as most evidence comes from observational studies with the inherent problem of confounding. Other limitations include the potential for recall bias associated with the retrospective design of most studies and differences in definitions of breastfeeding exposure. Nevertheless, numerous systematic reviews and meta-analyses provide suggestive evidence of a protective association between breastfeeding and several risk factors for cardiovascular disease in later life, including total and LDL cholesterol (Evidence Grade C) and glucose levels (Evidence Grade C) and probable evidence of a protective association between breastfeeding and high blood pressure (Evidence Grade B).^{17,18,45,48}

There is convincing high level evidence that, compared to infants who are formula fed, being breastfed is associated with reduced risk of becoming obese in childhood, adolescence and early adulthood (Evidence Grade A).^{17,18,47,48} The protection offered by breastfeeding appears to increase with duration of breastfeeding and plateaus at 9 months.^{86,87} In a random effects model, breastfed individuals were less likely than those who had never been breastfed to be considered overweight and/ or obese (OR 0.78; 95% CI 0.72–0.84).¹⁷ An inverse association

NHMRC Infant Feeding Guidelines for Health Workers page 17

between duration of breastfeeding and the risk of overweight has also been reported.⁸⁷ In a Western Australian cohort study, infants breastfed for more than 12 months were leaner at 1 year but not at 8 years and breastfeeding for less than 4 months was associated with greatest risk of overweight.⁸⁸ However this association was not found in another study in Belarus.⁸⁹ Familial factors may modify associations between breastfeeding and adiposity beyond infancy.⁸⁸

1.2.2 Benefits to the mother

Health

There is evidence that breastfeeding reduces the risk of ovarian and breast cancer, the latter particularly in premenopausal women.¹⁸ Meta-analysis of epidemiological studies in 30 countries showed a relative risk of breast cancer reduction of 4.3% (95% CI 2.9–5.8) for every 12 months of breastfeeding in addition to a decrease of 7.0% (95% CI 5.0–9.0) for each birth.⁹⁰

There is some evidence that breastfeeding reduces the risk of developing type 2 diabetes among women with a history of gestational diabetes.¹⁸

The evidence of an association between lifetime duration of breastfeeding and risk of fractures due to osteoporosis is limited.¹⁸

Breastfeeding hastens uterine involution after birth and reduces the risk of haemorrhage (thus reducing maternal mortality). As well, preservation of maternal haemoglobin stores through reduced blood loss leads to improved iron status.^{91,92} There is equivocal evidence that breastfeeding helps the mother regain her pre-pregnancy body weight.¹⁸ Methodological challenges in studying the effect of breastfeeding on postpartum weight loss include 'the accurate measurement of weight change, adequate control for numerous covariates including the amount of weight gain during pregnancy and quantifying accurately the exclusivity and duration of breastfeeding'.¹⁸

Contraceptive effect

Although breastfeeding is not regarded as a reliable method of contraception for individual women, it does provide useful benefits on a population basis. There is probable evidence that women who exclusively breastfeed for 6 months experience more prolonged lactational amenorrhoea (Evidence Grade B).⁹³ It is estimated that if all women in the world stopped breastfeeding, 30–50% more children would be born in the following 12 months.^{94,95} The likelihood of pregnancy during periods of lactational amenorrhoea is as low as 1.7% in the first 6 months if a woman is amenorrhoeic and fully or nearly fully breastfeeding day and night.^{96,98} Even in developed countries, that rate compares favourably with barrier methods of contraception, as long as the woman remains amenorrhoeic.⁹⁹⁻¹⁰¹ The contraceptive effects of lactational amenorrhoea were included in summaries of the Cochrane Review and the most recent study of lactational amenorrhoea in Australia, published in 2002.^{102,103}

Economic benefits

Breastfeeding confers economic benefits to both the family and to society. In 1992, the breast milk supplied by Australian women was estimated to be worth \$2.2 billion, which was equivalent to about 0.5% of Gross Domestic Product (GDP), or 6% of private spending on food.¹⁰⁴ In 2001, it was estimated that if breastfeeding levels were increased to those recommended by the US Surgeon General (75% in-hospital and 50% at 6 months), a minimum of US\$3.6 billion would be saved from the costs of treating three childhood illnesses – otitis media, gastroenteritis, necrotising enterocolitis.¹⁰⁵ Similarly, in 2002, it was calculated that not breastfeeding led to extra costs to the Australian Capital Territory health system of \$1–2 million/ year from five diseases – gastrointestinal illness, respiratory illness, otitis media, eczema and necrotising enterocolitis.¹⁰⁶ A more recent analysis from the US found that if 90% of families could comply with medical recommendations to breastfeed exclusively for 6 months, the US would save US\$13 billion per year and 911 deaths would be prevented per year.¹⁰⁷ The economic case for promoting breastfeeding to at least 6 months is overwhelming.

ANBS page 22

Increasing rates of breastfeeding in Australia in line with WHO and NHMRC recommendations will improve the health and wellbeing of infants, young children, mothers and families and may also benefit society as a whole.^{42 43 44}

'One of the most highly effective preventive measures a mother can take to protect the health of her infant and herself is to breastfeed'.⁴⁵

In 2017 the medical journal *The Lancet* published a major series of studies on breastfeeding epidemiology and intervention approaches. The authors of one of the review studies published in *The Lancet* estimate that worldwide about 40 per cent of infants aged 0–6 months are exclusively breastfed. Scaling up breastfeeding to a near universal level could prevent annually over 820 000 deaths of children aged under 5 years and 20 000 deaths of women from breast cancer.⁴² Most of the latter were in high-income countries such as Australia.

Not breastfeeding increases risks of illness for both mother and child

Findings from epidemiology and biology studies substantiate the fact that *not* breastfeeding a child has major long-term effects on the child's health, nutrition and development and also on the mother's health. Possibly no other health behavior can produce such different outcomes for the two individuals involved: the mother and the child.⁴²

Breastfeeding is an important first step to improved short-term and long-term physical and mental health outcomes for both babies and mothers and facilitates bonding between mother and child.

Children

Infants who are not breastfed are at increased risk of the following:

- *Sudden infant death syndrome (SIDS)*—Breastfeeding is an independently protective factor, with infants who have received no breastmilk being at highest risk (when other risk factors are adjusted).^{42 51}
- *Respiratory and gastrointestinal infections*—For term babies, not breastfeeding increases the risk of illnesses such as pneumonia, diarrhoea and vomiting.^{42 51} Preterm infants are also at increased risk of necrotising enterocolitis (NEC).^{42 51}
- *Acute ear infection*—The risk of acute ear infection (otitis media) is 100 per cent higher among exclusively formula-fed infants than among those who are exclusively breastfed during the first six months.^{42 51}
- *Asthma*—Infants who are not breastfed may experience higher rates of asthma and childhood wheeze.^{42 51}
- *Type 1 and type 2 diabetes*—Formula-fed infants are more likely to develop type 1 and type 2 diabetes later in life and have also been shown to have higher serum insulin concentrations in adulthood.^{42 46 51}
- *Overweight and obesity*—Longer periods of breastfeeding are associated with a reduction in overweight and obesity.^{42 51} In a large study among low-income children in the United States, those who were breastfed for at least 12 months were 28 per cent less likely to be overweight at 4 years of age than those who were never breastfed.⁴⁷
- *Leukaemia*—Based on current meta-analyses, 14 per cent to 19 per cent of all childhood leukaemia cases may be prevented by breastfeeding for six months or more.^{48 51}

Breastfeeding provides much more than just good nutrition for the developing infant. It provides direct skin-to-skin contact between mother and child, encourages early mother–child social exchanges, and calms the infant by triggering their natural sucking reflex.⁴⁹ Emerging research also

ANBS page 23

suggests that exposure to bioactive hormones through breastmilk may shape infant temperament.⁴⁹

Mothers

Breastfeeding also contributes to better health for mothers. In particular, breastfeeding reduces the risk of chronic diseases.

Mothers who breastfeed experience:

- longer periods of amenorrhea, leading to *greater spacing between pregnancies*^{42 48 50}
- reduced risk of invasive *breast cancer*^{42 51}
- reduced risk of *ovarian cancer*^{42 51}
- reduced risk of *hyperlipidemia*,⁵³ *hypertension*^{52 53} and *cardiovascular disease*^{54 53}
- lower postpartum weight retention^{55 56}
- reduced risk of type 2 *diabetes*^{57 53}
- reduced *maternal depression*.⁴²

Breastfeeding is associated with increased maternal sensitivity, reduced reactivity to stress, enhanced slow-wave sleep and reduced risk of postpartum depression.⁴⁹

Breastfeeding influences the development of the infant microbiome

Breastfeeding influences the proper priming and development of the *infant's microbiome* (or the collection of microorganisms living in or on the human body⁵⁸), which is integral to immune and metabolic health. A mother's breastmilk transmits probiotics and prebiotics, including elements of the mother's own microbiome and immune responses, to the infant.

