THE HISTORY AND POLITICS OF INFANT FEEDING

The composition of breastmilk and the method of supplying it to the infant have been evolved by Nature over an extremely long period, and on general principles we should hesitate to abandon a well-tried method. There are many ways in which we interfere with nature, but the evidence in favour of giving antibiotics, operating on pyloric stenosis, growing better cows or wheat, and for using umbrellas in the rain is much more solid than the evidence for a widespread change to bottlefeeding. The history of bottlefeeding is marred by mistakes...[examples given]...Near perfection may now have been claimed, but the history of infant feeding suggests that this remains unlikely, and that babies would be safer if they were breastfed. 'Humanisation' of preparations for bottlefeeding has led to some uncritical comparisons between breastmilk and modern cow's milk based preparations.

C. B. S. Wood and J. A. Walker-smith
Mackeith's Infant Feeding and Feeding Difficulties
(Churchill Livingstone, 6th edn, 1981), p. 96-7

Infant feeding has been recently discovered as a fertile field of inquiry by some very able historical researchers, and some old ideas are changing. Anyone interested in this area must also read *Dream Babies* by Christine Hardyment,[1] from which I borrowed heavily and cannot recommend too highly. Valerie Fildes' books and articles[2] too, make fascinating reading and are highly recommended. So too is Palmer's The Politics of Breastfeeding,[3] and Rima Apple's writings, referred to throughout this chapter. Here I can present only a rough outline. Because it is such a long and complex topic I have divided it into two parts: the first looking at the issue on a global scale until the early 1980's; and the second concentrating on world developments as they affect Australia and as Australia has dealt with world issues since that time.

PART 1 INFANT FEEDING UNTIL THE INTERNATIONAL CODE

The popular idea of infant feeding is that in other societies, and in past times, babies were either breastfed or died. This is substantially true, but it conceals enormous diversity in feeding habits. In Western Europe over the centuries, most babies were breastfed because their mothers had little or no alternative, and simply assumed that babies should be breastfed. Some commentators remarked upon the health and vigor of such babies of poorer families by comparison with the children of the wealthy.[4] Poor Irish in England breastfed their babies and the children were so healthy as to cause comment by sanitarians, who deplored their living conditions yet recognised that 'a comparative fewness of Irish in a town could improve the infant death rate'. Jewish districts also had lower infant mortality rates despite overcrowding and poverty, and this was attributed to breastfeeding.[5] Of course infant mortality rates from all causes, especially weanling diarrhoea, probably resembled those of today's developing societies. But even if babies were breastfed, they were rarely exclusively breastfed. Every society had a long list of foods, fluids, and herbs which were deemed especially suitable for

---

[1]Hardyment. C., *Dream Babies* (Jonathon Cape, 1983, OUP paperback). This is the perfect baby present for any new mother

[2]Fildes. V., Breasts, Bottles and Babies. (Edinburgh University Press, 1986); Wet Nursing (Basil Blackwell, 1988). See also The Age of weaning in Britain, 1500-1800, *J. Biosoc. Sci* · (1982) 14, 223-240. - The early history of the infant feeding bottle, *Nurs. Times* (1981) 77, 3, 128-9; 77, 4, 168-170. Other references can be found in these articles.

[3]Pandora Press, London 1988. Palmer has personally acknowledged her debt to *Breastfeeding Matters*, so similarities between her book and mine are not surprising.

[4]Smith, F. B., *The People's Health,* 1830-1910. (A.N.U. Press, Canberra, 1979), p. 91.

[5] Ashby, H. T., *Infant Mortality* (Cambridge, 1922), 24-25.]

newborns and their mothers; every society had its prescribed routines and rituals to purge or stimulate or protect. In India it was butter and honey, in Bali premasticated rice and banana, in Peru a syrup of wild endive and chicory.[6]. Given what we know now about the effects of such decoctions on the bacteria of the gut, and the long-term impact this can have, it is reasonable to assume that much of the mortality among breastfed infants was related to such food fads interfering with the protective mechanisms of breastfeeding.[7]

Many babies were breastfed but not by their own mothers. Wetnursing has been an age-old tradition and remains[8] a very successful way of rearing an infant whose mother cannot or will not feed it. Given that not all women can breastfeed without painful problems, this is to be expected- perhaps even encouraged in some situations, despite the HIV paranoia. The popular idea of wet-nurses (irresponsible poor women whose own babies were neglected as they sought comfortable employment) is being shown to be largely false for England in the period before the industrial revolution of the eighteenth and nineteenth centuries. Rather, there were three different types of wet-nurses: 'the parish nurse who took in infants and was usually receiving poor relief herself; the nurses of the London Founding Hospital who worked under the supervision of inspectors; and the privately employed nurse for whom wet-nursing was a significant and continuing occupation for which she received a good wage'.[9] Wet-nursing was a cottage industry carried on by respectable married women in their own homes. Their care for their charges was often first rate, and many of those who wet-nursed orphaned children for the London charitable foundations kept in touch once the children went back after weaning, and tried to secure the children as apprentices, or even adopted them, within the family. (Evidence for the bonding effects of breastfeeding, perhaps?) When other opportunities for gainful employment came to rural areas, wet-nursing declined as an occupation. As the supply of such respectable wet-nurses dried up, so to speak, the desperate poverty and exploitation of the less-fortunate increased. In the eighteenth century, more women were forced to resort to wet-nursing as one of the few ways of staying alive. That their own children were farmed out and neglected, doped with laudanum or gin, was due to the harsh conditions of employment imposed by genteel families who used wet-nurses. More humane families permitted the wet-nurse to keep her own child and breastfeed both. This was perfectly possible for many women, especially if they lived as some wet-nurses did, well-fed and with few chores or responsibilities and little physical exertion. The experience of one eighteenth-century wet-nurse would certainly suggest that there was no need to insist on mother feeding only one child:

'One of the most remarkable wet-nurses of all time was surely Judith Waterford. In 1831 she was written up in both medical and lay newspapers. She celebrated her eighty-first birthday by demonstrating that she could still squeeze from her left breast milk which was "nice sweet, and not different from that of young and healthy mothers". Judith was married to babies. She fed six children of her own, eight nurslings, and many children of her friends and neighbours. In her prime she produced two quarts of breastmilk unfailing every day, but admitted

---

[6]Radhill, S. X., Infant Feeding Through The Ages. *Clin. Pediatr.* (1981)20, 10, p.615

[7] Hanson

[8]The Report of the ACC Sub-committee on Nutrition's Consultative Group on Maternal and Young Child Nutrition (Nov 1979) put in order of priority for failed lactation in developing countries-

(a) Re-establishment of lactation.
(b) Breastfeeding by surrogate.
(c) Feeding non-human milk as a milk product.
(d) Feeding a cereal/other staple gruel augmented by milk/other protein sources.

Wet-nursing, or cross-nursing, remains the safest option for any child unable to be breastfed by its mother.

[9]Fildes, V., The English wet-nurse and her role in infant care, 1538-1800, (Thesis)

sorrowfully that after the age of seventy-five she could not have managed to breastfeed effectively more than one infant at a time'.[10]

Similarly, Budin in 1907 showed that milk output by one wet-nurse rose from 700ml when suckling two infants to 1750 ml when suckling five, over a period of only four days. Wood and Walker-Smith record that in one nineteenth-century royal household a wet-nurse 'was still giving milk lavishly thirty years after the birth of her last child'. [11]

Probably such cases represent the capacity of a small minority of women, but there are modern parallels - the diminutive Cambodian refugee mother who fed five babies in a camp without other supplies, despite her own malnourished state, for instance. Many other examples are on record. NMAA mothers have successfully fed twins and even triplets while doing far more than a wet-nurse was ever expected to, in a household without maids, cooks and other servants. Some Western Australian mothers, for instance, have produced 1-2 litres daily.[12] Women with only one functional breast exclusively breastfed to seven months. And as I emphasise elsewhere in the book, oversupply is a common cause of difficulty here in Australia, as it obviously has been elsewhere given all the concern about overfed breastfed babies.

Another reason why wet-nurses were employed in the seventeenth and eighteenth centuries was because doctors, who served the wealthier classes, forbade coitus during lactation. Mary Wollstonecraft asserted that 'There are many husbands so devoid of sense and parental affection that . . . they refuse to let their wives suckle their children'.[13] While medical advice has changed, there are still husbands who regard the infant as usurping 'their' territory.

Wet-nursing began to decline in the eighteenth century under the twin pressures of alternative employment and medical disapproval. Cadogan's *Essay upon Nursing and the Management of Children* in 1748 argued strongly for maternal breastfeeding. The example of the Duchess of Devonshire and other noble ladies caused routine wet-nursing to fall out of fashion in England long before it declined in France and Germany. [14] Methodism, too, like all other dissenting religions, argued strongly for maternal breastfeeding (Methodism became a major social force in the late eighteenth century). The philosophy of the Enlightenment, and Rousseau's back-to-nature theories, were all agreed on the necessity of maternal breastfeeding - somewhat curious on the part of Rousseau, whose five illegitimate children were all 'left to the tender mercies of the foundling hospital'. [15] This was not to be the last occasion when men of no firsthand experience confidently told women what to do with their children. Indeed, Cadogan's Essay, written for the use of nurses in the London Foundling Hospital, begins: 'It is with great pleasure that I see at last the Preservation of Children become the Care of Men of Sense. In my opinion this Business has been too long fatally left to the management of women, who cannot be supposed to have a proper knowledge to fit them for the Task'. [16] Some of his rules for wet-nurses (scheduled feeds, for example) did untold damage when translated into maternal breastfeeding situations by Men of Sense. All the same, between 1756 and 1761 of

---

[10] Quoted in Digby, I; Mathias, B., The Joy of the Baby (L. Frewin, London, 1969), p. 38.
[11] Wood, C.; Walker-Smith, J., MacKeith's Infant Feeding and Feeding Difficulties. (Churchill Livingstone, 6th edition, 1981), p. 71,75.
[12] Saint, L.; Smith, M.; Hartmann, P. E., The yield and nutrient content of colostrum and milk of women from giving birth on one month post-partum. *Br. J. Nutr.* (1984) 104, 187-194.
[13] Quoted in Hardyment, op. cit., p. 5
[14] Stone, L., The Family, Sex and Marriage in England (Penguin, 1979), p. 272.
[15] Hardyment, op. cit., p. 18.
[16] ibid., p. 10.

the 15,000 babies cared for at the Foundling Hospital, one-third survived infancy. This was very good for the period. Even babies breastfed by their mothers had first to survive the effects of purges, wine (or whisky and oatmeal in Scotland), [17] oils or gruels, in the first few days of life; and later 'tea, coffee, spirits, anything', even opium in order to make them sleep. Opium and alcohol were used as routinely as sedatives and anti-histamines now are, and were as freely - but more cheaply - available, and over-used. No doubt this helped to produce some 'cot deaths' too! Infectious diseases were rampant in filthy overcrowded cities. Foundlings not wet-nursed had almost no chance of survival - only 45 children survived of over 10 000 babies admitted to the Dublin Foundling Hospital between 1775 and 1799. [18] Changes in the Poor Law systems, a greater readiness to experiment with other foods for infants, and many other factors affected the mortality rate of infants; and many other factors also affected the rate of decline of wet-nursing in particular areas.

Thus it was that by the early nineteenth century respectable wet-nursing had seriously declined. Yet wet-nursing certainly continued in London throughout the nineteenth century, as Smith documents.[19] The wealthy used lying-in hospitals and workhouses as employment agencies, selecting vulnerable women who had perforce to abandon their own babies - 'sacrifices to lucre and fashion', as one concerned London doctor said. How many of these women were hapless servant girls and how many semi-professionals who became pregnant in order to enjoy the relative comfort of the wet-nurse's life, is unlikely ever to be known. Certainly the job was reasonably well paid, beyond the reach of poorer families. Artificial feedings of various kinds were being used more often by those mothers unable to breastfeed or to find or afford a suitable wet-nurse. (The enormous families of this period were also related to breastfeeding patterns and failure, and the loss of its contraceptive protection.)[20]. The nineteenth century, too, saw an increase in leisure for some, leaving middle-class mothers more time to invest in child feeding and care. There was an explosion of literature [21] dealing with how to do it right, from every conceivable viewpoint, sentimental, utilitarian, Evangelical, and medical. In spite of that (or perhaps because of it) in 1840 roughly a third of all children under five died, an improvement over earlier times probably related in part to the increase in maternal breastfeeding (80-90 per cent of bottle-fed children still died.[22]

But commercial and industrial influences became more pressing towards the end of the century. New, patented baby foods and bottles, all recommended by male authority figures, all 'perfect', were appearing. Women, too, perhaps in reaction against the constriction imposed by large families, revolted against the idea of breastfeeding now that they were assured by 'authorities' as potent as Isabella Beeton that artificial foods were as good as, if not better than, breast milk' . The concept of infant feeding "choice" emerged at this time, and it was spread by means of the printed word, which leisure and literacy made all-powerful. The anti-breastfeeders of this period were often women who knew 'of no greater misery than feeding a child', [23] considered to lead to female alcoholism! Doctors rapidly adapted to the new situation, finding painless rationalisations designed to keep their patients happy (later, guilt-free). The arguments used are still in vogue today, so it's worth quoting a few.

---

[17]ibid., p. 3

[18]Cone, T. E., History of American Pediatrics. (Little, Brown and Co. 1979). p. 57.

[19] op. cit., p. 71-3.

[20]Short, R. V., The biological basis for the contraceptive effects of breastfeeding in Jelliffe, D. B. & Jelliffe, E. F. P., (ed). Advances in International Maternal and Child Health, v.3. (O.U.P. 1983), p. 37

[21]Hardyment, op. cit., p. 94.

[22]Cone, op. cit., p. 131.

[23]Mrs Panton, 'perhaps the most outspoken of the anti-breastfeeding-school', Hardyment, op. cit., p. 95.

Mrs Panton, a popular female guru of child care, agreed that breastfeeding may have been natural once, 'but we don't live in that time now, and we must adapt our doings to the age in which we were born. . . Let no mother condemn herself to be a common or ordinary cow unless she has a real desire to nurse. . . Women have not the stamina they once possessed'. This fits in well with the 'insufficient milk syndrome' theory of breastfeeding failure.

Another guru of the day, perhaps the most eminent 'expert' on infant feeding, was one Dr Pritchard. Said he: 'Lactation is far more likely to go wrong in a woman than in the teetotal, vegetarian, nerveless cow'. [24] Women were to become as cow-like as possible, restricting social life, eating a boring diet and resting. Other doctors warned that 'sexual emotion' spoiled the quality of the milk, a development of the insidious doubts raised by Lydia Child's advice that mother's milk might appear plentiful, but have no nutritional value.[25] Both these latter ideas still enjoy currency today, despite their obvious error.

Other difficulties were created by the increasing habit of scheduled feeds, breast and nipple anomalies resulting from wearing tight stays, and the complicated supplementary formulae the doctors urged. 'From the first moment the infant is applied to the breast, it must be nursed on a certain plan. The baby must take a little thin gruel, or a mixture of one-third water and two-thirds cows' milk, sweetened with loaf sugar, until the breast milk is fully established'[26] (which of course it never would be, thanks to such supplementation).

Wet-nursing had not died out altogether. As late as 1890 there was a directory for wet-nurses at the College of Physicians in Philadelphia,[27] and a book on midwifery[28] published in 1922 spelt out the essentials for a wet-nurse, one of which now was that she wean her own child. Expense was becoming a major problem: as the supply of wet-nurses decreased, the costs rose at the same time as cheap infant foods were becoming available and were being recommend as safe. I would emphasise that it was not until the nineteenth century that the idea of using babyfoods by choice, in place of breastfeeding, began to take hold. Previously the recognition that 'breast is breast' was universal. (As an interesting sidelight, it is possible that cot deaths emerged, in one physician's experience, between 1839 and the 1860s. Initially Dr Chavasse urged mothers to continue the eighteenth-century practice of sleeping with their babies for nine months. He later reduced that to 'a few months and warned of the dangers of suffocations.[29] Presumably he was seeing infants dying unexpectedly in bed at about four months at age. If infant feeding is a contributory factor, this could be expected, given the ever-increasing use artificial substitutes.)

How could such a dramatic change come about when centuries of experience suggested that artificial feeding was intrinsically more hazardous, and when medical men had for decades inveighed against anything but maternal breastfeeding? There are a number of interlocking variables. Constant urging to breastfeed, without the help to make it possible, inevitably sets up a backlash (now, as then). The anti-breastfeeders had the means and the leisure to express their views; women had the means and the leisure to express their views; other women had the means and leisure to consider and respond. (Improved transport and communications were part of this process.) Failure to breastfeed and emotional distance from children went hand-in-

---

[24] ibid., p. 4.
[25] ibid., p. 49.
[26] ibid., p. 47.
[27] Radbill, op. cit., p. 613.
[28] Jellet, H., A Short Practice of Midwifery for Nurses (6th edition, J. & A. Churchill, 1922), p. 349-50.
[29] Hardyment, op. cit., p. 53.

hand in late-nineteenth-century England; whether one caused the other is debatable. This was the first era of the nanny,[30] not the wet-nurse; it was the era of 'scientific' mixtures and the beginnings of control by 'experts'. (A hundred years later in Australia, this cycle is coming full-circle as the affluent employ nannies once again.) Some of the general developments of the nineteenth century - sanitation and safer water supplies, improved food handling, refrigeration and railways - made it possible to conduct such experiments on babies without catastrophic increases in infant mortality. (Infant mortality did rise in this period, but people expected many children to die in infancy. And in any case, detailed statistics documenting changing mortality were not widely kept or publicised. The parallel for us is our refusal to document and publicise the steeply increased morbidity among babies put into childcare.) Female factory employment was another contributing factor. Attempts to prevent mothers working for some time after childbirth were fruitless: those who worked needed to do so, in most cases; and the 1891 Factory Act made little difference. Of course there were no childcare facilities. Many infants were heavily sedated with opium while the mother worked, and many died from its effects. But as Smith points out, to keep that in perspective we might remember that '200 000 children under 11 were being doped with doctor-prescribed tranquillisers in Britain in 1974'.[31] And chloral hydrate and much more potent drugs are readily given to Australian infants. According to Dr Schlebaum,[32] half of Australia's children under five were on regular medication in 1981, and much of that was such things as valium syrup and sedating antihistamines (freely available over the counter in chemists).

When commercial milk technology improved, it was America that pioneered the mass use of bottle-feeding, probably one of the most devastating aspects of America's impact on the rest of the world. Condensed milk was first developed in 1853; evaporated milk in 1885. Both were widely used; evaporated milk until the present day. Condensed milk is now causing the same problems in developing countries as it did in American, British and Australian working-class families in the nineteenth and twentieth centuries: malnutrition, rickets, diarrhoea, intellectual deficits, death.[33] The first patented substitute for breast milk was probably von Lieberg's 'perfect infant food', a mixture of wheat flour, cow's milk, malt flour, and potassium bicarbonate. This was such a commercial success that various other products rapidly appeared-some made of dried cow's milk, cereal and sugar (Nestlé Food and Horlick's Malted Milk); some form of malted carbohydrate (Mellin's Food); some simply pure cereals to be used mixed with fresh cow's milk (Eskay's Food, Robinson's Potent Barley). Most of these were nutritional disasters, some lacking or excessively high in protein, vitamins, minerals, even fats. But that did not stop any of them claiming to be entirely suitable for infants, 'the most perfect substitute for mother's milk'. The existence of these patent foods was one of the reasons that doctors felt they should take firmer control of the whole business of infant feeding.

By the 1890's enough was known of the composition of cow's milk and human milk for doctors to begin modifying cow's milk. Dr Rotch, of Harvard University, developed a technique of diluting cow's milk, then adding sugar and cream. He and his followers tried to tailor this to the needs of each individual child, varying the proportions as the child grew. The percentage feeding method was unbelievably complex. Mothers around the world grappled

---

[30]Gathorne-Hardy, J., Rise and Fall of the British Nanny (Hodder, London 1972)

[31]Smith, op. cit., p. 93-9.

[32]Schlebaum, A., From zygotes to zombies? - a critical look at our children's brave new world of chemical abuse - in (ed) Man, Drugs & Society 181-7. Yet adult allergy sufferers cannot buy the same quantity of the same anti-histamine drugs for their hayfever without consulting a doctor.

[33] Anderson, S. A., Chinn, H., Fisher, K. D. History and current status of infant formulas. *Am. J. Clin. Nutr.* (1982) 35, 381-397.

enthusiastically with such 'scientific' methods: as Hardyment says 'What was odd was that they were not driven back to their breasts in despair!' Obviously specialised knowledge and skills were required, so mothers were pushed further out of the process of infant feeding. The process of developing 'scientific' formulae was well under way. Rotch established a special laboratory to prepare modified cow's milk formulae according to the doctor's orders, and then deliver the formulae to customers. Milk Laboratories were established in various cities throughout the United States and Canada, and even in London.[34] But individualised formulas were time-consuming and expensive and could not hope to compete with widely advertised instant foods. Even doctors were intimidated by the responsibility and complexity of Rotch's system, and many recommended patent foods.

The medical profession tried to assert its authority. In 1893 Dr Rotch stated: 'it would seem hardly necessary to suggest that the proper authority for establishing rules for substitute feedings should emanate from the medical profession, and not from non-medical capitalists. Yet when we study the history of substitute feeding as it is represented all over the world, the part which the family physician plays in comparison with numberless patent and proprietary foods administered by the nurse is humiliating and one which should no longer be tolerated'.[35] Mothers could buy the patent products without ever seeing a doctor. This was seen as undesirable medically- the child needed medical surpervision- and financially, for artificial infant feeding could be 'the portal of entrance to a large practice'[36] (unlike successful breastfeeding).

The progress in food technology and science, outlined here, was undoubtedly an improvement on earlier, even less satisfactory ways of feeding infants whose mothers could not breastfeed. Unfortunately, as Hambraeus has said, such progress also included intensive commercial promotion, which led to a rapid decline in breastfeeding.[37]. By the early twentieth century this was causing alarm among doctors, and the formula companies recognised both the validity of the doctors' fears- who could trust mothers?- and the power they could choose to exert. The companies began to court the medical profession's approval. Directions were taken off the labels, so mothers could buy the product but had to ask a doctor how to use it. (Too bad about those who couldn't afford a doctor but bought the product , still widely available, anyway.) The doctor usually told the mother to come back in six weeks to have the formula changed. The company gave the doctor feeding calculators, formula blanks and other freebies, and stressed that' the physician himself controls the feeding problem'.[38] Similarly in 1915 the new product, SMA (Simulated Milk Adaption), was unveiled at a meeting of the American Pediatric Society and thereafter promoted exclusively to doctors.[39] Other products rapidly followed. Lactogen was produced by Nestlé in 1924 to be 'sold only on the prescription or recommendation of a physician'. Feeding directions were supplied only to doctors. By 1932 an AMA Committee had denounced the unsupervised use of artificial formulae and 'the promulgation of feeding formulas in advertising to the laity' (not the widespread advertising of the product: only the communication of how to use it). This left companies free to maximise sales, and doctors free to control their use, a mutually satisfactory compromise. Very few

---

[34]Apple, R. D., 'To be used only under the direction of a physician'-commercial infant feeding and medical practice, 1870-1940. *Bull. Hist. Med.* (1980)54, 3.

[35]ibid., p. 406.

[36] ibid., p. 404.

[37] Hambraeus, L. Food and growth in children with special reference to breastfeeding versus formula feeding. *J. Food. Nutr. (*1982) 39: 1-12.

[38] Apple, op. cit., p. 411, Cone, op. cit.

[39] ibid., p. 412.

influential people queried whether this shift from natural to artificial feeding could have deleterious consequences for society, or whether advertising of any kind was ethical. An honorable exception was the Philadelphia Pediatric Society which in 1923 urged the American Medical Association to stop advertising formula in this lay journal, Hygeia, because this implied AMA recommendation and undid the work of doctors trying to persuade the public'that infants cannot be fed in this indiscriminate manner'.[40] Parents followed trustingly where scientific and medical advisors seemed to lead. Many doctors, finding that control of feeding meant regular infant visits, even began to feel that breastfeeding might be less desirable because the baby did not return regularly for check-ups. Earlier weaning soon began to be encouraged, 'now that our present formulas are almost as good'. A familiar line?

It is not doctor-bashing to say plainly that the speciality of pediatrics owes much to the infant formula companies. It is the simple truth, and imposes on doctors a major responsibility to undo the legacy of harm created by naive co-operation in the past. it is also true that the infant formula companies could never have penetrated the American market so thoroughly without the legitimacy given to them by the AMA's Seal of Acceptance for their products and their close co-operation with doctors. Withdrawal of the Seal of Acceptance was a significant factor in the demise of the one infant food manufacturer whose crime was to refuse to remove feeding tables from his advertising. Brand names adopted at this time have persisted through many composition changes; this is obviously designed to provide assurance that the products were and are 'as close as possible' to human milk. To change brand names with every change in formulation could undermine public confidence in the product.

The economic depression of the 1930s, and fierce internecine competition , gradually reduced the number of American companies promoting infant formula. The major firms emerged as Abbot (Ross Laboratories) Bristol Myers (Mead Johnson) and American Home Products (Wyeth).[41] When smaller firms attempted to enter the lucrative US market in the 1960s and 1970s, they were squeezed out. The method chosen by Ross and Mead Johnson was to began supplying formula to hospitals completely free, rather than at a lower cost, and to increase their services to professionals.[42] There were conditions attached to such "free" gifts (often worth thousands or even millions); for example a free pack of company products was to be given to each mother in a hospital receiving free formula and supplies from the company. Ross and Mead Johnson were charged with breaching U.S. anti-trust legislation by a third company; the lawsuit was settled privately, and terms were never disclosed. While small quantities doubtless had always been given, this was the origin of the practice of providing free and low-cost supplies as a marketing technique

What of sunny Australia? In the nineteenth and early twentieth century diarrhoeal diseases were so prevalent that it was standard medical advice not to wean in summer, when foods were most contaminated. The NSW Department of Public Health produced a pamphlet of infant care in summer, which stated 'The first duty of a mother is to her baby...You should never let your breast milk disappear in summer. It may be the means of saving baby's life if

---

[40]ibid.cf. also Levenstein, H., 'Best for babies' or 'preventable infanticide'? The controversy over artificial feeding of infants in America, 1880-1920. *J. Am. Hist.* (1983) 70, 1, 75-95.