A longitudinal study of 107 healthy mother–infant pairs found that 30 per cent of the beneficial bacteria in an infant's intestinal tract come directly from the mother's milk and an additional 10 per cent come from skin on the mother's breast.⁵⁹

The development of the infant's microbiome is disrupted by several practices, including Caesarean section, perinatal antibiotics, and formula feeding and these practices have been linked to increased risks of metabolic and immune diseases.⁵⁸

Introduction of formula or complementary foods early in the postnatal period affects the colonisation and proliferation of the neonatal intestinal microbiota and may reduce the benefits of exclusive breastfeeding. Formula feeding has been associated with increased bacterial diversity and can alter the structures and relative abundances of the bacterial communities normally found in a breastfed infant's gut.⁵⁸

Breastfeeding reduces health costs

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

- Research in 2002 estimated that Australian hospital costs of premature weaning for four conditions (gastrointestinal illness, respiratory illness, eczema and NEC) was of the order of \$60 million to \$120 million per annum.⁶⁰
- A UNICEF UK report authored by Renfrew and colleagues found that even modest increases in breastfeeding rates in the UK were associated with substantial economic and health benefits.⁶¹
- A USA study showed that, if 90 per cent of mothers could exclusively breastfeed for six months, the USA would save \$13 billion per year and prevent more than 911 deaths, nearly all of which would be of infants.⁶²

Breastfeeding benefits society and the environment

Breastfeeding also has many benefits and implications beyond health. Early childhood experiences and caregiving practices, including breastfeeding, are critical to optimal human development. A parenting orientation that emphasises comforting touch, breastfeeding and responsiveness to the child's needs is associated with positive socio-moral development.⁶³

Breastfeeding is a sensible and cost-effective investment in society because it enhances human capital. It is associated with higher intelligence, higher school achievement and higher adult earnings.⁴²

'If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics ... Breastfeeding is a child's first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity.'⁴³

Breastfeeding also has benefits for the environment. Breastmilk is an environmentally friendly product, as it does not waste scarce resources or create pollution. There are no packages involved and no transportation is needed to deliver the product, as opposed to infant formulas and other substitutes for human milk, which require packaging and transport.⁴⁵ Feeding babies with non-human milk is associated with a range of poorer outcomes for mothers and babies and, more widely, is detrimental economically and ecologically.

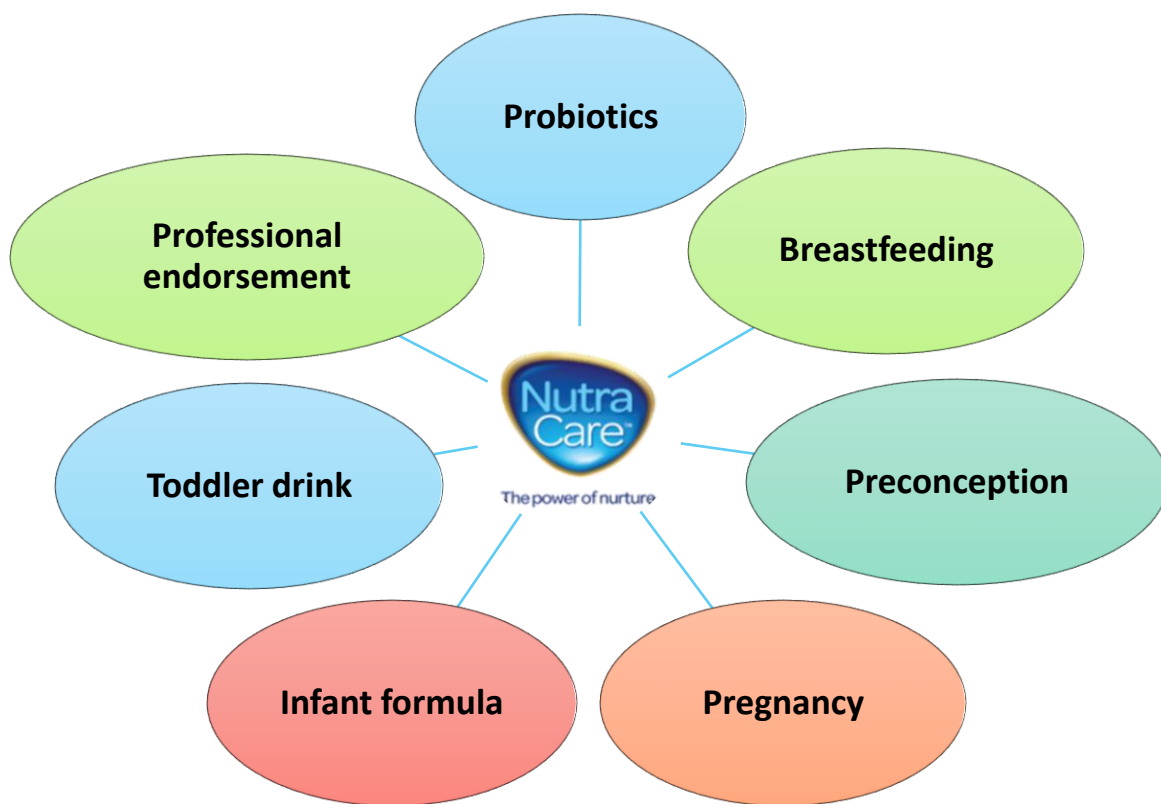
Breastfeeding provides a dependable method of infant feeding in rural and remote locations with limited or sporadic access to alternative infant feeding options. It also provides a safe and reliable method of infant feeding in emergencies, providing a consistent source of adequate nutrition and protection against infections.⁶⁴

3. Examples of cross-promotion beyond the infant formula/toddler drink model

Cross-promotion reaches way beyond simply toddler drinks and infant formula. Here are some of the many examples available. The masquerading as a source of credible information about pregnancy, health, breastfeeding and diet and the claims made **remain unsubstantiated**.

Example 1 NUTRACARE Site accessed 19th March 2021

<https://infantformula.com.au/>





Nutracare Image 1 – Breastfeeding – Probiotics – Infant formula

Advertisement



Advertisement



HOME INFANT FORMULA TODDLER FORMULA PREGNANCY FORMULA ARTICLES FAQ'S CONTACT US

DISCOVER THE BEST ORGANIC BABY FORMULA FOR NEWBORNS AT INFANT FORMULA AUSTRALIA

Science backs that breast milk is the best form of nutrition a newborn can receive, which is why the recommendation for breastfeeding extends to the first 12 months of an infant's life. However, if breast milk is not a viable option for a child, then natural, organic baby formula is acceptable.

Infant Formula Australia provide a comparison for an extensive range of natural baby formulas, helping you find the best option for your newborn when asking which is best to buy. These contain options of cow's milk, soy, goat's, organic formulas and a whole host of others! We are proud to offer all major labels within our range, including Blackmores and Bellamy's, S26, NAN. Browse through our selection today, and please feel free to get in contact with us if you have any questions.

What is the Best Baby Formula to Buy? Our Comparison Helps You Decide

Selecting which natural baby formula is best to buy for your newborn can be difficult, which is why Infant Formula Australia aims to make the choice for baby milk easier. By providing comprehensive baby formula comparisons, you can simply match brands and select the right formula for your baby.

Advertisement



Advertisement



NutraCare Infant Formula

NutraCare's Step 1 Infant Formula is suitable for most babies from birth. It's made from the purest 100% Australian cow's milk blended and enriched with vitamins and minerals to support natural brain and eye development and the natural development of a healthy immune system. You need to be sure that you're giving your baby the very best nutrition in accordance with world-class food guidelines and standards. With NutraCare you can trust that your baby is getting the support it needs. Your baby will love the taste and it's gentle on their stomach too. If your baby is older than 6 months, you can consider moving up to our Step 2 Follow On Formula...

NutraCare Follow-on Formula

NutraCare's Step 2 Follow-On Formula is specially formulated using 100% Australian ingredients to meet the nutritional requirements of your growing baby. Formulated to keep your baby fuller for longer, it is intended to complement the introduction of solids at around 6 months and is enriched with nutrients that help support the natural brain and eyes development as well as the development of immune system. If your baby is content with our Step 1 Infant Formula and is over 6 months, it's normal and safe to continue using this until 12 months of age...

← Advertising banners
Alternate text
←



Nutracare Image 2 – <https://pregmaplus.nutracarelife.com.au/>

Pregnancy - Breastfeeding – Probiotics – Infant formula – Dieticians






Nutracare Image 3 – https://www.facebook.com/NutraCareLife/

Facebook -Pregnancy - Toddlers – Probiotics – unsubstantiated claims

NutraCare Life Shop Now Like Message Search More



Are you currently planning or in First, Second or ...

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- Chicco Australia** Kellie Eason likes this Baby Goods/Kids Goods Like
- Bubs** Cheryl Hammen likes this Like

NutraCare Life January 6 · 🌐

New Year, New Resolutions. Are you taking the initiative to live a healthier and happier life in 2021 and beyond? 🥰

Thanks and credit to Kimmie @that.bambam.life_ for sharing such a beautiful photo of her kids enjoying picnic and sipping their H2O (not knowing it's filled with liquid probiotics ProBioPlus+ as it's tasteless even for the fussiest kid!)