[41] Confronting the U.S. Infant Formula Giants-*The Corporate Examiner* 1982, II, 7-8. Available from the Interfaith Centre on Corporate Responsibility, 475 Riverside Drive, (RM.566) New York, N.Y. 10115.

[42] Post, J., Statement to the Sub-committee on oversight and investigations of the Committee on Energy & Commerce, House of Representatives, U.S. Congress, June 17 1981. (U.S. Government Printing Office, Washington 1981, serial 97-73)

diarrhoea should occur.' [43] (Continued breastfeeding through diarrhoea is once again urged by international health authorities, but somehow during this century many doctors picked up the idea that a child with diarrhoea should be taken off the breast.) [44] It was this incredible mortality from diarrhoeal disease, and the realisation that correct nutrition and hygiene could prevent it, which was the basis of a newly emergent infant welfare system. And the companies were to build their market through that system too, by providing helpful leaflets, booklets, and advice about the use of their product for breastfeeding mothers when breastmilk was "insufficient".

In England and in Australia breastfeeding was seen as advantageous mainly because human milk was uncontaminated (untrue then, as now: breastmilk exposes a baby to manageable doses of a wide variety of environmental pathogens). So while breastfeeding was recommended, attempts to provide hygienic milk supplies were seen as being just as important. In England milk depots were opened in a number of towns. 'Attendance at a milk depot meant that the children were closely scrutinised": they were weighed once a week, their homes were visited by health visitors who reported their progress to the Medical Officer of Health, and the mothers were provided with cards on which to record the weight of their child.' [45] Clinics were a natural outgrowth of these depots, and in England they became the chief source of cheap, relatively clean, artificial powdered milks such as Glaxo. In the U.K., a National Dried Milk powder was available at very little cost for decades. This has been since discontinued as it was one of the high–solute mixtures implicated in the annual epidemic of hypernatraemic dehydration in artificially fed babies. Formula manufacturers also supplied mothers with literature. Glaxo's The Baby Book, immensely popular, sold 800,000 copies between 1908 and 1919.[46] It is very clear from the pages of testimonial that Glaxo had a policy of supplying doctors, nurses and groups such as the Ladies Health Association[47] with generous quantities of free samples, rightly guessing that such promotion would pay dividends. The 1919 edition recorded that 1400 of Britain's 1750 municipal baby health centres regularly used Glaxo; that the Ministry of Food had purchased 4000 tons in 1917-18. In theory, of course, both milk depot and clinics praised breast milk. In practice, 'they encouraged attendance to obtain [low-cost] cows' milk so that the child could come under observation'.[48] The British medical profession also seems to have been sure that a child is healthier if artificially fed but medically supervised, than if breastfed but rarely seen. Deaths were regarded as being a consequence of poor personal hygiene, [49] rather than social deficiencies such as poor sanitation, poverty and substandard housing. This continued the theme of the incompetent mother, whose ignorance was responsible for her child's ill health, a theme that remains very much alive in medical writing, despite the warning of 1917 that this was 'a comfortable doctrine for the well-to-do person to adopt...It goes far to relieve his conscience in the contemplation of excessive suffering and mortality among the poor.'[50] (We

---

[43]Lewis, M., The Problem of Infant Feeding: the Australian experience from the mid 19th century to the 1920's. *J. Hist. Med,* (1980) April, p. 174-187.

[44]WHO Press release: Don't withold food from children with diarrhoea-Aust. Nurses' J. (1983) 12, 8, 35. See also Minchin, M., Food for Thought Alma/Allen Unwin 1983) ch. II, 7; Ciba Foundation Symposium, new series, no. 42: Acute Diarrhoea in childhood (Elsevier/Excerpta Medica 1976), pp. 171-80.

[45] Armstrong, D. Political Anatomy of the Body: medical knowledge in Britain in the 20th century. (Cambridge University Press 1983) p.14.

[46]The Glaxo Baby Book-(Glaxo, 1918, 11th edition), p. 25.

[47]The body of charitable, well-intentioned ladies from which Britain's system of Health Visitors derived

[48]Armstrong, op. cit., p. 15.

[49]Lewis, M., (1980), p. 177-8.

[50] Sir Arthur Newsholme-On the child mortality at the ages 0-5 years, in England and Wales-*J. Hygiene,*

may smile, but how many studies of more recent date consider an association with maternal ignorance, age, or marital status, sufficient explanation for infant disease, and talk of 'standards of mothering' rather than 'the actual milk' explaining the consistently lower morbidity and mortality in breastfed infants?) 'Mothercraft' was the solution; and while in Australia breastfeeding was seen as important, the fact that it was supplemented soon after birth with all sorts of inappropriate foods meant that its perceived benefits were underestimated. (Sago, arrowroot or cornflour were almost universally used, 'due to the belief that the milk by itself was an inadequate food'. Cornstarch is still used, despite the evidence that it is of no benefit, for reflux babies.)

This naturally made the transition to processed milks and patent foods easier and earlier. Among the varieties available here in Australia were condensed, evaporated and dried milks, similar to those still in use today for infant feeding by those who cannot afford infant formula. Roller-and spray-dried milk was even being exported from the 1900s on; Glaxo, a New Zealand product, was basically full-cream milk powder 'standardised in the proportions the highest medical authorities recommend'. The dairy industry in both Australia and New Zealand was quick to see important new markets opening up. Patent foods, too, similar to those described earlier, were readily available and widely advertised. In the 1890's the medical profession discussed the issue and gave limited approval[51] to several such foods, including Nestlé, Mellin's and Benger's, but only for children over six months old- a crucial distinction, but one that few parents took seriously, then as now. These were, however, an improvement over the almost-pure starchy mixtures such as boiled grated flour or cheap condensed skim milk.

The main thrust of the infant welfare clinics was seen as the promotion of breastfeeding. Artificial substitutes were 'only advised when it is...necessary to complement the breast milk'. It has been generally accepted that this early-twentieth-century breastfeeding crusade did help to increase the proportion of wholly breastfed babies in certain areas,[52] although recent studies have questioned this. It is undoubtedly true that a sympathetic knowledgeable nurse can help mothers to continue to breastfeed even under adverse social conditions. It is also true that many nurses were far from sympathetic or knowledgeable about breastfeeding. The hierarchical nature of medicine meant that nurses were subject to the doctor's authority - as doctor and as male. This contemporary style of exercising power was mimicked by nurses, in their relations with those beneath them in the medical hierarchy. The ignorant, incompetent mother has always been the lowest point in the scale, and attitudes towards her have ranged (and still do) from censorious to patronising in a kindly manner. Many women found it utterly intimidating to subject themselves to the scrutiny of the clinic sister when things were not going well with the baby. If baby was cheerful and thriving, her authority gave the mother an official stamp of approval, bolstering her confidence. If baby was not thriving, or was colicky, the nurse's questions usually implied that the fault was the mother's. (Because many of the original clinic sisters had no children, their assumptions that maternal defects caused infant problems had never been challenged by personal experience.) Given the lack of accurate information about management of breastfeeding problems and the doctrinaire ideas then in vogue, many mothers must have had difficulties, which resulted in the clinic sister handing

---

Cambridge, (1917) 16, 69-71.

[51]*Australian Medical Gazette.* (1894) 13, 60-61. Editorial: the diet of infants deprived of breast milk.]

[52]Lewis, M., Populate or perish - Thesis held at Australian National University, Canberra. One Sydney campaign between 1905 and 1911 raised the percentage of wholly breastfed infants from 72.2 to 94.2% but there is no record of duration of breastfeeding. Interestingly, this campaign used visitors rather than asked mothers to come to clinics

them a sample tin of some 'medically approved' substitute. For in Australia too, the clinics were distribution points for all sorts of free samples.

One of the areas that needs close investigation is how far the work of such clinics promoted artificial feeding. At this stage, I don't think anyone could give a balanced picture. But I am quite certain that we need to question the assumption that all clinics were and are unequivocally promoting breastfeeding. On the contrary, even today, some actively urge inappropriately early weaning and serve to legitimise the infant formula industry. Many community midwives and MCH nurses have spoken to me of their concern about the way commercial forces influence what other clinic sisters do, and how they label as 'extreme' those who try to promote exclusive breastfeeding.

The same links between medicine and commerce, apparent in the United States, were gradually forged here. To their credit, Australian doctors were generally slower to accept that artificial substitutes could be 'almost as good' as mothers' milk. (Unfortunately, some of those who were slow to be converted to the idea that modern formulae are almost as good, are similarly slow to accept the newer information about breastfeeding, so in some instances this may indicate innate conservatism rather than native perspicacity.) Before the Second World War, Australia was a less-developed country, too, with a much smaller, more conservative population. So conversion to the use of expensive perishable infant foods was naturally slower. Promotion was much less aggressive in the pre-war era, but nevertheless the formula companies consolidated their position as reputable ethical bodies concerned - as were doctors - with the relief of infant suffering; willing to contribute handsomely to professional journals through advertising; or willing to finance research, professional conferences, and the like. There seems to have been little uneasiness within the medical profession over any possible conflict of interests, such as Jelliffe discussed.[53] But then no one could foresee the enormous post-war expansion of the formula industry world-wide, and the development of its marketing and advertising networks.

Little has been documented in any detail about the patterns of infant feeding after the Second World War. By 1960, 80 per cent of bottle-fed infants in America were being given home-made evaporated-milk formulae.[54] It may be pure coincidence that by the late 1950s and early 1960s Americans were concerned about the decline in national IQ levels; indeed, they may have been inaccurate results/tests.... But as these milks have been condemned as unsuitable for infants and were certainly deficient in some elements necessary for brain growth, some curiosity would seem in order. (My next book will review this connexion between infant feeding and cognitive development.) Only since the 1960's have factory-made products taken over. Indeed, considering the major changes to formulae in the 1970s and since, one could say that many formulae currently in use are less than a decade old.

Breastfeeding steadily declined in Western nations after the war. In America it halved between 1946 and 1956, dropping to 25 per cent at hospital discharge in 1967. [55] And the West exported our style of infant feeding to the urbanised elites of less-developed countries.

---

[53]Jelliffe, D. B. & Jelliffe, E. F. P., Human Milk in the Modern World (O.U.P., 1979), P. 274 letter to Pediatrics, (1979).

[54] Cone, op. cit., p. 253.

[55]Such figures conceal huge geographical, class, and ethnic differences - Boston breastfeeding rates had reached this point by 1958. For a good discussion of available data and its limitations, see Hendershot, G. Trends in breastfeeding. Report of the Task Force on the Assessment of the Scientific Evidence Relating to Infant Feeding Practices and Infant Health. Supplement to *Pediatrics* 1984, 74, 4.

During the 1950s and 1960s various missionary and health workers began to be alarmed by the apparent effects of the decline in breastfeeding. In some countries such as Chile, it was quite spectacular. Largely through the well-intentioned but misguided efforts of baby health clinics distributing free milk powder, by 1969 fewer than 20 per cent of babies were being breastfed for as long as two months.[56] This rapid decline in developing countries was often due to the simplistic aid programmes of the late 1940s and 1950s, which distributed surplus skim milk powder to developing countries. As Jelliffe has said, this 'could only have appeared as endorsement of bottle feeding, with a resulting displacement effect of breastfeeding.'[57] Between 1951 and 1960, low-income families in Singapore were exposed to rapid modernisation influences, and the breastfeeding of infants to three months decreased from 71 to 42 per cent; by 1971 it was perhaps 4 per cent. [58] In any society, rich or poor, such a change will have a marked impact on infant morbidity and mortality. Studies in the 1930s in England and America illustrate this clearly, and the topic has been reviewed well by Cunningham.[59]

Infant formula advocates now say that current products cannot fairly be compared with the evaporated and other milks once sold as perfect foods, and that current formulas have not been demonstrated to do such harm. I have not seen any such extreme statements by senior executives of or men employed *directly* by formula companies, perhaps because they are aware that 'in real life' their products have proved to be both 'nutritionally inadequate and dangerous', albeit in only a small minority of cases of which we are aware thus far. There are two points that should stressed here.

Firstly, we cannot yet assess what harm the very latest formulas do. Why not? Because in the complete and continuing absence of randomised controlled trials of the safety and efficacy of individual products, we have not been using them, much less using each brand exclusively, for long enough to know. Because in addition we do not know the inter-generational impact of the infancy bottle-feeding of those women who are now breastfeeding. And because rarely have studies considered exclusively bottle-fed and exclusively breastfed children (the influence of the bottle being so pervasive by the mid 1970s that almost all babies have been given at least the odd bottle).[60] Dugdale, for instance, so frequently quoted by the formula manufacturers, fails to consider these and other variables. [61] Yet many of the changes to formula are potentially very significant. For example, once it was cheaply available as a by-product of cheese manufacture, companies increased their use of bovine whey, which contains many of the most potent milk allergens. I know of no study assessing outcomes in terms of allergy on a population basis, where casein-dominant formulas are compared to whey-dominant ones. Perhaps both are as bad as one another: but perhaps not. They do result in different plasma amino acid levels in infants, after all. That could affect not only immunological but also cognitive outcomes. Similarly, companies are now using egg phospholipids in infant formula

---

[56] Jelliffe & Jelliffe, (ed) op. cit., p. 294.

[57] ibid., p. 234.

[58] Wong, H. B., Breastfeeding in Singapore (Choon Kee Press, Singapore, 1971).

[59] Breastfeeding and morbidity in industrialised countries, 1900-1980: an update in Jelliffe & Jelliffe (ed) Advances in International Maternal and Child Health v. 1. (O.U.P. 1981). For further discussion, see the Report of The Task Force alluded to earlier

[60] Martin, J. E., Infant Feeding 1975: attitudes and practice in England and Wales (London: HMSO 19778), p. 86. Only 14% of UK mothers delivered in hospital had NOT given formula within the first week after birth.

[61] Dugdale, A. E., The effect of the type of feeding on weight gain and illness in infants. *Br. J. Nutr.* (1971) 26, 423-432. This study is criticised in the Task Force Report (ref. 55. More recent statements included in *Med. J. Austr.* 1981, July 25, p. 107.

(to improve neurological outcomes, we hope) without monitoring rates of egg allergy in children exposed so early to egg. Where are the independent voices of paediatricians and allergists protesting such changes without appropriate RCTs proving safety and efficacy? We were reassured for years that peanut oil was safe in formula: now it has been shown to cause anaphylactic shock and deaths, it is to be banned - in Australia, anyway, if no major objections are raised, on the grounds that this might restrict trade, for example. Common sense critics who raised such concerns years ago were pooh-poohed.

Secondly, the splendid new super-duper formulas, which we are once again told are closest to mothers' milk, are too expensive to be used properly - even if mother had the clean water, fuel and other necessities of hygienic bottle-feeding - by any but the very rich, in every country where government subsidies are unavailable. In the mid 1970s, the cost of fresh cows' milk for a properly fed Indian infant would have been equal to 76 per cent of his mother's monthly income.[62] Surveys have shown that poor mothers can afford to spend at most 10 per cent on infant food; so formula being even more expensive than cows' milk, that 10 per cent buys even less and it is diluted to last longer. Things have not improved. In 1982, the cost of artificially feeding a baby on the cheapest (and least adequate) substitute available in the Philippines was 25 per cent of the official minimum wage. (Many workers get less.) In Nairobi, it was 46-75 per cent of the official minimum wage. Clearly, even if these products were as safe and adequate as their manufacturers claim them to be, they cannot be used safely by the vast proportion of the world's population who have living standards less than that of the affluent middle class. Even in America in cities affected by economic recession, overdilution of formula leading to infant sickness and death has been documented. There would undoubtedly be even more such malnutrition if the federally funded Department of Agriculture WIC (Women, Infants and Children) programmes were not supplying infant formula, at a cost subsidised by taxpayers, to many of America's poor. The WIC programme is the largest buyer in the world, spending over a billion dollars on formula each year. This has been a triumph for the major formula companies. Similarly in Australia, many poor families rely on free formula or else feed cheaper mixtures. A week's supply of formula costs around 10% of the unemployment benefit.

Of course there are wider ecological and social implications for the world and especially for poorer nations: the diversion of resources to feed energy-wasteful cows; the foreign debt generated by formula imports; and so on. In the Philippines in the early 1980s, almost $90 million annually went to pay for such imports. This also helps to impoverish families and depress wages in such countries, as governments raise taxes to meet their debts.

Combine the cost/income factor with the widespread belief that most milks are equally suitable for raising healthy children, a belief held not only by credulous mothers but apparently also by a nutritionist from John Hopkins University, who stated publicly in the late 1970s that sweetened condensed milk was 'probably the safest and least expensive nutritionally adequate substitute for breast milk'.[63] Department stores in many countries have walls of milk products- almost all with pictures of babies advertising everything from dried skim milk to the most sophisticated formula. Many poor mothers buy the cheapest, and overdilute what was unsafe to begin with. The formula companies and the medical profession

---

[62] In Cameron, M., Hofvander, Y., Manual on Feeding Infants and Young Children (2nd edition, U.N. 1975), p. 103, there is a table showing cost/income ratio of formula feeding in a number of countries. This is discussed also in Jelliffe & Jelliffe (1979). And the figures are updated in the latest edition, published by Oxford University Press in 1983.

[63] For some idea of its safety and nutritional adequacy, cf. The Other Baby Killer, by Consumers' Association of Penang, Malaysia. (Available from CAP, 27 Kelawei Road, Penang, Malaysia.)

are now trying to dissociate formula from animal milks, but a century of propaganda is not easily undone. . . and if mothers cannot afford formula, what is the point of telling them how harmful dried milk products are? What will they use instead?

The results were becoming obvious to field workers by the 1950s and 1960s. In 1970, amid concern about increasing commerciogenic malnutrition, WHO and UNICEF convened a meeting in Colombia. Industry representatives were there, and the question of unethical marketing created a stir. In 1972 the UNs Protein Calorie Advisory Group drafted a statement suggesting action to resolve the obvious problems.[64] By 1974 consciousness had increased after New Internationalist and War on Want (WOW) had made widely publicised statements. A Swiss group translated WOW's The Baby Killer as Nestlé Kills Babies and were sued for libel. The World Health Assembly unanimously adopted a resolution calling for governments to review and regulate marketing practices, and in 1975 the International Pediatric Association passed a similar resolution. Church-based groups, aware of the problem through their overseas members, began research and concerted action such as resolutions from stockholders at company annual general meetings, and withdrawal of church funds from industries believed to use unethical marketing practices.

In November 1975 the Nestlé case began. In many ways this was exactly the forum that was needed. Sworn testimony from medical experts around the world was made public, and popular concern mounted. Although the Swiss consumer group was found technically guilty, they were fined a derisory sum, which made clear the judge's moral verdict. Shortly before the trial, the major formula manufacturers had got together to form the International Council of Infant Food Industries (ICIFI) and issued a voluntary Code of Ethics which was denounced as too weak even by Abbott/Ross - who withdrew from ICIFI and adopted their own code. (They could afford to give up direct consumer advertising, increasingly seen as too expensive and less effective than promotion to naive healthworkers and through the medical system. They were at that time the American market leader, and direct-to-parent advertising was not necessary to maintain their market share. In fact, it was probably their entrenched power in the US institutional market which in the late 1980's led to the emergence of widespread consumer advertising as the only commercially viable route of entry for new brands by comapnies such as Carnation, seeking to carve off a chunk of the highly profitable US market for themselves.)

Another US company reacted differently. In a company report, Bristol Myers denied promoting formula in hazardous conditions. The Sisters of The Precious Blood filed a lawsuit charging the company with false reporting, and with the deaths of babies. The case was settled out of court on a technicality, but it too had served to publicised the issue, and both Abbott and Borden promptly announced changes in their marketing practices. US consumers continued to file stockholders' resolutions. The Rockefeller and Ford Foundations supported such resolutions, greatly increasing the power of minor ethical stockholders such as the ecumenical Interfaith Centre for Corporate Responsibility (ICCR). This avenue of protest and change was not possible with privately owned companies such as Nestlé which at that time controlled the lion's share of the "Third World" market. Hence a boycott was begun by a group formed in Minneapolis in July 1977, the Infant Formula Action Coalition (INFAC). They stated that Nestlé was targetted because of its position in developing countries, and because the United States was their biggest market for other products. This first boycott was to last until January

[64]For an excellent overview of the infant formula controversy as it developed in the 1970s, I would recommend a tape by Kathleen Cravero, UNICEF, NY, Staffer, recorded at the 1983 LLLI Physicians' Seminar. Available from LLLI.

1984, when Nestlé signed an agreement to comply substantially with the WHO Code. [65] It was one of the most successful consumer actions in history, not simply because of its effects on Nestle but also its wider consequences internationally. A variety of interpretations and perspectives on the Boycott are now available in print, for readers wishing to know more.

In 1976, the US Congress had called for an investigation. Hearings were held in May 1978 - the Kennedy hearings. It became clear that US industry was obdurate, believing that their responsibility was to produce the product, not to monitor how it was used. This attitude has long characterised vested interest. In 1899 a medical deputation to the President of the UK Board of Agriculture asked to have skimmed, concentrated and condensed milks compulsorily labelled 'not fit food children or invalids'.[66] The reply epitomises unbridled-enterprise philosophy: 'If the public liked to buy a thing they must be allowed to buy it.' Note how a proposal to educate the consumer to choose wisely is interpretated as a restriction on sales. . .

Senator Edward Kennedy requested the World Health Organisation to do more. This led to the historic October 1979 Geneva meeting, at which government, industry and consumer groups were all represented. This meeting agreed, inter alia, that a code of marketing practice should be formulated. In the meantime, everyone agreed that promotion of bottle-feeding to the public should be prohibited, a fact that explained the sudden and total absence of advertisements in Australian women's magazines for formula, bottles, teats, and so on for a short period. (Infant formula was not to reappear until Mead Johnson's 1991 campaign for a follow-on product, but advertisements for teats and bottles have since proliferated.)

The non-governmental organisation representatives at the Geneva meeting formed an umbrella group, the International Baby Food Action Network (IBFAN), to represent their views to the WHO, as the WHO officials struggled to find a compromise solution acceptable to everyone. IBFAN rapidly developed a wide network being serviced by paid and volunteer staff in a few key centres: then Minneapolis, Geneva, Penang and Cambridge. Money to support these centres came from a wide variety of sources, including development agencies and public donations elicited by the Boycott campaign, as well as the sale of products. By March 1981 a draft code which seemed acceptable had been developed, though no one was very happy with it. In May 1981 the World Health Assembly met. There was extraordinary pressure from industry. It has been publicly stated[67] that delegates were wined and dined, offered free trips; fraudulent letters from fictitious organisations wasted time; a company lawyer posed as a Guatemalan delegate; ICIFI (the International Council of Infant Food Industries) hired public relations firms and even, at an undisclosed figure, a retiring senior WHO official to lobby for them. Despite this, the WHO adopted the Code as a recommendation. The vote was 118:1 with three abstentions (Korea, Japan and Argentina). The one anti-vote was, ironically, the United States. An election had brought Reagan to power, and sweeping changes in top administration were to follow. But the US 'no' vote made world headlines, and probably did a great deal to raise public consciousnes of the issue, as well as persuade many governments to adopt the code.

---

[65]For details of what did and what did not change, see IBFAN News, March 1984. Available from IBFAN, cf. p. 332. see also The taming of Nestle-F. Clarkson. *Multinational Monitor*, April 1984, 14-17. Other companies can now expect a greater scrutiny of their behaviour, long overdue.

[66]Smith, F.B. op. cit. p.93.

[67]Baer, E., An update on the infant formula controversy. *Studies in Family Planning,* 1983. Also on U.S. Congressional Record-Senate-May 26, 1983.

Public reaction in the US was outrage. Congressmen reported getting 100 letters a day for a week. In June 1981 Congress condemned the Administration and announced its intention to pass legislation enacting the Code. Reagan's attempt to appoint Ernest Lefever as Assistant Secretary of State for Human Rights failed when it revealed that his Ethics and Public Policy Center had received a $25,000 grant from Nestlé and $10,000 from Bristol Myers, both formula manufacturers. Some of this money had resulted in the publication of an article in Fortune,[68] which smeared formula activists as 'corporation-haters' (many were investors) and 'Marxists' (many were Catholic religious sisters). While this sort of tactic was readily exposed, I believe that it was effective at the time in certain middle-class circles- effective in creating a perception of ALL formula activists as rabid political extremists, rather than as a broad-ranging coalition of people concerned about child health and industry accountability, with only a minority of those more concerned about multi-national industry than about infant health. The initial reluctance of some breastfeeding groups in the early 1980's to become involved in this aspect of the breastfeeding issue is more readily understood when this tactic is taken into account. Green politics have always been somewhat left of centre; only a decade later are we seeing environmental causes as acceptable to the mainstream. Certainly this was part of the reason for the refusal of one breastfeeding group to own and publish a book of mine, written for them, which contained IBFAN information about Code monitoring: by working as and promoting IBFAN I was seen as "radical". As indeed I hope I genuinely am, in the sense that, like every good historian, I try to get to the root of things!

Infant feeding became a highly volatile and emotive issue in the United States by 1980, partly because a number of further disasters with US infant formula had helped to sensitise Americans to some of the hazards of bottle-feeding in their own country. In 1978 some batches of Enfamil with iron powder were bacterially contaminated.[69] In 1979 Wyeth had to recall 300,000 cans of SMA because of a homogenisation problem that had made infants sick.[70] This was what the industry described later as an 'elegance problem': problems such as fat separation or protein agglomeration which might make babies vomit but which left the formula 'safe', i.e. bacteriologically uncontaminated and able to provide 'adequate nutrition'. As a mere mother, aware of the speed with which babies can become dehydrated and die, I am a little puzzled by the industry recommendation that formulas with 'elegance problems' should not be recalled.[71] How can a formula provide adequate nutrition if it has been vomited? Would adults want to eat foods with 'elegance problems'? Industry urged the FDA that recalls of formula with problems of such a minor nature tended to reduce the efficacy of recalls of formula with major, potentially fatal defects; they did not refer to the possible effect on consumer perception of the product as 'perfect' and throughly reliable.