#probiotics #guthealth #healthy #healthylifestyle #immunityhealth #health #healthyfood #stronger #strongerfromtheinsideout

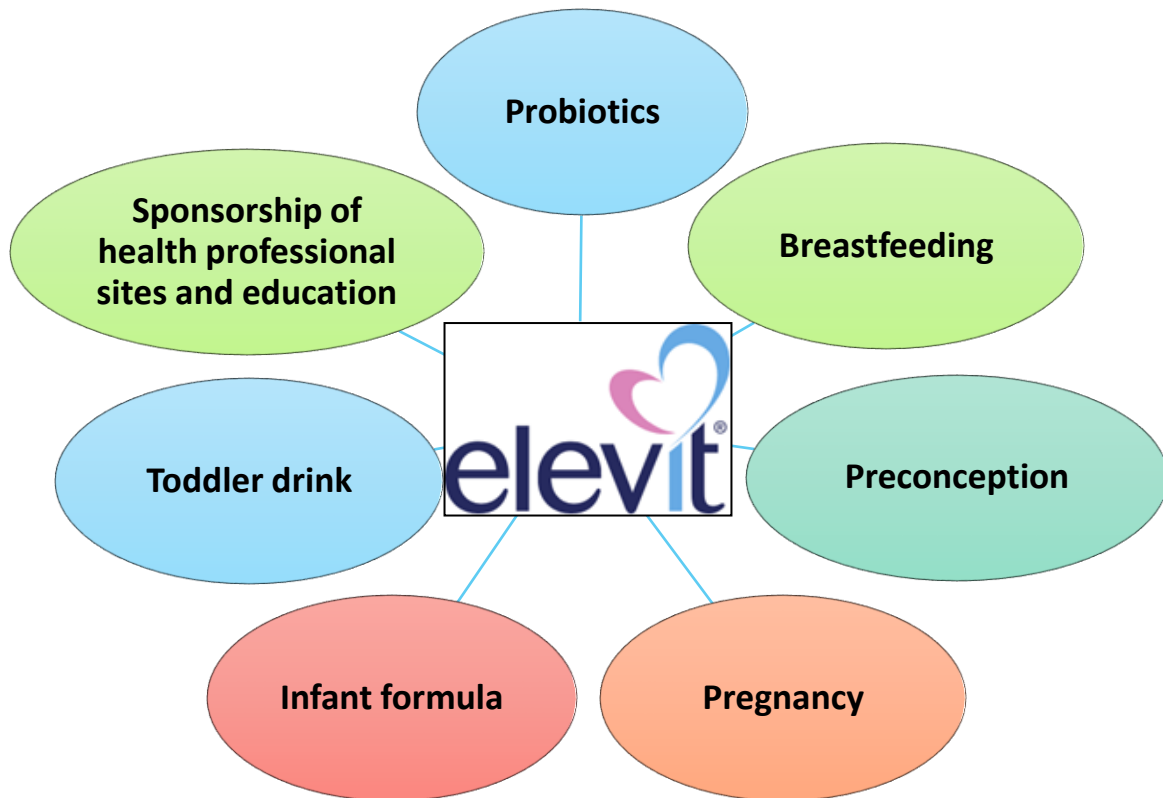


1 Like 2 Comments

Like Comment Share



Example 2 ELEVIT/NOVALAC Site accessed 19th March 2021



Elevit Image 1

Pregnancy – Breastfeeding – Probiotics – Multivitamins -Infant formula – Toddler drink





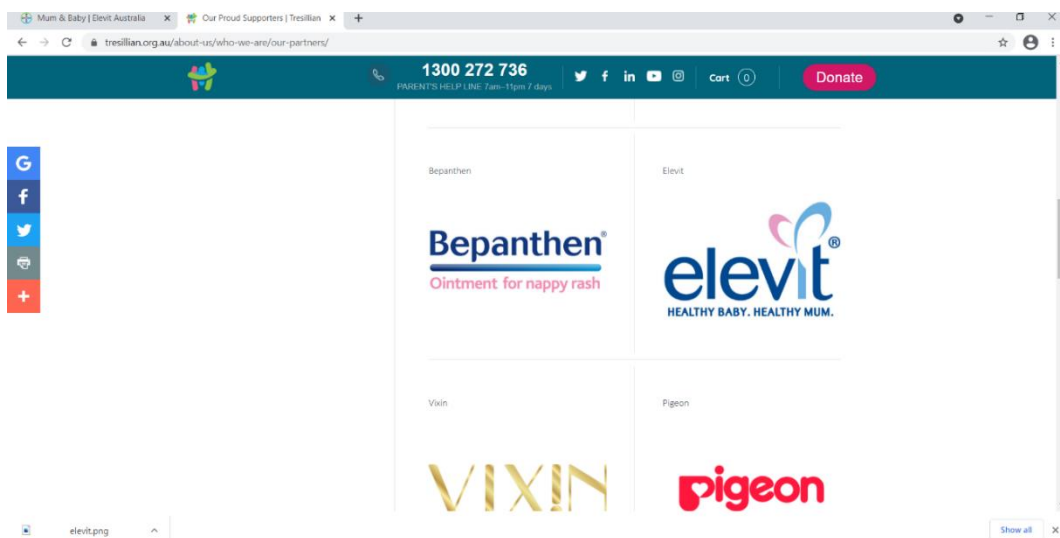
Elevit Image 2 –

Health professional education - Multivitamin - Infant formula



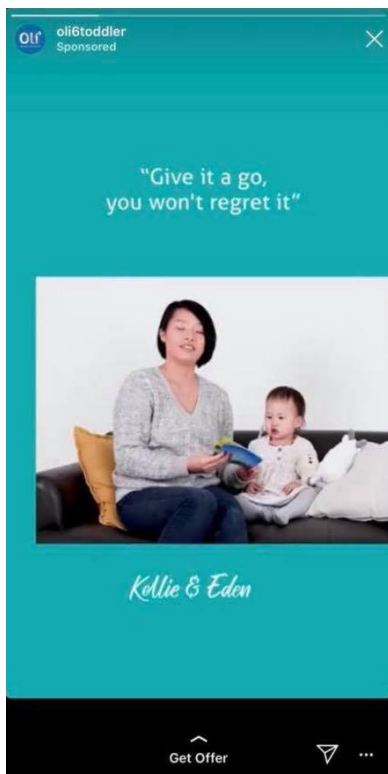
Elevit Image 3 – Sponsorship of health professional parenting site - note the other WHO Code violator, Pidgeon – parenting information needs to be free from ALL commercial influence. This is not a safe space for parents to get their information, none of the information provided by Tresillian is evidence-based or in line with the NHMRC Infant Feeding Guidelines for Health Workers.

<https://www.tresillian.org.au/about-us/who-we-are/our-partners/> accessed 19th March 2021





Example 3 Blackmores – at Sydney International Airport, targeting Chinese families
Pregnancy – Vitamin supplements – Toddler drinks



Example 4 Oli6 - Targeting Chinese families using the word “toddler”, but clearly a very young baby.



Example 5 Nestle

The word “Baby” very prominent – cereal labelled for 4 months – toddler drink – probiotics.



Nestlé Mum & me AU

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FREE SHIPPING **ON ALL ORDERS** NO MINIMUM SPEND. LIMITED TIME ONLY!*

4 Months Smooth Texture **Cerelec** INFANT CEREALS **Baby Rice** CAREFULLY selected GRAINS Probiotic BIFIDUS B. Source of IRON & VITAMIN C 200g e

Nestlé NAN SUPREME 3 Premium milk drink for toddlers 500g e From 1 year of age

BioGaia. PROBIOTIC DROPS For Infant Colic Relief **NANCARE** Probiotic Supplement 5ml e

*The offer is valid from 15th January until 31st March 2021. Open to AU residents only.

Always read the label. Follow directions for use. If symptoms persist or worsen, talk to your health professional.

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4. Corporate influence and development of potentially harmful public health guidelines

Industry financial involvement in organisations that affect health outcomes and guidance is a threat to public health and requires scrutiny and regulation. Without the control in all scientific studies being exclusive breastfeeding, then nothing of any applicable merit can be considered for recommending as medical guidelines.

The involvement of industry in the guidelines for managing allergy is an example of how advertising and product promotion can be disguised as “science”.

“Allergy to cow’s milk protein may be acting as a Trojan horse for the \$50bn (£40bn; €44bn) global formula industry to forge relationships with healthcare professionals in the UK and around the world. Experts believe these relationships are harmful to the health of mothers and their children, creating a network of conflicted individuals and institutions that has wide ranging effects on research, policy, and guidelines. Potential overdiagnosis of the allergy can also have negative effects on breast feeding.

Between 2006 and 2016, prescriptions of specialist formula milks for infants with cow’s milk protein allergy (CMPA) increased by nearly 500% from 105 029 to over 600 000 a year, while NHS spending on these products increased by nearly 700% from £8.1m to over £60m annually. Epidemiological data give no indication of such a large increase in true prevalence—and the extensive links between the formula industry and the research, guidelines, medical education, and public awareness efforts around CMPA have raised the question of industry driven overdiagnosis.

Nigel Rollins from the World Health Organization’s department of maternal, newborn, child, and adolescent health tells The BMJ, “It’s reasonable to question whether these [prescription and spending] increases reflect a true increase in prevalence.”⁸

Tulleken, Chris. (2018). Overdiagnosis and industry influence: how cow’s milk protein allergy is extending the reach of infant formula manufacturers. *BMJ*. 363. k5056. 10.1136/bmj.k5056.

These two respected Australian bodies have significant financial support from industry, however none of this financial support is disclosed in their public information and guidelines.

- Australian Society for Clinical Immunology and Allergy
- Allergy and Anaphylaxis in Australia

<https://www.allergy.org.au/about-ascia/sponsors> Site accessed 19th March 2021



We include here a transcript of Dr Norman Swan interview with Dr Debbie Palmer, (*Head, Childhood Allergy and Immunology Research, Telethon Kids Institute, University of Western Australia*) to offer an Australian perspective. The transcript from the ABC programme, The Health Report is provided below.

<https://www.abc.net.au/radionational/programs/healthreport/cows-milk-allergy-fears-stop-women-breastfeeding/12864224>

Norman Swan: Let's stay with infant feeding, because around 15% of parents think their baby has a cows' milk allergy, when the real rate is around 1%. The result can be changing formula to a specialised formula, the sales of which have boomed in recent years, mothers restricting their diet or even stopping breastfeeding altogether, and it's not the fault of parents. According to a review of the evidence, it turns out that expert guidelines on cows' milk allergy around the world have got it wrong and make overly stringent recommendations to restrict cows' milk in response to very common symptoms in babies. Most of these guidelines seem to have been seriously conflicted, with links to infant formula manufacturers, and probably misled GPs and paediatricians across the world. One of the authors is Dr Debra Palmer who is head of childhood allergy and immunology research at the Telethon Kids Institute at the University of WA. Welcome to the *Health Report*, Debra.