Parents were to learn that lesson the hard way. The Neo-Mull-Soy/Cho-free disaster became public knowledge by late 1979. There were many disturbing features about this incident.[72] The publicity it received was almost entirely due to the fact that among the damaged children were two whose parents had all the requisite skills to find out what was happening and then to prevent the matter being quietly forgotten. Carol Laskin was a health care management

---

[68]Nickel, H., The Corporate haters. *Fortune,* June 16, 1980, p. 126-8, 130, 132, 134, 136. Letters, 14 July 1980, p. 172; July 28, 1980, p. 100

[69] *Food Chemical News*, April 27 1981.

[70]*Food Chemical News*, Nov. 12 1979, p. 25, 47.]

[71]*Food Chemical News*, Dec. 10, 1979, p. 15.

[72] Laskin, C. R., Pilot, L. J., Defective Infant Formula: the Neo-Mull-Soy/Cho Free Incident in Early Intervention Programs in Infancy (ed) Moss, Sweet & Swift. (Haworth Press, 1982). Reprints available from C. Laskin, 2723 Devonshire Place, N.W. Washington, D C. 20008.

consultant whose clients included the Department of Health and Human Service. Lynn Pilot was an attorney with experience in Congress as administrative and legislative assistant. Alan Laskin was a management consultant with wide knowledge and contacts in the media. Larry Pilot was an attorney then employed by the FDA, specialising in food and drug law. With that sort of expertise it was natural that they turned to the FDA for confirmation that the formula was responsible for their children's hospitalisation. They were staggered to find that in July 1979 the only requirements for infant formula manufacture were: (1) the product must be maufactured under sanitary conditions, and (2) the label must reflect what is in the can. There were no up-to-date requirements concerning the nutrient composition of the formula, nor were there requirements for quality control procedures to ensure that the formula contained the ingredients it was intended to contain.' Two weeks after their enquiries, months after the first reports and FDA enquiries, the company recalled its formulae from the market-place. Both the FDA and Syntex (the manufacturers) treated this as a routine matter, 'with little attempt to ensure the effectiveness of the recall.'[73] (FDA has asked Syntex for information in May. At the November hearings Syntex were criticised for withholding much of the vital information requested by the FDA, which has no power of coercion.) As a result, deficient formula was still on sale at retail outlets month later. This was too much for Laskin and Pilot. They went to the media and to the politicians. By November 1979 Congressional hearings were underway, [74] legislation to provide some sort of protection was being drafted, and FORMULA, a non-profit parent-support group, had been formed. (They were to receive more than 60,000 queries as a result of the publicity they engendered.)

The major outcome of these latest errors (and Laskin and Pilot's work) was the passage of the Infant Formula Act of 1980,[75] setting nutrient standards (the 1976 ones, temporarily) and requiring routine testing by manufacturers, as well as immediate notification of any further problems that might present a health risk. A US Congressional subcommittee asked the Justice Department to prosecute the company, Syntex Laboraties, for their tardy and ineffective recall. (Investigations by a reporter uncovered not only Syntex products but also many out-of-date cans of formula, some dating back to 1972, still on store shelves.)[76]. This was not done. [77]

But much of the power of the 1980 Act depended on regulations that were yet to be formulated when Reagan took office. Manufacturers agreed in principle, but disagreed in practice when the FDA drafted fairly stringent recall procedures. They were able to get the support of their long-standing allies, the organised medical profession. The American Medical Association (AMA) saw no need for legislation or regulation because - familiar theme - industry could and should regulate itself.[78] The Justice Department argued that criminal prosecution was not necessary to prevent similar incidents in future, as though this was the only point of such prosecutions. (Would they fail to convict an arrested burglar who had since been injured and in future could not steal?) The American Academy of Pediatrics (AAP)

---

[73]ibid., p. 99.

[74]Reported in *Food Chemical News*, No. 5, 1979, p. 41

[75]Public Law 96-359-Sept. 26, 1980. Infant Formula Act of 1980. One FDA official then argued that the financial penalties imposed by this Act if a recall was not properly managed would possibly lead companies not not to institute recalls at all (for which there is no penalty) rather than face the possibilty of fines for doing it wrong. This implies a belief in the companies as capable of heinous behaviour suprising in men who then went on to allow companies wide powers of self-regulation.

[76] The Nation's Health. American Public Health Association) 1980, April, p. 4 When visiting the U.S. I was told (how truthfully I cannot assess) that outdated formula was very common in poorer areas located near manufacturers' plants.

[77]*The Nation's Health.* (Newsletter of American Public Health Association), April 1980, p. 4.

[78] *Food Chemical News*, May 14 & May 21, 1984, p. 29. Laskin & Pilot, op. cit., p. 103.

'displayed a passive attitude toward the FDA infant formula activities and the progress of legislation'[79] Later, the AAP was to come out in support of industry's opposition to the regulations because they might make formula unaffordable and reduce the number of specialised formulae available to doctors.[80] These are debatable points when the industry makes so much profit and spends so much of it on free dinners and services to doctors. Since, according to one member of the Congressional subcommittee, industry refused to divulge the costs involved in better quality control, it is impossible to judge the validity of their case.[81] Yet who won in the end? A 1983 conference was told that the US Congress gave the FDA power to regulate infant formula recalls... only after the company had decided on the recall.[82] How reassuring! Like most parents, I should prefer to pay more for safety and less for promotion. I see no reason why a product that is recommended as the sole source of nutrition for a child at its most vulnerable age should not have to meet at least the requirements that non-prescription drugs must meet before they are freely available. After all, formula is currently so expensive that a cost analysis would be very interesting reading. Are present prices related to the fact that they no longer compete directly with evaporated and condensed milks in developing countries, because the whole force of the medical profession has swung behind recommending only formula - or its "equivalent", breastmilk - for babies? Can such prices be justified?

It has been no surprise to read Laskin and Pilot's 1982 criticism that the AAP 'has displayed no interest whatever in pursuing any research or coordinating any efforts which might stimulate any collection of new and useful information about this subject. This lack of cooperation on the AAP's part has hampered our efforts to inform pediatricians of the seriousness of the children's problems.'[83] (Or of their devastating wider impact: psychological and marital breakdown, bankruptcy because of medical costs, agency charges of child abuse, long-term demands for special therapy and education.)

What happened to the FDA regulations? Well, as both the industry and the medical authorities opposed them, the outcome was predictable after Reagan came to power. As reported in the trade journal, Food Chemical News, 'FDA got the message recently from the Department of Health and Human Services in no uncertain terms to discontinue tough regulation writing . . . the HHS admonition was aimed at career FDA officials who had not yet gotten the message from the new administration. FDA was to take back the proposal and rewrite it shorter and in a more general fashion. Objection was made to the many details involved in the recalls and the tough reporting requirements.[84] So the drafts continued over the next year, becoming ever weaker. As a result, there were no regulations when the next major mishap[85] occurred, years later.

In March 1982, a month after cans had gone on sale, FDA issued a public warning that Wyeth was recalling all half-million cans of its Nursoy Concentrate and Ready-to-Feed, as they lacked vitamin B6 and had twice the recommended amount of vitamin B1. (B6 is essential; deficiency could cause 'serious health effects such as irritability and in more serious instances

---

[79] ibid., p. 104.
[80] *Food Chemical News*, May 25, 1981, p. 23-4.
[81] *Food Chemical News,* March 15, 1982, p. 46.
[82] AOAC
[83] Laskin & Pilot, op. cit., p. 104.
[84] '*Food Chemical News*, Oct. 19, 1981, p. 29.
[85] *Food Chemical News*, March 8, 1982, p. 31.

convulsions.' Did every pediatrician attending babies with convulsions think of this as a possible cause?) A week later, another half-million cans were recalled, this time of SMA, [86] after some debate between FDA and Wyeth as to whether this was necessary. This came as a shock to people who had assumed that all the talk about infant formula safety must have created a fool-proof system. The Washington Post asked Wyeth why it still did not pre-test its formula to ensure content and quality. Wyeth replied that it was not required by law to do so.[87] This episode was reported in Malaysian papers as being 2.3 million cans ultimately recalled.[88]

This provided further impetus toward regulation, especially as evidence of the permanent neurological damage done by B6 deficiency was available in the US after the 1952-54 formula accident.[89] Interestingly, the FDA recall made no mention of any such horrific possibilities [90] - they too have no desire to alarm the general public or to weaken public confidence in infant formula, because like everyone else they accept it as an inescapable part of the American social fabric. (As of course it is, but need not be in future.) In April 1982 the FDA published its quality control regulation, which would become effective in July 1982. The trade press headlined this as 'Flexibility foremost feature of final infant formula quality control rule', [91] which sounded ominous enough. Naturally the document was a compromise between the original tough regulations proposed and the criticisms of the companies and other vested interests. It remains to be seen how well it will work: industry is likely to be far more careful in any case, but the crunch will come over such things as:

*whether exemptions can be granted to products that presently do not meet the nutrient guidelines. (The Act and regulations cover only 'infant formula', which medical/industry groups interpret as meaning 'standard formulas for normal infants'[92]. According to them, other products, including that most rapidly-growing segment of the market, the so-called low-allergy formulas, ought to be exempt from the Act's provisions, both of nutrient composition AND quality control. FDA officials held to a stricter definition of formula, and notified companies that products like Nutramigen were not 'exempt formulas'. What happened? 'In the future, FDA will be proposing regulations . . . to deal with this situation. In the interim, FDA will not take regulatory action provided the manufacturer substantiates to our satisfaction that a deviation . . . is necessary.' FDA uses "independent" consultants to help in this process. One such consultant on aspects of quality control was Dr D. L. Heuring, formerly of Mead Johnson, and 'the principal author of Mead Johnson's comments objecting to the proposed regulations.'[93] This underlines a major problem arising from the dominance of the industry in research - truly independent expert consultants are not easy to find! So for the moment it's business as usual.

*whether full-scale recalls (class1) are necessary for particular problems.[94] Recalls are not all total or widely publicised. Class 1 recalls necessitate recall down to the consumer level, with

---

[86] ibid., March 15, 1982, p. 46.

[87] *Washington Post*, March 11, 1982.

[88] *Star, Penang,* 14-3-1982.)

[89] Vitamin B6 was inadvertently destroyed by heating. Medical journals in 1954 discussed the effects, some of the victims, permanently damaged, appeared on television during 1981. cf. *Food Chemical News*, Feb. 2, 1981, p. 55; March 15, 1982, p. 48.

[90] ibid., March 15, 1982, p. 48.

[91] ibid., April 26, 1982, p. 26

[92] *Food Chemical News*, May 25, 1981

[93] *Food Chemical News*, 6-12-1982, p.16.

[94] *Food Chemical News*, Jan 18, 1982, p. 11-17.

enormous publicity. A mother need never know about recalls from distributors or retailers, and the specials she stocked up on might all be dangerous.

*whether industry can rely on data bases about milk products[95] (i.e. presume that certain ingredients are present in the right quantity because in theory they should be), and so on. What this said was "business as usual, folks, and we'll argue about the details once the heat is off in Congress!"

FORMULA and other parent groups were not impressed by the new regulations, and have filed a lawsuit charging that the Reagan Administration has violated the Infant Formula Act of 1980 by leaving the specifics of quality control up to the manufacturers.[96] (Manufacturers were not required to test any pre-mixes they bought from suppliers, and manufacturers increasingly used such pre-mixes, for instance.) Lynn Pilot commented that the supposedly explicit regulations did not even rise to the level of FDA's rules for cold remedies, yet were dealing with an infant's sole source of nutrition. By October 1983 the US District Court Judge had denied both sides a summary judgment, and the matter was to go to trial. The judge's order indicated 'some skepticism that the final regulations reflect the intent of Congress in enacting the Infant Formula Act.' Congress clearly intended 'that henceforth no nutrient-deficient (or, for that matter otherwise defective) infant formula should be accessible to potential consumers at all.' And the judge wondered how 'the analysis of a single newly-processed batch of formula at random every three months is calculated to give assurance that those produced in the interim are not flawed'.[97] Well might he wonder. Wyeth's B6-deficient formula (more than a million cans) was produced in just over two weeks.

And these were the world's strictest standards for quality control. . . We in Australia certainly do not pre-test imported formula. CHO-Free was used for premature infants in Australia. Syntex attempted to export its defective batches;[98] it is unknown whether they succeeded in selling any overseas, as is common for goods too dangerous for the US public.[99] US export and labelling standards also remained to be set.

US infant formula activists in 1997 would do well to see what the outcomes have been, and to actively participate in the current revision of Infant Formula standards now ongoing. It is at this political level that the important decisions are made: in Australia, for example, it was the definition of "infant" in our Food Laws which enabled us to ban advertising of follow-on formulae in 1991. It would be a major benefit to the world breastfeeding movement if US breastfeeding advocates were able to create in the US a series of very high quality control standards: one only has to look at how influential high US standards have been in other consumer areas. But only US activist groups can do such work: it would be a pity if their focus on non-US companies such as Nestle meant that they overlooked the real and obvious needs in these areas.

Additional results of the 1979 US disaster included the analysis of other current infant formulae; there were some surprises, and other formulae were hastily altered. Among concerned US professionals, awareness of the hazards of bottle-feeding has probably never been higher. On 17 June 1981 an historic document was filed by Public Advocates Inc., a legal

---

[95] *Food Chemical News* Jan. 31, 1983 p. 4
[96] *Food Chemical News* Dec. 6, 1982, p. 15
[97] ibid., Oct. 31, 1982, p. 18.
[98] *ICEA News*, 1981, 20, 4, p. 2.
[99] Consumer Interpol, or Health Action International, can provide many examples of practices.

firm representing a wide-ranging coalition of concerned professional, parent and ethnic groups. This Petition to alleviate domestic infant formula misuse and provide informed infant feeding choice[100] represented the first major public attempt to state that problems with formula and bottle-feeding were widespread within America itself. It ranged right across the problem, detailing trends in breastfeeding among specific groups, medical harms associated with formula use, factors that discouraged breastfeeding (including hospital practices, professional attitudes, and company promotional practices); institutional role models (successful breastfeeding promotion measures); and suggestions for change. Extensive bibliography and appendices were also included. Those interested in infant feeding should read this document- and then pause to consider whether things are any different (apart from a greater degree of ignorance and inertia) in their country.

The industry reacted to this document very strongly indeed[101] for it attacked the basic assumptions about infant formula that had for so long gone unexamined: assumptions about the safety of formula in America, about the beneficial nature of industry/medical interaction, about the need for formula, whether women were truly informed before making decisions about feeding, and so on. Some of the questions raised were to be tackled in what seemed like a more impartial way by a special Task Force on the Assessment of the Scientific Evidence Relating to Infant Feeding Practices and Infant Health.[102] This is an important document, which raises more questions than it answers, but the value of human milk emerges clearly- as does the pro-formula bias of certain chapter authors. Perhaps the most blatant example of this is a key summary chapter, which was a plagiarised FDA report of 1979, improperly acknowledged, updated to 1984 by the inclusion of all possible breastmilk problems, but without a similar updating for all the American infant formula problems, that emerged in that period. When in Washington at the FDA I spoke to one of the authors and asked her why this was so. Initially she said that there were no problems with US infant formula in that period. I expressed surprise and told her I was about to publish a book, with at least half a dozen recalls sourced from the FDA: was she unaware of the problems her colleagues had told me about? Her reply" Oh, you know about those!" "Yes, I do." "Well, you have to understand the situation here. After the CHO-Free disaster in the late 70's, American parents were really scared about infant formula. We had to reassure them that formula was safe, because American society depends on bottle-feeding." God forbid the FDA should do something so subversive as suggest American women use their mammary glands! And God forbid anyone assume without proof that even senior bureaucrats are any more objective than the society they live in. This dear lady was most offended by my mildly-spoken response, "So you're saying that the chapter's defects are because of its political motivation, which was to reassure parents." Yet what else was she saying?

In the 1980-81 atmosphere of widespread concern about infant feeding, the US decision not to endorse the WHO Code, and the American Academy of Pediatrics support for that decision, seemed all the more outrageous. Yet in some ways this was the best thing America could have done: it ensured that those parts of the developing world where anti-American feeling is a real force should take the Code seriously, and it made headlines around in the world. While

---

[100] L. Salisbury; A Glover-Blackwell, Petition to alleviate domestic formula misuse and provide informed infant feeding choice-filed June 17 1981. Available from Public Advocates Inc., 1535 Mission Street, San Francisco, CA 94103. # (415) 431 7430

[101] *Food Chemical News*, Jan. 4. 1982, p. 18-19. The Infant Formula Council produced a massive response, available from them at 5775 Peachtree-Dunwoody Rd., Suite 500-D, Alanta Ga. 30342.A further reply and counter-reply followed, both fairly predictable and both capable of being critisied for their interpretation of data.f

[102] *Supplement to Pediatrics* (1984 74, 4.)

adoption of the Code was rightly regarded as a great victory by those concerned with infant health, many consumer groups regarded it as far from adequate. As the Director-General of Health for Western Samoa put it, 'The Code has such great loopholes in it that any unscrupulous manufacturer could drive a herd of milk cows through it.' But it was the best that was possible given the tactics of vested interest groups. (Commercial firms and governments of milk-exporting nations have no desire to see their markets dwindle.) And of course the Code was only a beginning: once it was accepted it would always be possible to develop these concerns further by WHA resolutions and WHO actions. While it is true that WHA resolutions will not alter the International Code per se, and Code advocates should not argue that they have, resolutions have as much moral force as the Code itself for those governments whose representatives voted for them. However, advocates should not muddy the waters of international debate by alleging that infant formula companies are automatically bound by agreements entered into by their national governments: it is a separate and necessary stage of negotiation to get any company to support a WHA resolution, and governments need to approach their national industry (and WHO the major industry group, IFM, the Infant Formula Manufacturers' •••, which succeeded ICIFI) to elicit such support every time there is a new resolution. Any WHA resolution should have great moral force, and we can hope that any ethical formula company will adopt them. But it is unreasonable to expect groups not involved in their development or adoption to give automatic consent to them. Breastfeeding advocates never feel bound by industry Agreements to which they were not party. We should not expect industry to act any differently. And even breastfeeding advocacy groups may not give full assent to some poorly worded WHA resolutions: none is a sacred document commanding the uncritical belief of the faithful. WHA resolutions are not the Ten Commandments and we are not the children of Moses, however much the unaccountable persons who draft such resolutions may wish us to assent to the words written because we agree with the intent of the resolution. Words are words and have precise meanings, to which other meanings can be given in different circumstances. Activists and industry alike need to remember that WHA resolutions, while having considerable moral force (and more if not badly worded), are recommendations to be interpreted in the light of national circumstances. This is explicitly stated by WHO and WHA: national pride would prevent most countries accepting as a mandatory instruction something which other nations attempt to impose. So readers need to be very clear that whatever is agreed in international forums such as the World Health Assembly, it is still up to governments to implement the Code, in conformity with local circumstances. And it is up to concerned citizens in every country to see that governments get on with that task among the myriad others they face. And in my view the place for westerners to start is with the government in one's own country. How much better the world would be if US activists had persuaded the US government to control the activities of US companies world-wide, and Japanese and Swiss and Dutch and German and French activists likewise!

The WHO Code has often been grossly misrepresented. It **did not**:
*ban the use of formula, or its sale to the public;
*prohibit industry from informing health professionals about their products, or providing supplies for legitimate research purposes;
*apply only to poor countries;
*contravene national sovereignity or restrict the 'rights' and democratic freedoms of free-enterprise industries.[103] This was the US excuse for opposing it, later rejected by the Justice Department, which ruled that the Code was not 'unconstitutional';

[103]This argument is fully discussed in Toll, M. A., "Spilled Milk": a rebuttal to the U.S. vote against the International Code of Marketing of Breastmilk substitutes. *Boston University International Law Journal* (1983) vol.2: 103; 103-132.

*restrict women's right to choose how to feed their babies.

What the WHO Code **did** do was to call on governments:
* To halt the advertising and promotion of breast milk substitutes, bottles and teats, to the public.
* To halt the free distribution of samples, directly or indirectly, to pregnant women, mothers, or members of their families. (This does not prevent institutions from providing needy families with supplies so long as they 'take steps to ensure that supplies are continued as long as the infants concerned need them.' (article 6.7)
* To prohibit mothercraft nurses, or any other manufacturing personnel, from contacting pregnant women and mothers. No facility of a health care system may be used to promote breastmilk substitutes - no display of products, placards or posters, or 'educational' material other than materials requested and approved by governments which do not refer to any proprietary product and which meet stringent rules about content.
* To restrict industry gifts to health workers, which might range from free products for their children to an annual all-expenses-paid trip with spouse. Research grants, study tours, conferences, etc., paid for by companies were to be publicly disclosed by both company and recipient. (Shortly before the American Academy of Pediatrics refused to endorse the WHO Code because of legal (not medical) reservations, Ross Laboratories gave them a $1 million renewable grant.) Such 'gifts' are eventually paid for by the mother who buys the formula and often dilutes it because of its high cost. Remember that the AAP opposed quality control regulations -but not gifts to them- that will raise the cost of formula!!
* To require improved labelling, emphasising the superiority of breastfeeding and the hazards of inappropriate preparation; omitting misleading terms that imply closeness to human milk, and pictures of infants or pictures idealising the use of infant formula.

Other labelling provisions include such pertinent facts as ingredients composition/analysis, storage conditions, batch number and use-by date, 'taking into account the climate and storage conditions of the country concerned', which should mean 'how long might this last when sold from the open-air shops of Asia'. Given US concerns about the effects of heat and storage on nutritional quality, and the 'elegance problems' that cause vomiting and diarrhoea (referred to earlier in this chapter), these are serious issues. After all, 'Liquid infant formulas are fat and protein emulsions that will separate with time. . . resulting in an objectionable appearance or clogged nipples. . .the rate of separation and deterioration of nutritional quality increases at higher temperatures.'[104] Omission of these key labelling features by any country will mean that if more salmonella-contaminated formula were exported, recalls of the relevant batches would be difficult; if children develop allergies, no one will know what formula ingredients they were consuming; if the shopkeeper doesn't rotate his stock, poor mothers may buy nutrient-altered and maybe defective formula which they cannot afford to throw away or replace; and so on. This really would be a cynical exercise in exploitation It could also prove very costly to the dairy industry of the country involved.

Because the Code was a recommendation to governments, the key to its success is obviously what governments did about it. Most manufacturers were happy to endorse the WHO Code, fully aware that they would be consulted before any national codes got off the ground. In most cases they have written national codes, or at least heavily influenced them; often because where artificial feeding was concerned, they were the most knowledgeable or powerful players at key national meetings. In the next section I will focus on events within Australia 1981-1997. For me to write the full history of this decade from a global perspective is not possible

[104] *Food Chemical News,* July 18, 1983, p. 6.

at present: it is in fact another book rather than a chapter, and as crucial events are still ongoing I prefer to leave that global history for the present. A summary record of what the world's nations had done about the Code to 1991 is available from the Nutrition Section of WHO Geneva (1211 Geneva 27, Switzerland); so too are excellent bi-annual reports of activities from 1983 to 1993. The drawback of many of these reports is that of course they do - and must -represent what governments have told WHO; which only rarely includes an accurate account of national deficiencies or problems. Equally, IBFAN-linked reports for the period tend to focus on the reverse side of the coin: what has not yet been achieved. There is a crying need for independent scrutiny and academic analysis in this area of history as any other. But here as elsewhere in contemporary history, independent writing is a risky enterprise: anyone foolhardy enough to criticise the actions of industry *and* its critics can expect to be anathemised by extremists from both groups. C'est la vie.

PART 2 AUSTRALIA, THE WHO CODE AND INFANT FEEDING 1980-1997: MARKETING PROBLEMS AND SOLUTIONS

Australia is a huge continent with a small population, now about 18 million, united under a complex federal-state-local government structure that ensures more politicians per capita than most countries. Its present government is conservative and their policies have been likened to Margaret Thatcher's. Policies perversely labelled "economic rationalism" (historians may deem this ironic) had increasingly dominated political debate in Australia through the 1980's, and despite differences in social service safety-nets (Labour being more generous than the conservatives) both major political parties have been keen to realise public assets, cut back public services, allow "market forces" mysteriously to regulate themselves, enshrine the shibboleth of "Free Trade" and generally de-regulate wherever necessary to allow these market forces to work their magic of creating wealth and through it a fairer society.[105] Competition has been enshrined as an unquestionable good, and monopoly is intrinsically bad, even where common sense suggests this to be a nonsense. Those raised to consider social justice and democracy important values have been struggling to affect policy. This is not the nanny state any more, but rather the bully-boys' paradise, where a horse named Might and Power winning the Melbourne Cup in 1997 was seen as a fitting metaphor for the country. In short, we live in unfavourable times: not the best of climates for volunteers to be challenging the marketing strategies common to multi-national companies the world over. So any gains have been hard-won, and those of us fighting for them have had to accept certain non-negotiable realities in the struggle to achieve them.

I believe that this is why the achievements of Australia in implementing the International Code make more encouraging reading than the global history to date. What is more, these achievements give the lie to arguments so often heard by (and sometimes from) breastfeeding advocates in countries like Canada, USA, Germany, New Zealand, and other so-called "advanced" Western democracies, that a federal national government cannot act to implement the Code without the full support of the various states or jurisdictions; or that women's freedom and rights cannot be protected if the Code is implemented. Australia is integrating the Code into existing national systems in a way that has not been seriously opposed as yet, because it meets all the reasonable objections of those less convinced of the importance of breastfeeding. As one of the dedicated team of long-term unpaid advocates from NMAA and ALCA and the Australian College of Midwives, I am very conscious that we in Australia have much more to do: but we are getting somewhere. In fact, comparisons of hospitals or shops or parents journals from the US, the UK, Malaysia, Germany or NZ show that we have achieved

[105] Why it is assumed that this will be the result, rather than greater social division as previously in history, eludes me.

a good deal. Yet when Australia is reported on internationally by IBFAN, the positives are not mentioned. The Code is not Law in Australia they say, it is a Self-Regulatory Scheme, as though that says everything. Such selective negative reporting is not only a breach of the solidarity we Australian breastfeeding advocates should be able to expect from our fellow-IBFANers. It is also a great help to industry, as it keeps IBFANers everywhere locked into "politically correct" thinking (Law is Good, we must insist on the Code as Law) that does not help Code advocates attract wider support or strategise in the unfavourable political and economic environments of many western communities; it ensures that the battles and confrontation continue, with power-brokers seeing IBFANers as marginal and industry as part of the mainstream. So IBFAN centres seek financial support from the compassionate in society to keep battling on, and industry keeps advertising - in England, in Switzerland, in USA, in Malaysia, despite more charitable resources and paid staff in each of those countries addressing these issues in a year than we have ever had in Australia over decades. It is my hope that this chapter will allow some re-evaluation of national approaches to complex issues. Were it the 1960's in Australia, law might have been the right way to go, and in future it may be once again be the rational way to proceed in Australia. Already we in Australia use existing law as an important part of implementing the Code, and much of the Code is enshrined in Australian law. To go for legislating The Code in toto may be the right approach in some countries today. But it isn't here and now in Australia. The moral of this chapter, if there is one, is that national breastfeeding advocates may need international support, but not international pressure to pursue approaches that will not work in their national context. And published ratings of national achievement ought in justice to be more objective, more complex and less dogmatic than current ones, if those responsible for those published ratings wish to retain any international credibility.