Debbie Palmer: *Thank you for having me.*

Norman Swan: What have the guidelines recommended that you've questioned when you've looked at the evidence?

Debbie Palmer: *So we've looked at nine guidelines from around the world, and commonly they report very common infant symptoms, so like infant colic, reflux or regurgitation, rashes, eczema, which a lot of babies have, more than one in five babies will commonly have those symptoms, and unfortunately those symptoms also can be linked to cows' milk allergy, but the common nature of these symptoms is far more common than those children who actually have cows' milk allergy, which is roughly only one in 100 versus one in five may have these symptoms. And it's very difficult to diagnose cows' milk allergy in very young infants, especially when they are breastfed. And unfortunately there has been an overuse of recommendations of potentially diagnosing children with cows' milk allergy when they may just have other symptoms.*

Norman Swan: And that has led to what?

Debbie Palmer: *Unfortunately it has led to a lot of mums stopping breastfeeding. Often their first recommendation is to actually try and see if you can remove cows' milk from the mum's diet to see if it actually helps the baby. But sometimes that's actually extremely difficult for*



some women and they really find the pressure of trying to do that...also, dairy foods, it's quite inconvenient and it is really difficult to change your diet while you are still trying to feed a baby. And so they often feel that, well, I'll just stop breastfeeding and switch on to a specialised formula. And then they miss out on so many benefits of the breast milk and breastfeeding.

Norman Swan: And as I indicated in the lead, the sales of these specialised formulae have boomed.

Debbie Palmer: *Yes, they have really skyrocketed in the last couple of decades, they have become more available, more readily available for families, and sometimes at a lower cost as well. And so their accessibility has led to a fairly high use, as is the recognition that these guidelines are there but unfortunately they may be overused and leading to this overdiagnosis of cows' milk allergy. And then yes, we have the consequences of a lot of babies having breastfeeding ceased prematurely.*

Norman Swan: And you've found that when you look at the evidence, first of all randomised trials don't support some of these actions, and it's unlikely that even a woman who is taking cows' milk in her diet is transmitting enough of the cows' milk antigen in their milk to make a difference.

Debbie Palmer: *That's correct, because the amounts that pass through the breast milk, we do know that cows' milk protein and other food allergens pass through the breast milk, but they are in tiny minute amounts that is not really the levels that normally cause allergy reactions in infants, so they are very tiny amounts. We also know there's a dose response. So if mum has cut down, if they are having a lot, say, of dairy foods, and cows' milk allergies, they cut down to a lower level, they will actually reduce the amount of those proteins passing through. But overall the amount is absolutely tiny compared to if a baby was to eat dairy food or have a standard bottle of infant formula that contains cows' milk protein.*

Norman Swan: So you found that 81% of the guidelines or the people involved in the guidelines had a conflict or were conflicted because of support from the infant formula industry.

Debbie Palmer: *Yes, it's a tricky situation. Often what happens is expert panels are formed, and to be able to bring those group of experts together there is often funding, both travel and also meeting funding from the companies, so it is a tricky situation because sometimes these panels cannot get together without some form of support and funding, but it does lead to this conflict situation.*



Norman Swan: It certainly doesn't recommend the infant formula industry as caring for babies if they are supporting guidelines which are misleading.

Debbie Palmer: *Yes, it's a very tricky situation I'm afraid...*

Norman Swan: Are there any reliable guidelines in this area?

Debbie Palmer: *They are all pretty similar, and they all unfortunately come to basically the same summary where a lot of these very common infant symptoms are listed as potential causes of cows' milk allergy, which they can be, but the frequency of these causing cows' milk allergy is absolutely minimal, one in 100 I'm afraid.*

Norman Swan: So what have you got, you've got a baby who is regurgitating, you wind them and they bring up milk over your shoulder, they are drawing up their legs, some people call that colic, it's a big question about what's going on that, so you've got a baby that's crying a bit or maybe a lot and they're regurgitating, and they just seem uncomfortable. What's a parent to do? What are they to attribute those symptoms to and how would you know if it's cows' milk allergy?

Debbie Palmer: *Yes, I think one of the first things, and this might lead on from your previous discussions this afternoon, is that potentially if the baby is breastfed, and we were talking about breastfed infants who might have these symptoms, is seeing if the mum can have a bit of support or help looking at breastfeeding patterns, looking at sucking technique of the baby, positioning of the baby when feeding, because sometimes that can actually make it...just a little tweaking of the way the baby is feeding or the pattern of feeding, that can actually help some of these symptoms in some babies. It was also just important to recognise, unless the baby is really distressed, some of these symptoms are quite natural and normal, and it's a balance as to how distressed or not the baby may be with these symptoms. And other symptoms like eczema or rashes, it really can be more of refining skincare and moisturising the baby rather than changing the mum's diet or ceasing breastfeeding.*

Norman Swan: Is there a definitive test for cows' milk allergy?

Debbie Palmer: *There is a way of...the definitive test is doing a challenge where you actually give the baby cows' milk protein, but for most young breastfed babies you wouldn't do that if they hadn't commenced on some form of cows' milk allergen already. So the only way if they are fully breastfed is to remove the cows' milk or reduce the cows' milk in the mum's diet and then just see if that actually improves their symptoms considerably. But it really*



needs to make a considerable improvement, not just a small improvement, otherwise it's probably not the answer.

Norman Swan: So, don't believe the guidelines, GPs have got to be a bit sceptical, and support mothers before you start intervening with their diet.

Debbie Palmer: *Definitely, definitely.*

Norman Swan: Debra, thanks for joining us.

Debbie Palmer: *Thank you.*



4. Independent Research on marketing practices of infant formula companies

Journal Articles

1. Infant formula and toddler milk marketing and caregiver's provision to young children.⁹

Romo-Palafox, MJ, Pomeranz, JL, Harris, JL. Infant formula and toddler milk marketing and caregiver's provision to young children. *Matern Child Nutr.* 2020; 16:e12962. <https://doi.org/10.1111/mcn.12962>

Key Messages

- Infant formula and toddler milk advertising may substantially affect caregivers' choice of milk for their child.
- Most caregivers believed marketing claims promoting unsubstantiated benefits of infant formula and toddler milks.
- Parents who believed these marketing claims were more likely to serve infant formulas or toddler milks to their child.
- Advertising that suggests infant formula and toddler milks provide developmental and other benefits for young children may neutralize public health messages and obscure health risks.
- Awareness of recommendations to offer toddlers whole milk and avoid sugary beverages did not prevent parents from providing toddler milks.
- Common infant formula and toddler milk marketing claims may mislead caregivers about product benefits and appropriateness for their child; public health campaigns to counter marketing claims and regulation of toddler milk labels are required.

2. US toddler milk sales and associations with marketing practices.¹⁰

Choi, Y., Ludwig, A., & Harris, J. (2020). US toddler milk sales and associations with marketing practices. *Public Health Nutrition*, 23(6), 1127-1135. doi:10.1017/S1368980019003756

Key Messages

- Aggressive marketing of toddler milks has likely contributed to rapid sales increases in the USA (Advertising spending on toddler milks increased fourfold during 2006-2015 and volume sales increased 2-6 times.)
- These sugar-sweetened drinks are not recommended for toddler consumption.
- Health-care providers, professional organisations and public health campaigns should provide clear guidance and
- Educate parents to reduce toddler milk consumption and address misperceptions about their benefits.
- These findings also support the need to regulate marketing of toddler milks in countries that prohibit infant formula marketing to consumers.



3. Breastfeeding in the 21st century: epidemiology, mechanisms and lifelong effect¹¹

Victora C, Bahl R, Barros AJD, Franca GVA, Horton S, Krusevec J, Murch S, Sankar MJ, Walker N & Rollins N (2016). Breastfeeding in the 21st century: epidemiology, mechanisms and lifelong effect. *The Lancet*. 387(10017):475–490.

Key Messages

- The International Code of Marketing of Breastmilk Substitutes and its subsequent resolutions (the Code), adopted at the 34th World Health Assembly in 1981, is intended to offer protection from inappropriate marketing strategies used by BMS companies, but it is inadequately implemented and monitored in the UK and elsewhere.
- Investigations by WHO and Save The Children find that, in contravention of the Code, some BMS companies seek to influence governments and health professionals in various ways, including through event sponsorship, incentives to promote their products and links with professional bodies.
- Some also promote their products directly to pregnant and breastfeeding women.
- Conflicts of interest and conflicting political priorities undermine efforts at all levels to support women to breastfeed.
- It's an industry that is growing, with global sales expected to reach US\$70.6 billion by 2019
- Only in France and the USA are sales expected to fall, as a result of legislation, public awareness campaigns and actions by civil society in support of breastfeeding.

Exploitation during the COVID-19 Pandemic

4. Old Tricks, New Opportunities: How Companies Violate the International Code of Marketing of Breast-Milk Substitutes and Undermine Maternal and Child Health during the COVID-19 Pandemic¹²

Ching C, Zambrano P, Nguyen TT, Tharaney M, Zafimanjaka MG, Mathisen R. Old Tricks, New Opportunities: How Companies Violate the International Code of Marketing of Breast-Milk Substitutes and Undermine Maternal and Child Health during the COVID-19 Pandemic. *International Journal of Environmental Research and Public Health*. 2021; 18(5):2381. <https://doi.org/10.3390/ijerph18052381>

Key Messages

- COVID-19 has increased vulnerability and taxed health systems and healthcare workers
- Tactics including unfounded health claims and misguided information on breastfeeding are designed to cultivate parents' fear and uncertainty.
- This makes them susceptible to not just the BMS products, but also the inherent marketing messages the sense of reassurance found in the idea of immunoprotection.
- The donations campaigns and offering of support and services have a solidarity effect that allows companies to appear as supporters or even comrades in the fight against COVID-19.