Australia and the International Code, 1981-1996

A conservative coalition government was in power in Australia in 1981, and endorsed the Code. The Commonwealth Health Department took the line that industry is responsible and should be self-regulating; that legislation or strict regulations would be undemocratic and unnecessary. Few bureaucrats in the Health Department then seemed to realise the value of involving the community in decision-making processes: in the early 1980's a most undesirable atmosphere of secrecy prevailed. The Department of Primary Industry set up a 10-person committee, including four industry representatives, but no consumer advocates, despite repeated requests from the Australian Consumers' Association.[106] Consultations were between the Australian Dairy Board, the Commonwealth Departments of Health and Primary Industry, and the five leading formula manufacturers.[107] The initial outcome was thus predictable. The 'Code' that resulted allowed Australian manufacturers to do business as usual. True, direct advertising of formula to the public was forbidden - but bottles and teats were not, and instantly advertisements for both were again being published in the women's magazines, even if these were careful not to include references to formula, and some promoted breastmilk feeding by bottle. Perhaps the reasoning was: 'bottles are used for water and juices, therefore they're not promoting infant formula'. But note that the WHO Code did cover feeding bottles and teats, and breast milk substitutes were *any food marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.* Using babies in advertisements implies that the product is suitable for use by infants. As any complementary feeding, or solids, decreases breast milk intake, orange juice or even water is similarly not to be encouraged. And of course, some of the advertisements of the early 1980's

[106] Who were later to nominate me as their first choice of representative for a monitoring panel, only to have it refused by the Health Department

[107] Minutes of these meetings are available under the Freedom of Information Act.

quite clearly did promote formula feeding. One even had the gall to depict a svelte, immaculate mum in glamorous scanty negligee, smiling serenely, offering her laughing child a bottle of white liquid, presumably formula, the clock behind showing 2.45. The wording: 'If it were any simpler he'd do it himself'. [108] (Which is just what baby does do, snuggled in beside breastfeeding mother in a warm bed.) Any picture taken at 3am of any parent staggering about carrying a baby and preparing a bottle would bear no resemblance to this image; and what parent offers juice or water at 3 am? Yet this was supposedly not advertising formula- only the bottle? In 1996 we still see advertisements for bottles and teats that are supposed to prevent colic and orthodontic problems in infants. This is a most remarkable feat, when so many babies have colic due to the contents of the bottle,[109] or facial deformities as the result of the teat, but how misleading for gullible new mothers. Why is the Trade Practices Act, with its $10 million-dollar penalties, rarely invoked for such fraudulent and dishonest advertising?[110]

But this 1983 Australian industry Code differed from the WHO Code in many other ways. Manufacturers could use far more initiative in providing 'informational' material within the health care system; the material could refer to proprietary products; point-of-sale promotion was allowed; almost all of the stringent control of educational literature was gone, even the requirement for inclusion of a 'clear explanation of the hazards of improper use'. Manufacturers could provide samples indirectly (a significant piece of article 5. 2 that was omitted) to pregnant women and mothers. The moral responsibility of ensuring long-term supplies for people given samples (article 6. 7) was also deleted.

In Australia, no breastfeeding advocate was able to obtain a copy of this 1983 Industry Code prior to its signing by a newly elected Labour Government Health Minister, who was presented with the Industry Code as a virtual fait accompli in May 1983, as the World Health Assembly was due to begin and Australia had to report its progress. However, the new Minister asked the NH&MRC to set up a working party to examine the implementation in Australia of the Code. This was also to respond to submissions from NMAA and myself alleging that healthworkers and hosapital practices were responsible for much breastfeeding failure. The NH&MRC approved guidelines in 1984 (see below, p.) and in 1985 recommended the setting up of a formal monitoring committee. A monitoring committee, with limited consumer input, was set up briefly in 1985 but achieved nothing, partly because the Department rejected any consumer representative with knowledge of the issue or IBFAN links, such as myself or Yong Sook Kwok, who succeeded Dr. Kate Short at ACA. ACA, the Australian Consumers' Association, had given IBFAN financial and logistic support during the Nestle Boycott. While Kate was working on the issue she had been a crucial figurehead and leader in this debate, pressuring government, organising groups around Australia to support the Boycott and, unlike many other consumer activists, continuing to work on infant feeding issues after the Boycott was lifted in 1984. It was Kate who organised the IBFAN protest at the 1984 International Confederation of Midwives conference in Sydney. However, Kate's relationship with the Health Department was unavoidably adversarial; this created some problems and eventually Kate moved on to help create the excellent Toxic and Hazardous Environmental Chemicals Centre, working on pesticide issues, and has played no part in infant feeding issues for most of the last decade. Her successor at ACA, Yong Sook Kwok, had

---

[108] Advertisement for Maws Simpla sterilising and feeding set, Women's Day, July 18, 1983, p. 70. Mind you, it does say that 'after 150 years of making baby products we've found the ideal method of sterilizing and preparing your baby's feed.' Perhaps in another 70 years the companies will find the ideal mixture to put in it.

[109] That colic is due to the contents of the bottle was clearly established by Lothe, T. et al, Cows' milk formula as a cause of infantile colic: a double blind study. *Pediatrics* (1982) 70, 1, 7-10.

[110] It is of interest that in Australia the NUK advertisements no longer talk of their closeness to breastfeeding, after the Trades Practices Commission in 1993 asked the distributor to justify its claims or face prosecution.

many other duties and was to play a less prominent role in the events that followed, although she was for a time active in the Australian Coalition for Optimal Infant Feeding, and was the IBFAN representative for the Pacific region until 1991, when maternity leave took her off the active workforce. (After that, Jan Mangleson, a former NMAA Board member, became the IBFAN South Pacific representative until the very position itself was abolished after Jan failed to toe the party line on the issue of the Code as law in Australia.[111].) In fact throughout the mid-to-late-1980's it was Janey Christopherson, of the NZ Coalition for Trade and Development, who was the most active IBFAN representative in the region[112], and NZ initially achieved more than Australia, only to lose momentum by the early 1990's, [113] while Australia then began to reap the harvest of the work put in.

Australian breastfeeding advocates' discontent with the status quo, and with the Commonwealth Health Department, steadily increased over the 1980s. The 'industry' code was amended in 1986, again without consumer knowledge of the process: while the Minister's office had become more open to consumers, the mindset of the Department seemed to observers to have changed little by then, and this was an administrative procedure. Again breastfeeding advocates protested; and continued to demand an active monitoring committee to assess industry compliance. Consumer activism against the infant formula industry, led initially by ACA as noted, together with Glenyss and Graham Romanes at CAA (Community Aid Abroad) had steadily declined after the ending of the Nestle Boycott in 1984. This was no doubt due in part to the many crises an international group such as CAA had constantly to respond to through the 1980s. And of course if the problem has been defined or perceived narrowly (and inaccurately) as that wicked Nestle breaching the Code, then a commitment by Nestle to do better may seem like a victory, the conclusion of a struggle. From the perspective of the committed breastfeeding advocate, it sometimes seemed as though the broader, more difficult issues related to infant feeding in Australia were too complex, or the consumer movement too divided in its responses to infant feeding issues at home, for certain types of consumer activism to continue once that negative anti-multinational focus was gone. The supporters of the breastfeeding advocacy cause are generally not intrinsically opposed to multinational capitalism, only to those of its behaviours damaging to infant health.

---

[111] Jan was a very experienced breastfeeding counsellor who had pioneeered working with aboriginal women on breastfeeding; subsequently a co-founder with Grace Close and others, of ABBA, the Aboriginal Birth and Breastfeeding Association, and in 1996 President of ALCA.

[112] It must be recognised that in every country where progress is made, there are usually a few key individuals who work tirelessly on the question, and if they cannot support themselves to do so, or if funding for the position dries up, progress starts to slow. In these days of economic pressure on families, it is harder than ever to find volunteers able to give the time needed. It is often not recognised that breastfeeding advocacy centres in receipt of any ongoing funding are scarce around the world: whatever funds[112] UNICEF or WABA may have made available world-wide for this work, in Australia not a cent of overseas or government assistance has been received by ACOIF to assist in Code implementation. Of course Australians have no problem with the idea that all UNICEF funds should go to nationals of even less affluent nations, but do not consider UK America or Europe as such! It remainds a source of irritation that WABA does not publish any accounting for the moneys received from UNICEF for world-wide breastfeeding advocacy, and that all processes relating to finance are unaccountable to the WABA membership.

[113] In 1995 there were signs that interest was again increasing in NZ and monitoring has begun again, but consumers are unhappy with the way this has been done to date. At present in mid 1996 the NZ Government is trying to develop an Industry Code, and the companies which market formula there have drafted a very weak Code. This will be quite unacceptable to Australia, and as our Food Laws are to be "harmonised", it has caused a great deal of concern to Australian breastfeeding advocates. Interestingly, almost all of these same companies agreed in 1992 to the much tighter Australian Agreement, which had Nestle Australia's full support: Nestle does not market formula in New Zealand, and no formula company there has taken a comparable lead role among the industry groups.

The Nestle Boycott was once again revived in 1987 by the North American group which had declared it ended in 1984.[114] Despite requests from IBFAN Penang to join the Boycott, no experienced Australian breastfeeding group or individual saw a renewed boycott as a useful strategy, for reasons which will emerge as this narrative continues. It was not until 1991 that the newly-formed "Babyfood Action Group" members were trained in Penang to undertake the launch of a boycott of infant formula manufacturers in Australia. BFAG eventually became part of the INBC, or International Nestle Boycott Committee. While it advocated action against all formula companies, most of its public emphasis centred on Nestle and Wyeth, not then the most aggressive Australian marketers. Initially this increase in consumer activism was welcomed and supported by other breastfeeding advocates, who saw it as a positive awareness-raising force on the fringe of the broader movement. This was despite the fact that neither NMAA nor ALCA could endorse the Nestle boycott without jeopardising their own credibility with those healthworkers well-aware of the much less Code-compliant behaviour of other companies in Australia.

With the 1987 founding of ALCA, the Australian Lactation Consultants' Association Inc., a new focus for healthworker conscientisation came into existence, and leadership of the struggle to control industry began to be assumed by this new health professional group, which from the beginning was prepared to go beyond NMAA's focus on breastfeeding (and not artificial feeding), but worked hand-in-glove with NMAA. Indeed, NMAA set up the first meetings tthat led to the formation of ALCA. ALCA was the first professional organisation in the world to include support for the International Code as part of its Constitution, and as a pre-condition for election as office-bearer.[115] ALCA, NMAA, the Nursing Mothers' Association of Australia, and individuals working for these organisations and independently, were the key change agents in what was to follow in Australia. Over the 1980's, NMAA had gradually moved towards a more active political role, and was documenting Code violations, having established a computer database for that purpose in 1989. Other breastfeeding organisations encouraged their members to send violations to NMAA, as there was no point in duplicating the work being done by a valued colleague in the struggle. Through education, ALCA actively sought to persuade healthworkers to use the power they possessed to influence the situation. A key factor assisting the development of this educational mission was the development of the International Board of Lactation Consultant Examiners and its annual Examination: see below.

<u>The Trades Practices Comission and the Code</u>

By late 1988, after Health Department bureaucrats had been widely quoted as saying that the problem in implementing the International Code was that "anti-competitive" actions such as restricting advertising were impossible due to Australia's Trade Practices Act, the Trades Practices Commission in the Attorney General's Department was asked to look into the matter and replace such generalities with a considered detailed report. The Trades Practices Commission then realised that the previous infant formula Industry Codes (as they were then called) were illegal, a breach of the Trades Practices Act, which could be authorised only if substantial public benefit could be shown which outweighed the presumed public detriment of restricting competition. In 1989 meetings were held separately with all the parties concerned, and the process of working towards the full implementation of the International Code really began. ALCA's submission in 1989 was to be the virtual blueprint for what followed.

---

[114] By a group which in 1996 has been declared persona non grata by IBFAN because of its links with American industry.

[115] As a founding member I wrote this in; when on the ILCA Board 1989-1991 I was able to persuade ILCA to do likewise, and NZLCA has similarly adopted this position; ILCA has since made it a pre-condition for affiliation.