- This helps companies gain goodwill, a valuable marketing asset.
- Companies take advantage of the vulnerability inherent in these sentiments through emotional appeals.
- As people spend more time on digital platforms, their personal data become more accessible to advertisers for marketing purposes.
- Economic downturns have caused financial hardships to many families. Companies target vulnerable populations, including low-income families, with free samples and sales discounts linked to COVID-19.
- The lack of public awareness about how BMS donations harm public health has ‘empowered’ companies to continue to reinvent this old trick—packaging them into charitable initiatives through partnerships with foundations and NGOs.
- Beyond the pandemic, decades of aggressive marketing, inadequate maternity protection, and scarce breastfeeding support have enabled formula and bottle-feeding to become a widely-accepted social norm, with which breastfeeding has to compete.
- The stark difference in resources between BMS companies and those available for protecting and supporting breastfeeding places women and children in a kind of structural vulnerability—one that undermines women’s confidence in their ability to breastfeed, the public’s access to accurate health information, and children’s right to optimal health.
- The fact that inappropriate marketing can even thrive in global emergencies, indicates that companies are nefariously taking advantage of the lagging Code implementation and enforcement.
- This study has provided evidence that companies are exploiting a global pandemic as a new marketing entry-point.
- The imminent risks of increased child mortality, morbidity, and malnutrition during the COVID-19 pandemic should convey to governments the urgency to drastically scale-up efforts to restrict harmful marketing practices of BMS companies to protect breastfeeding.

5. The Timing, Nature and Extent of Social Media Marketing by Unhealthy Food and Drinks Brands During the COVID-19 Pandemic in New Zealand.¹³

Gerritsen S, Sing F, Lin K, Martino F, Backholer K, Culpin A and Mackay S (2021) The Timing, Nature and Extent of Social Media Marketing by Unhealthy Food and Drinks Brands During the COVID-19 Pandemic in New Zealand. *Front. Nutr.* 8:645349. doi: 10.3389/fnut.2021.645349

Key messages

- This New Zealand study highlights the inadequacy of the industry-led self-regulatory system and demonstrates the need for a government-led approach, which is free from conflicts of interest, to effectively protect children from economic exploitation by these large trans-national brands and companies.
- This paper adds to an emerging literature base on the commercial determinants of health, specifically related to corporate marketing.



- Companies used the tactic “COVID-washing,” that is, the misappropriation of social concern about the pandemic in order to promote unhealthy products and build brand loyalty.

Other documents

6. Cross-promotion of infant formula and toddler milks¹⁴

World Health Organization, UNICEF, 2019 WHO/UNICEF INFORMATION NOTE Cross-promotion of infant formula and toddler milks <https://www.who.int/nutrition/publications/infantfeeding/information-note-cross-promotion-infant-formula/en/>

Key messages

- The now common cross-promotion practice by which breast-milk substitutes for infants are promoted through labelling and advertisements of toddler formulas is a threat to breastfeeding and infant health.
- This marketing tactic has become highly prevalent in an apparent attempt to circumvent national regulation of the marketing of products for infants.
- Mothers are confused by this strategy and often believe that there is little difference among the different products in a line.
- As a result, young infants are being fed with toddler milk, which cannot meet their nutritional needs.
- The practice of cross-promotion of breast-milk substitutes must be curbed.

7. Brands off our kids! Four actions for a childhood free from unhealthy food marketing.¹⁵

Hickey K, Schmidtke A, Martin J *Brands off our kids! Four actions for a childhood free from unhealthy food marketing*. Obesity Policy Coalition, Melbourne, 2021.

Key messages

- Australian governments must regulate to protect children from unhealthy food marketing.
- The processed food and advertising industries should not be allowed to make their own rules – they will always put profits above children’s health.
- Policy development must be protected from the food and advertising industries’ efforts to influence it.



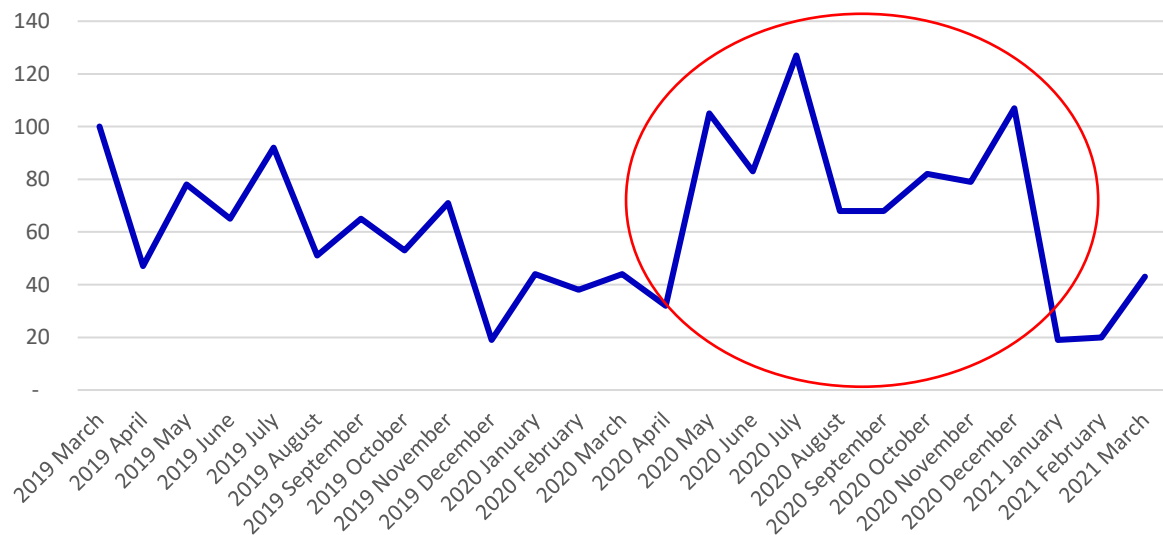
5. Record of 25 months of WHO Code violations in Australia

BAA has collected and collated over 1600 breaches in the last 25 months. The data has been organised for analysis and is shared here so there can be no understatement of the deliberate unethical behaviour of these companies. Despite rhetoric from the Department of Health stating they do collect WHO Code breaches, even if they fall outside of MAIF, there is no evidence that this has happened to date.

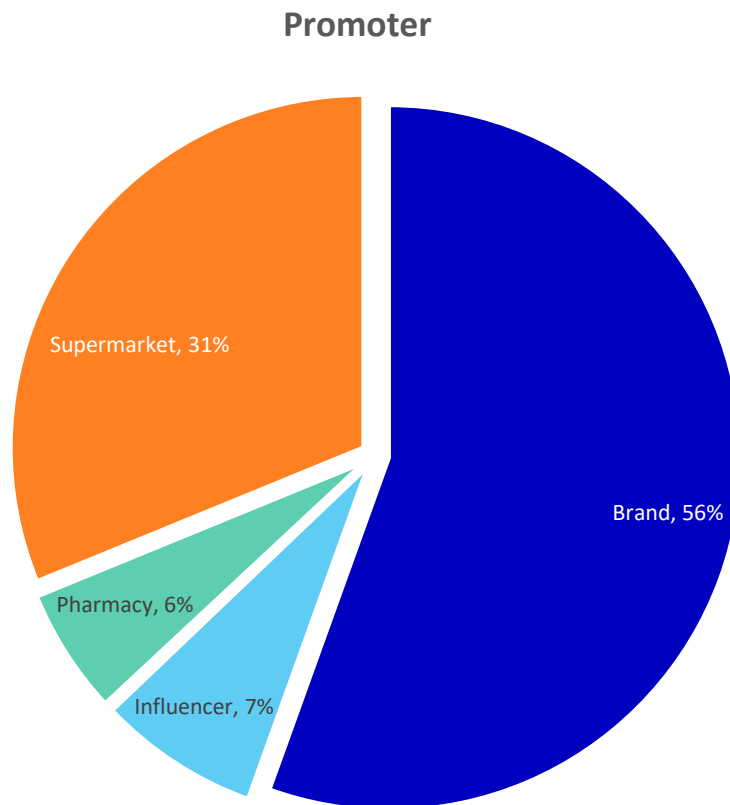
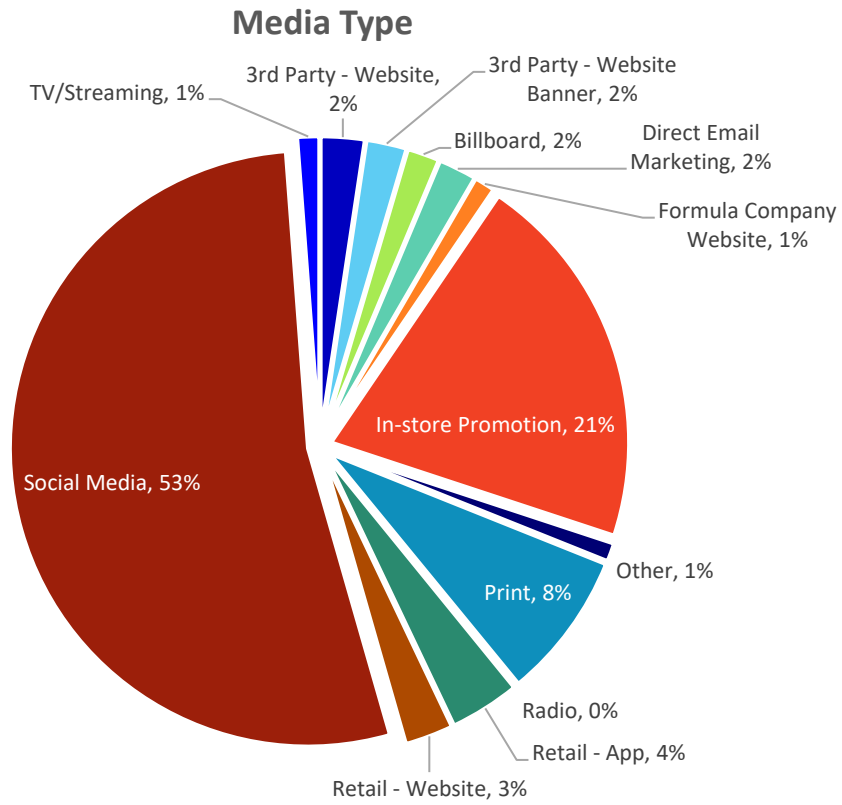
In summary:

- Toddler milk drink has been observed as being the most frequently advertised product in observed potential breaches (46%), which is significant given it is a product that is medically unnecessary for healthy children and more akin to soft drink from a sugar content and general health perspective
- Unsurprisingly more than half of all observed potential breaches (53%) were observed on social media; an emerging advertising medium which is not well governed/regulated
- Formula companies' own-brand advertising is responsible for the majority (56%) of observed potential breaches
- Formula companies are themselves responsible for the vast majority (80%) of concerning social media activity

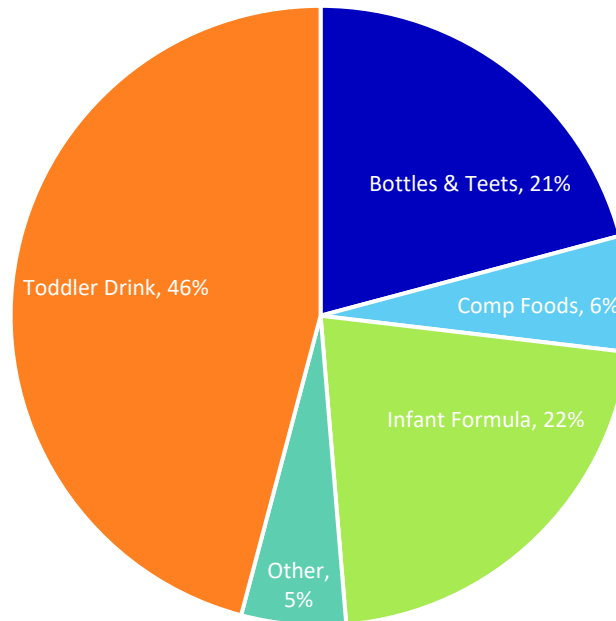
Observation Volumes



Please note the spike in volume of advertisements beginning with the COVID-19 pandemic

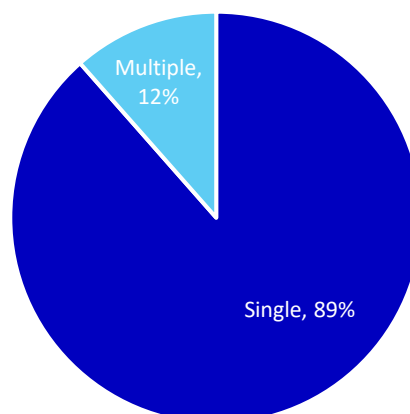


Product Type



The most frequently advertised Product Type, **Toddler Drink**, has a **biased/higher Explicit Cross-Product Promotion rate** of 16% (the vast majority of which cross-promoted infant formula). To be specific, infant formula is pictured alongside or explicitly referred to in the ad.

Explicit Cross-Product Promotions





DETAILED RESPONSE TO INDIVIDUAL POINTS IN THE DRAFT DETERMINATION

Conflicting use of information

In many places the same point is made using different language then this repeated point is dismissed in another point, there is no clear message about the situation, the role of the ACCC and the action required. The inconsistency works in the favour of industry, not consumers. There is an expectation that the ACCC will act in the interest of the community, by presenting the information collected clearly and fairly without interpretation.

BAA observes that all statements made by industry have been accepted as fact and that evidence and information provided by volunteers, with no pecuniary interest are questioned and the use of language that seeks to create doubt and speculation is a repeated feature of this draft determination. This includes evidence from the WHO and peer-reviewed studies that have no industry links.

Tax-payers would expect that the claims made by those who benefit financially from undermining public health would have at least the same level of scrutiny and doubt demonstrated in the wording of this determination.

2.4 The statement “Australia currently implements the WHO Code and related WHA Resolutions in the following way” is a sizeable misrepresentation of the situation in Australia. The exact situation is; Australia has created a voluntary agreement with industry as a superficial response to their obligations as signatories to the WHO Code. The word implement does not reflect the reality.

MAIF has been found, on more than one occasion to be lacking and whilst some of the clauses mimic clauses from the actual Code, the scope and detail of MAIF misses the principles and intention of the Code. The Code has always been a WHA resolution that includes all subsequent resolutions and not a stand-alone document.

For this myth to continue in the background, means that there is limited understanding of the WHO Code by the ACCC and the Department of Health, rendering decisions about its merit clouded by misinterpretation. This is a continued frustration for those face to face with mothers and babies impacted negatively by this failure every day and everyday no action is taken to protect them.

It is a curious suggestion that there is guidance on the WHO Code for health workers in the NHMRC Dietary Guidelines for Children and Adolescents (2003).

http://movewelleatwell.tas.gov.au/data/assets/pdf_file/0006/78810/Dietary_Guidelines.pdf

On page 14 of this document it states *“The Infant Feeding Guidelines for Health Workers, provide detailed advice on adolescent pregnancy and breastfeeding; indications for the introduction of solids; breastfeeding initiation and management; problems encountered in*



breastfeeding; health professionals' responsibilities under the WHO Code; and the use of infant formula."

This document further references the NHMRC Infant Feeding Guidelines for Health Workers; we will assume this is now referring to the current document from 2012. The guidance in this document is included here so there can be no misunderstanding of how unclear and misunderstood this statement in 2.4 really is.

"10.1.2 Health workers' role

All health workers in Australia have an important role in promoting and supporting breastfeeding. Some aspects of the WHO Code are the responsibility of other parties, such as government or industry, but it is important that health workers are able to support and understand the objectives of the WHO Code as appropriate to Australian conditions. In keeping with the aims of the WHO Code, and its application in Australia, all health workers should:

- *promote optimal infant nutrition by promoting breastfeeding*
- *provide information about infant formula when required and support families who are using infant formula*
- *understand the intent of the MAIF Agreement in limiting the marketing of infant formula, particularly in regard to gifts and samples from infant formula companies.*

Advice for health workers

Continue to implement the WHO Code and be aware of health professional obligations under the MAIF Agreement." Pages 97-98

Our questions relating to this statement are:

Is the ACCC saying that Australian Health Workers should abide by the WHO Code, but Industry and Government can use MAIF?

Is this 2003 document relevant in 2021?

BREASTMILK MILK SUBSTITUTES

Infant formula

2.7 The description of Infant formula as a food for infants up to 12 months is accurate. The additional information is superfluous and misleading to understanding this product and its role in infant feeding. All products sold in Australia must meet the FSANZ Standard 2.91.¹⁶ This means a minimum nutritional content to ensure the child can grow and not have brain damage because cow's milk is meant for calves, not human babies. Modifications are necessary to reflect the significant difference between the species. Suggesting this product meets all the nutritional needs is a misrepresentation of the product, it meets the minimum requirements.



The omission of this critical detail in all discussions about toddler drink products fails to recognise the deliberate promotion of these products to all toddlers as a necessary and beneficial part of their diet. Regardless of their inclusion in MAIF and the need for the ACCC to act on that matter independent to this determination.

Infant Nutrition Council

2.12 “The ACCC does not have information as to the proportion of sales of infant formula by volume, is covered by the signatories of the MAIF Agreement.” It is reasonable to expect that this information is researched independently in order for the decision to be well informed. To accept an unsubstantiated statement by the interested party in this matter as “evidence” is unbecoming of a body such as the ACCC and below community expectations of due diligence in this matter.

In the BAA submission a list was provided of at least 20 other companies selling these products with more emerging in this financially lucrative, unrestrained, market every day.

2.13. This list represents 40% of the known players in the market (as evidenced in the BAA submission) and an unknown percentage of the market so cannot be assumed to be an industry wide representation. Industry-wide participation is an ACCC criteria required for a voluntary agreement to be deemed effective. For a relevant decision, this information is critical to the decision and must be researched independently to the industry. The mothers and babies of Australia deserve a well-informed decision for their tax-payer funded consumer protection body.

New Complaints Handling Process

2.15 BAA would strongly disagree with the statement that the public health representative was independent. His career is populated by industry funded projects. To not acknowledge this, is again, not consistent with due diligence and begins the process by being misinformed.

2.16. BAA would remind the ACCC that the number of complaints reflect the concern of those in the public that understand the harm and influence, to suggest that because they do not “technically” breach MAIF they are not relevant is to dismiss the significant public concern.

National Breastfeeding Strategy

2.17 There is **no evidence** of any action or funding related to the Australian National Breastfeeding Strategy 2019 and Beyond (ANBS), until such evidence exists there can be no assumptions made about a MAIF Review or implementation of this strategy when considering the current situation for mothers and babies in relation to this decision.

2.18 *“The Breastfeeding Strategy also noted that research suggests that Australian consumers fail to distinguish between the advertising of infant formula and toddler drink, and that there had been an increase in toddler milk and other baby food advertising in Australia.”*



The actual wording from the ANBS is much clearer and avoids any doubt or hesitation about the situation for Australian consumers. The statement above misses the point about the evidence shown in these studies about the increase in product sales. The omission of this detail changes the meaning and significance of this background information. BAA questions the use of minimising language to cast doubt on existing well-established evidence.

*“Australian studies **have shown** that, while there has been a reduction in the marketing of infant formula, there has been an increase in toddler milk and other baby food advertising. Research suggests that Australian consumers fail to distinguish between advertising for infant formula and for toddler milk. Some have argued that toddler milk advertisements are functioning as de facto infant formula advertisements and that this is likely to reduce breastfeeding rates.”*

2.19 BAA expresses concern that after at least 4 invited and tax-payer funded explorations of MAIF, and the externally verified findings from the WBTi 2018 Report¹⁹ on Australia, finding it inadequate, the action is not to immediately act to protect breastfeeding but to use tax-payer dollars to pay for another external review when no action has been taken on any other previous reviews.

4. ACCC ASSESSMENT

BAA recognises the stated role of the ACCC in this process to *“assess whether the likely public benefits of the current MAIF Agreement and guidelines for which the parties have authorisation will outweigh the likely public detriments. The ACCC’s assessment does not extend to determining or commenting on health policy in relation to infant feeding.”*

As the tax-payer funded body that purports to promote *“competition and fair trade in markets to benefit consumers, businesses, and the community. We also regulate national infrastructure services. Our primary responsibility is to ensure that individuals and businesses comply with Australian competition, fair trading, and consumer protection laws - in particular the **Competition and Consumer Act 2010**”* there is an expectation that if products are shown to be harmful and a danger to public health then the ACCC will act with advice and recommendations to address any gaps in legislation in order to demonstrate their interest in public safety and NOT as a protector of big business.

Hiding behind existing inadequate protective measures falls outside reasonable public expectations. This deficient voluntary agreement requires ACCC to comment and make recommendations that go beyond authorisation. The misleading industry rhetoric about this having public benefit must stop and the realistic portrayal of the situation for mothers and babies needs to be spelt out in this determination. To pretend that they aren’t maximising their sales with their marketing teams is frankly naïve and insulting to us, the volunteer advocates, (who have no pecuniary interests), and to all the families harmed by these unsubstantiated claims.



Relevant areas of Competition

These products have zero points of difference that any manufacturer can claim. The points of difference are not allowed under the labelling laws.

- How does the ACCC see them competing?
- What claims can be made that sets their product apart from another that can be held up with robust independent science?

The notion that they can compete would suggest the ACCC believes that one product has a discernible difference from another that the company can claim in their marketing.

- Can the ACCC please identify what components of these products can be used in their advertising claims when they are competing?

The essence of competition is for the consumer to see the differences in the products and make informed decisions. If this is true, then a list of all the components of breastmilk must be on all cans.

The risks of the ultra-processed powder as well as the unsterile state of the product must also be disclosed for public safety.

Future with and without the Conduct

4.10 The ACCC asserts that without MAIF there is no restriction on marketing, **ONLY**, related to members. There is recognition of the need for **ALL** companies selling and manufacturing these products to follow food standards legislation. The current state of marketing is that there is no-one monitoring any company, any claims and there are no penalties for overt and ongoing flaunting of non-adherence to these regulations.

- What measures will the ACCC take to ensure compliance of existing breaches of this legislation (FSANZ standards) by signatories and non-signatories?
- How are these laws enforced?
- How can volunteer advocates report and follow action taken in relation to these breaches?

4.11 The ACCC has ample evidence that these companies, both signatories and non-signatories flaunt existing legislation related to labelling and; as acknowledged repeatedly in this determination, circumvent MAIF underlying principles and aims. To suggest inaction as a response because proper measures may take time to implement is an unacceptable response.

- What action can volunteer advocates take, when they are not using their spare unpaid time to offer support to mothers and babies, to facilitate changes?

4.12 It is not acceptable for a tax-payer government body to “assume” anything. The decision needs to be based on fact and using the underlying principles of consumer protection when facts are unavailable.



- Can the ACCC provide proof and examples of “reputational damage” as an adequate deterrent for unacceptable corporate behaviour?

Public Benefits

It is a mockery for all concerned to suggest that there is any public benefit to this voluntary agreement and for the ACCC to continue to follow this noticeably clear industry fairy tale is an improper response from the commissioners tasked with reviewing this authorisation. The considered review of the evidence provided to them from respected and credible sources that are free from commercial influence would certainly indicate no proof of public benefit.

4.15 It is not necessary for the ACCC to reinterpret the public health outcomes related to protecting and supporting breastfeeding. In doing so it demonstrates the paucity of their understanding of the issues and the risks of artificial feeding. The ACCC has already stated that public health is not in their scope. (4.3) However the public should be able to expect the ACCC will protect them from harmful products and untrue health claims.

4.16 Why would the ACCC find it necessary to reinterpret and make statements about the contents of the WHO Code, the only relevant fact here is that “usual marketing practices are unsuitable”. This statement, and acknowledgement by the ACCC, is not reflected in any **action**. This omission is critical to interpreting these complex issues and should underpin all decisions related to infant feeding in Australia.

4.17 – 4.19

- Could the ACCC please describe the existing restrictions on marketing that protect the public that are not currently circumvented by current marketing practices of both signatories and non-signatories?

It is extraordinary fiction to suggest that there is any measurable, functional public benefit, for the ACCC to continue to make this unsubstantiated claim and is truly an affront to the mothers and babies and those who seek to offer support to them.

Factors which may limit the public benefit

Is there a reason the word “may” has been used here when robust research by independent academics around the world have found it to be a certainty?

If this ongoing claim is made, evidence of such benefit should be provided to support it.

Marketing of toddler drinks

The ACCC recognises and accepts the following points:

- Labelled similarly (logo, names, labels and colours) and shelved together (4.21)
- The WHA resolution 69.9 related to toddler drinks was not available at the time of the 2016 determination. This would be relevant information for the next (that is this one) authorisation. (4.22)



- Numerous parties have expressed concern about the marketing of these products. (4.23) It is noted that ACCC have interpreted this concern as calling for inclusion of these products included in the MAIF agreement, whilst that is true, the concern around mislabelling requires addressing within or outside of MAIF. The expressed concerns are not expunged because MAIF is not the appropriate instrument to manage them.
- WHO has recognised these products as breastmilk substitutes and therefore require the same attention to marketing practices. (4.24)
- Manufacturers use these products for deliberate cross-promotion to circumvent restrictions on promotion of infant formula. (4.25)
- WHO expresses strong concern about this deliberate indirect marketing activity. (4.26)
- WHO recognises international and Australian studies that demonstrate (not “in their view” but proven scientifically without commercial influence,) confusion by consumers between infant and toddler products.
- ACCC acknowledges the increasing body of knowledge supporting this, and that infants have been fed the wrong product because of this confusion.

With this admission of evidence-based risk, harm, and deliberate action by companies to mislead consumers in the interest of profit, the ACCC then accepts the word of industry that these issues have been addressed. Is this a correct interpretation? Or, is there evidence that has not been presented here?

4.29 To suggest that issues related to the marketing of toddler drinks have been addressed is frankly inconceivable. For the ACCC to accept the word of the industry and avoid overwhelming evidence and not investigate independently is not due diligence. To know these products are marketed as a normal part of the diet with misleading claims and fail to act is negligent.

4.30 The ACCC, in its expert opinion has overridden the WHO Code about these unnecessary products. This clearly demonstrates the influence industry has in Australia and makes a mockery of what is meant to be an independent body protecting consumers.

4.31 The guidance document referred to is ONLY for members and is not proof of action.

The ACCC is required to investigate that these fallacious claims are proven to actually have been actioned to prevent the behaviour. No such investigation has happened and there is no evidence of any action, our screens and lives are full of toddler drink false advertising. The full acceptance of what is told by the industry to the ACCC and the questioning of evidence provided by the volunteer advocates with no pecuniary interests is to be noted and documented in the interests of accuracy.

4.32 The committee’s interpretation of infant product labelling and toddler drinks is not relevant to the situation or the harm. The labels on many infant products are loaded with misleading facts, made up scientific sounding words and idealising images. Instead of

accepting the information from the industry body, an external examination into the actual situation (not claims made by those with financial interest) would be welcomed by the taxpayers. This factual information is necessary for a well-considered decision, especially when the consequences are so harmful to infant and maternal health.

4.36 BAA draws attention to this minimising/trivialising language in this point. The question to ask is if it is self-protective or deliberate understating, the motive can only be guessed.

*“While marketing practices in relation to toddler milks have been occurring in Australia for some time, recent WHO statements on toddler milk advertising, together with increasing academic studies, **lend increased weight** to the conclusion that toddler milk marketing is effectively a proxy for the marketing of infant formula. The ACCC considers that advertising of a number of toddler milk products in Australia exhibits characteristics **consistent with those over which concerns have been raised by the WHO and studies**, such as an emphasis on elements which are common to the entire ‘range’ of breast milk substitute products including packaging and branding.”*

The truth is, **CONCERN**, about marketing of these products has been expressed for a very long time, not simply marketing of the products. To be clear, the WHA was so concerned by the overwhelming evidence of harm that it made a resolution, WHA 69.9. Given that no actual investigation has been undertaken by the ACCC to understate this and suggest it is just an “increasing concern by the WHO” is gross understatement and has potential to mislead. BAA questions the motive for understating and trivialising the situation.

4.37 BAA again draws attention the minimising language in this statement. It may be helpful for the commissioners to do a simple search for a single product in this category then sit back and experience the assault on every way they can be reached by the marketing imagination of these companies. To state that “*The WHO material referred to above supports this conclusion, as do a number of submissions from interested parties*” Then to cast doubt on this statement by starting the next sentence with “*If this is the case...*”, sends a mixed message. There is no such questioning or doubt cast on any claims accepted by the ACCC from the INC.

*“Given the extent of the marketing and promotion of toddler milk in Australia, and the clear similarities between toddler milk packaging and infant formula packaging across many product ranges, the ACCC considers **there is a risk** that the marketing of **some** toddler milk products communicates indirectly with consumers about infant formula products, and is **likely** to have much the same effect as the direct marketing of infant formula in that product range. The WHO material referred to above supports this conclusion, as do a number of submissions from interested parties. **If this is the case**, the impact on consumers of the marketing and promotion of toddler milks may be such that the purpose of the MAIF Agreement is undermined and the public benefit resulting, or likely to result, from the Conduct significantly reduced.”*



4.43 *“The ACCC considers there is not sufficient evidence that brand and product range marketing is likely to reduce the benefits of the MAIF Agreement for the purpose of the current assessment.”*

To make sense of this statement evidence needs to be provided, it is incredulous that the evidence provided to the commissioners would lead to this statement. I think BAA and the rest of the world would respond by expressing extreme disappointment in the lack of due diligence and ignorance demonstrated in this statement.

Oversight and complaints

There is no information offered on the process of oversight. BAA wrote a thorough explanation providing evidence that it is not effective or reflective of the public concerns.

4.47 The ACCC asserts that the industry organisation calling itself the INC, has an “in-depth knowledge of the industry”. BAA would ask the ACCC, on what grounds does a profit driven understanding of an industry contribute anything of value to the issue of public benefit?

This notion that there is something of scientific and of public health merit to contribute has no basis and this claim comes from the industry, there has been no independent investigation of whether this is factual. Their purpose is to make profit for their share-holders, to meet the food standards and provide accurate information for consumers that does not mislead or misrepresent. The un-sterile nature of the product is still not something that consumers are aware of. The ACCC is called to act to ensure this information is provided on the cans.

The Department of Health has done no independent investigations about the process that address public concern or relevant issues. The omissions from the tax-payer-funded review are outlined in our existing submission. The suggestion that it is a more transparent process has not been proven accurate and BAA would disagree strongly.

4.49 The upholding of breaches and the behaviour of companies after breaches are upheld, is a reflection of the inadequacy of the process. The ACCC not being aware does not in any way demonstrate that this complaints process is effective and transparent.

4.50 It is confusing for the ACCC to accept and make statements supporting a complaints process that is clearly inadequate then to say they can make no recommendations about the make-up of the committee. This is confusing.

Industry Coverage

The wording in the information regarding industry coverage (4.52 The Council understands... 4.54 the ACCC understands that the majority) suggests that the organisation of manufacturers and importers have given this information to the ACCC and no further investigation of the actual situation has been done. The ACCC, having accepted this as fact, goes on to say, without any evidence, “this supports the likely public benefits arising from the Conduct.” (4.54) **There are no established grounds for this statement.**



BAA would disagree with the statements made in 4.55 that marketing behaviours, because they are voluntary, are outside their role in this assessment. A workable voluntary agreement would at least require industry wide participation.

Further Comments

Further comments related to the Draft Determination will continue after this incomplete response has been submitted to meet the March 22nd deadline. When complete, an updated version will be forwarded to the ACCC. We thank the commissioners for their patience in this matter.

RECOMMENDATIONS

This affiliation of manufacturers and distributors of infant formula is now asking for a 10-year re-authorisation of MAIF. Australian mothers and babies deserve better protection than this voluntary industry agreement, and we call on the ACCC and the Australian government to act decisively to implement legal and punitive measures that mirror the incalculable burden of financial and health consequences which are now being carried by Australian mothers, babies, volunteers, and taxpayers.

Recommendation 1

Implement legal and punitive measures that mirror the incalculable burden of financial and health consequences which are now being carried by Australian mothers, babies, volunteers, and taxpayers.

Financial penalties should reflect percentage of profits.

Authentic Action

Listing the companies on the DoH website presents a dilemma. For a complaint to be made, the public need to know which products these companies make, but to list the products may seem like advertising. How is the public to know which products are covered under MAIF? It is not obvious from the list and it can take some digging to find the actual product made by the listed company.

Any complaints that have been upheld should be listed with the company, not in a separate list. It should include what the breach was, what action was taken and confirmation that the matter has been resolved. BAA recommends immediate action to remove this barrier to making complaints.



Recommendation 2

Create a list of companies with their products that is visible on the DoH website so the public knows which products each company makes.

Recommendation 3

Breaches, the action taken, confirmation that the breach has been resolved should be visible for the public. Both company and product should be clearly identified.

An affiliation of infant formula manufacturers and importers of infant formulas calling themselves “the Infant Nutrition Council” is a misrepresentation of the role of the organisation.

Recommendation 4

The INC is renamed to represent the reality that it is an affiliation of companies who import and manufacture these ultra-processed powders so no mistake by government, public servants or the public can be made into thinking they have anything to contribute to public information about infant feeding.

Infant nutrition is a matter for independent health experts, not those selling the product and the Australian public has the right to truth in advertising. The significant public health issue of infant wellbeing should not tolerate this charade. INC can be effective and contribute of the wellbeing of Australian families by:

- ensuring there is no mistaking who and what they are in the public eye
- focusing meticulous attention on ensuring ethical and appropriate sale of their infant formula products
- actively monitoring the participants in the infant formula market in Australia by keeping a list and actively checking the behaviour of all members
- seeking independent opinion on the brand messaging
- ensuring truthful labelling and removal of all health claims
- sponsorship of any health professional education/events should equal the amount spent on independent breastfeeding education.
- No contact with families or pregnant women for any reason, including clubs, subscriptions, parenting advice and access to company paid health workers.

BAA would also highlight that the volume and scope of unacceptable advertising, claims that both breach MAIF and skirt the principles of MAIF is so overwhelming that it is not humanly possible to collect and report them all. The tsunami of advertising is drowning Australian families and health workers and requires urgent deliberate action.

**Recommendation 5**

Collaborate with independent stakeholders to facilitate a simple effective way to report breaches.

Recommendation 6

The Department of Health collect and record all complaints and report this information to the public, whether they fall into the scope of MAIF or not because they reflect public concern.

Legislation

BAA echoes the United Nations (2016) Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination Against Women in Law and in Practice, and the Committee on the Rights of the Child in Support of Increased Efforts to Promote, Support and Protect Breast-feeding.²⁰

“These efforts include the International Code of Marketing of Breast-milk Substitutes (1981) [viii](#), as well as subsequent relevant World Health Assembly (WHA) resolutions. The International Code ensures the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution, including by prohibiting advertising, provision of free samples, or promotion in health-care facilities. It also requires all information on artificial feeding to explain the benefits of breastfeeding and the hazards associated with artificial feeding. Another encouraging development is the new WHO Guidance on ending inappropriate promotion of foods for infants and young children [ix](#). States are encouraged to make use of these crucial tools to regulate and reduce inappropriate marketing practices by baby food manufacturers and distributors.

However, the experts warned that there are clear signs of the lack of progress made in, and urgent need for, the adoption of effective measures by States to eliminate harmful, inappropriate marketing strategies and practices. Simply too few States have adopted the necessary stringent and comprehensive legal measures- only 39 States have laws enacting all provisions of the Code [x](#)- and even fewer have put in place robust and sustainable Code monitoring and enforcement mechanisms.

We call upon States to adopt comprehensive and enforceable normative measures to protect babies and mothers from such practices, and fully align with the recommendations contained in the International Code and the aforementioned new WHO Guidance. Adopting such measures must be recognized as part of States’ core obligations under the Convention on the Rights of the Child and other relevant UN



human rights instruments to respect, protect and fulfil children’s right to life, survival and development; their right to safe and nutritious foods, and their right to the enjoyment of the highest attainable standard of health; and to ensure that women’s rights are protected from harmful interference by non-State actors, in particular the business sector.”

Recommendation 7

Recognition of the failure of this agreement to protect breastfeeding is acknowledged in the Determination and the process towards legislation is recommended by the ACCC and begun.

Recommendation 8

Immediate action is taken to ensure labelling laws are adhered to for all infant and toddler products.

We recommend the current MAIF Agreement expire in **no more than 2 years** and the WHO Code (and subsequent WHA resolutions) legislated with fines and penalties for breaches that reflect the harm and financial cost of health conditions identified in the overwhelming body of evidence.

Recommendation 9

This authorisation is no longer than 2 years and includes toddler products as set out in WHA 69.9.

Recommendation 10

Immediate action is taken by the ACCC in response to evidence provided in these submissions to ensure labelling laws are adhered to for all infant and toddler products.

Recommendation 11

Warning about the non-sterile state of infant formula products and the risks of artificial feeding are placed clearly and prominently on all infant formula cans.

The WHO Code represents a **minimum** standard, if regulation to close loopholes is needed for genuine protection to be afforded in Australia.

We further recommend a register of all companies manufacturing and selling formula in Australia is kept by the DoH with a requirement that the privilege of operating in Australia is



granted only if they agree to the conditions of the legislation both domestically and internationally.

Recommendation 12

A central register of all companies manufacturing and distributing infant feeding formula and toddler drinks is created and available publicly.

Recommendation 13

All companies wanting to operate in Australia, selling these product must agree to any marketing and labelling requirements both in Australia.

Recommendation 14

Companies exporting these products overseas abide by local laws.

Recommendation 15

Action to include the minimum standard set out in the WHO Code and all the subsequent resolutions is begun immediately.



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