ACOIF (Australian Coalition for Optimal Infant Feeding)

ABC Television consulted with key breastfeeding advocates, including Yong Sook Kwok of ACA, and myself, when making The Formula Fix, a documentary showing that babies were still dying for want of breastmilk. After this was screened, the key players in the breastfeeding field were strengthened by a new awareness on the part of aid and development agencies, some of whom declared that they had thought the problem solved in 1984. Greg Thompson, of World Vision Australia, and Margaret Bailey of Freedom from Hunger, called a meeting in Canberra in June 1990, where representatives of a wide variety of organisations were briefed about infant feeding issues, the Code and the current Australian situation. The decision was taken to form ACOIF, the Australian Coalition for Optimal Infant Feeding, to act as a peak lobbying body. This was enormously important: it demonstrated to government that wide cross-sections of the community, including many health professionals, were united in seeking change, and that there was a responsible agency with whom to liaise, not a series of disparate groups with different agendas. Greg Thompson became chair of ACOIF, and his input over the next few years was invaluable. The Industry Agreement's rapid achievement was ACOIF's first success.

Regrettably however, despite everyone's best efforts, the different emphasis and style of the Babyfood Action Group (BFAG) helped create tensions within the breastfeeding lobby, tensions which by late 1993 had developed to the point where ACOIF was unable to develop a united policy or agree on a representative to meetings, and some organisations were no longer sending representatives to ACOIF meetings. Collaboration on important projects has been impeded by debate over doctrinaire points and the accuracy of reportage. As a long-term participant in the process, it seems obvious to me that this tension slowed the pace of national advocacy from 1993 to 1996. Prior to this, ACOIF had been an informal group that was able to achieve genuine consensus and rapid action. In an attempt to overcome this creeping paralysis, in 1995 moves to create a formal democratic and accountable structure for ACOIF began. ACOIF has since become incorporated nationally as a peak body for national organisations concerned about infant feeding issues (although enthusiastic individuals are welcome to contribute at any level they wish). Once a proper structure was in place, disagreement could be handled democratically. The continuing core members of ACOIF, the permanent breastfeeding advocacy groups such as NMAA and ALCA, continued to liaise and collaborate both on a Constitution for ACOIF'S incorporation, and on a joint response to ongoing issues such as the consultation on the Marketing of Bottles and Teats. (see below). Meanwhile, in the last couple of years before its demise[116] in mid-1996 BFAG increasingly went its own way. Three ad hoc meetings about implementing WHA Resolution 47.5, on the issue of free and low-cost supplies, were set up by the ACTU in October and November 1994 and then in August 1996 (see below p.), with a re-named Baby Food Action[117] as secretariat. Fortunately this association of a key infant feeding issue with the trade union movement at this late date, when a conservative coalition government is again in power, has not damaged the cause. In itself this is a tribute to the widespread support created over the previous decade for breastfeeding as the Australian norm: NMAA has friends and colleagues in power everywhere in Australia, despite some hostility from powerful women who chose or were forced by circumstances to artificially feed.

The 1991 Formula Industry Agreement

---

[116] Although CAA agreed that BFA(G) should be wound up in 1996, at the time of writing the Web still contains pages of old BFAG material using CAA's name and affiliations.

[117] It is not clear exactly when the word "Group" was dropped from letterhead.

In 1990 that was still to come. ACOIF meetings led to the development of ALCA's 1989 TPC Submission into an ACOIF submission, which basically argued for the implementation of the International Code and the establishment of a credible monitoring body, with consumer and industry representatives and an independent chair. Nestle Australia's submission made it clear that one of Australia's largest infant formula manufacturers supported this basic concept; and none of the other companies explicitly opposed it in writing. The Federal Bureau of Consumer Affairs convened a meeting in June 1991 of all the various interest groups covered by the Code, and allowed each to express their views in open forum, with the government representatives stating plainly that their Minister's instructions were to implement the Code in conformity with Australian law. It immediately became obvious that only the infant formula companies (as distinct from say bottle and teat or weaning food interests) were then willing to negotiate an agreement restricting their marketing practices. It was also obvious that if breastfeeding advocates insisted on negotiating the whole Code at once, and waited until all interests were aware of the issues and willing to deal, nothing would be achieved in Australia for many years. A policy of implementing the Code piece by piece was formulated and agreed by breastfeeding advocates and government bureaucrats alike. The Federal Bureau of Consumer Affairs therefore called a smaller working meeting in November 1991 to negotiate an Agreement on the Marketing in Australia of Infant Formula. Despite a BFAG vigil seen by many as inflammatory, this meeting went ahead, but only after some very plain speaking about the need for responsible behaviour by industry's critics as well as by industry. The FBCA chairperson, Garry Johnson, said that the role of street demonstrations is to get issues on to the public agenda; but once issues are on the agenda, demonstrations run the risk of inflaming tempers so that issues cannot be resolved. This particular demonstration had inadvertently offered a wonderful pretext for a boycott or walkout by any company not really ready to negotiate, and that possibility was canvassed both before and at the meeting by some angry industry delegates. However, there was clear commitment from both breastfeeding advocates and some companies (notably Sharpe Laboratories and Nestle) to achieve an agreement, which was stated as being the only way to end such actions. The negotiating skills of those present were able to deal with this unintended threat to the negotiations, and the meeting finished ahead of schedule, and successfully, with the words agreed. Again, this was largely due to two things: the fact that the FBCA Chair had a clear mandate from the government: to implement the Code in conformity with Australian law; and the prior development by FBCA of a useful working document. This listed by article number the Code, the 1986 Australian Industry Code, and legal advice in three paralllel columns. Negotiation was simple: where there was no valid reason under Australian law to change the International Code, its provisions stood. Where Australian law made the Code illegal, the Code was altered.

At the Minister’s direction, the Industry Agreement developed could not include any practice illegal in Australia.[118] Under the Trades Practices Act, retail price-fixing is illegal, and punishable with fines of up to $10million. Hence some minor items such as point-of-sale displays had to be allowed.[119] The huge benefit in this approach of working within **Australian** law was the fact that in Australian law an infant is a person up to the age of 12 months; thus the term “infant formula” automatically includes follow-on formulas, specialised formulas, and the rest. Australia was thus the first western country to deal effectively with the problem that had haunted Code advocates since the companies invented so-called follow-on formulas. Such formulas did not exist in 1981 when the Code was passed, so that the Code spoke of

[118] This is not a permanent restriction. Should the voluntary Agreeemnt not work, consumers can press for legislative change. But the whole ethos of Australia at present makes it unlikely that without serious financial resources such a course of action is doomed to failure.

[119] This could be abused: there will still be a role for consumer criticism of companies which observe the letter of the Agreement but not its spirit.

infants up to the age of 4-6 months only, since at that stage this was seen as "prolonged breastfeeding" by many Europeans and Americans. At that time, most western babies were off breast or formula alike by six months, and on to family foods and animal milks. Regrettably, industry's likely response was not foreseen by consumer advocates. By the end of the 1980's nutritionists, following industry's lead, were advocating a continuation of both breast and formula feeding to 12 months of age. (Formula is quite unnecessary where infants are eating good family food, but that's another chapter!) The US companies in Australia in 1991 seemed well aware of the significance of this "four to six months" figure and the need to protect their ability to market "follow-on" products. Mead Johnson had suddenly advertised its follow-on formula Enfapro in parents' magazines in the period leading up to the negotiation, despite universal industry condemnation of an action unknown in Australia since 1978. (In 1996 some of these same companies seemed to be hoping NZ would agree that infants are persons up to 4-6 months and follow-ons are not infant formulas: NZ has permitted advertising of follow-on formulas. It seems a sadly missed opportunity in an English speaking country where "infant" is usually defined in the dictionaries as it is in Australia, rather than as "infant formula" is in the Code.)

This 1991 Industry Agreement had to be submitted to and authorised by the Trades Practices Commission before it was legal. By May 1992 this had been done and the Agreement was signed; in September the first Chairperson of APMAIF, the Advisory Panel on the Marketing in Australia of Infant Formulas, was appointed. This was Professor Kerin O'Dea, of Deakin University; unfortunately she was to resign in early 1993 due to pressure of work. The second Chairperson, Dr. Wendy Holmes, was not appointed until later that year. Two very able and experienced representatives, Michael Sharpe for industry and Ros Escott for consumers[120], were appointed to make up a Panel of three, directly responsible to the Minister and working with a secretariat within the Federal Bureau of Consumer Affairs. The task of APMAIF was to monitor the observance of the Industry Agreement. Regrettably, thanks to staff crises and changes of personnel, and re-organisation within the FBCA, it took until October 1994 for the Panel to produce its first report, naming the documented Code breaches. Wyeth (20) and Mead Johnson (17) headed the table of those who were reported as violating the Industry Agreement. Douglas Pharmaceuticals (Karicare) had one violation. A second report, Keeping an Eye on the Market, has since been produced in August 1995. In the period August 1994 to June 1995 only Wyeth was stated to have breached the Agreement, by claiming that its formula's fatty acid profile "closely matches that of breastmilk." Scientific evidence was sought: this is neither scientific nor factual information and hence a breach.

A third APMAIF report, aptly titled Room for Improvement became available in 1996, covering the period July 1995 to August 1996. (The conservative coalition came into government in March 1996). This Report sounds a warning: Mead Johnson had breached the Agreement 5 times, Wyeth twice, Douglas Pharmaceuticals and HJ Heinz (free samples) both once. Mead Johnson's objectionable battery-powered singing cards offering a chance to win a free video display unit, were never going to be seen as "scientific and factual" material designed to educate healthworkers. Nor were its claim about its fat blend "closely mirror"ing breastmilk, or the statement that all babies needed iron-fortified formula after six months. Emphatically not "scientific and factual", these claims were ipso facto "false and misleading" and so arguably a breach of the Trades Practices Act. It seemed to ACOIF members that industry was feeling more adventurous with the new government in power, that these violations were by companies which by now knew the APMAIF interpretations and should be

[120] I was appointed Consumer Alternate representative and have been actively involved with the Panel's work, although I later recommended that the position of Alternate be abolished.

complying with the Agreement. ACOIF therefore warned that in future, in addition to lodging complaints with APMAIF, it might seek criminal prosecutions under the Trades Practices Act, which applies even-handedly to all commercial interests, preventing them from making false and misleading or fraudulent claims about products. Hence when in 1997 Mead Johnson launched their new thickened infant formula, EnfalacAR, ACOIF lodged a formal complaint with the Australian Competition and Consumer Commission, which administers the Trades Practices Act, alleging that the law has been broken. If found guilty under this Act, Mead Johnson faces serious penalties. And there is no community sympathy for any company which lies to the public: infant formula manufacturers are being treated no differently from any company which lies or cheats in an effort to sell its products. Singling them out for special treatment and alleging that their product needs unique controls meets with reflexive opposition; whereas saying that they, like other companies, should not mislead consumers, does not.

There is a good deal of scope for Code advocates in developed countries to establish that infant formula advertisements are untruthful and misleading, and then see them prosecuted, wherever consumer protection laws exist (as they do in most so-called developed countries.) It is the responsibility of the authorities to investigate claims that the law has been broken and to prosecute criminals. I cannot understand that there have been no such prosecutions in North America, having seen grossly untruthful and misleading advertisements for so long there. As for the UK, how did the Wyeth "nucleotides" advertisements ever get past truth in advertising laws? Of course, Code advocates must learn the science, or secure the evidence from those who have it, which shows that these advertisements are lying by omission and commission: what they leave out as well as what they say. Government regulators probably believe the claims being made just as so many healthworkers do. But the whole Mead Johnson Peter Rabbit formula label could not survive five minutes in Australia: it idealises artificial feeding by showing Peter Rabbit standing by while his mother feeds his sibling a bottle. Cows milk formula would kill a baby rabbit. (Well, perhaps that is an appropriate label picture....) ACOIF sought an undertaking, and were given it, that Mead Johnson would not attempt to introduce that label in Australia, even before APMAIF determinations made it clear that it would be utterly unacceptable.

Obnoxious too, is the move into formula-feeding of lactating women. For quite some time Mead Johnson has been advertising a cows' milk-based product for pregnant and lactating women. This undermines breastfeeding in both subtle and obvious ways. For the covert message that is read into the advertising of such products by women conscious of the imperfections of their diet, is that breastfeeding is draining, exhausting, a strain on mothers; that special foods are needed to make good milk; that a mother who does not eat the right foods will suffer, or worse, her child might. How often have healthworkers dealt with women convinced that of course breast is best, but that their own milk could not possibly be right for their baby because I drink coffee or smoke or eat chocolate or love spicy food or don't eat enough vegetables and fruit or don't eat fish or hate milk or.... Such products are unnecessary in a country where good food abounds; and they are expensive for no good reason. What is more, they increase a woman's intake of cows' milk, in a community where infant reactivity to bovine milk in the mother's diet is quite common, thanks to earlier generations' feeding practices. Yet products such as this are not covered by the Code, and provide a vehicle for infant formula interests to undermine breastfeeding and present themselves as caring people who provide solutions to breastfeeding problems. Oh yes, and formula too.

The exceptions remained Abbott , Nestle, and Sharpe Labs: no breaches again in 1995-1996. In the 1996-7 APMAIF Report,

Copies of APMAIF Reports are available from APMAIF, c/o Dept of Industry Science and Tourism, GPO Box 9839, Canberra ACT 2601. It is to be hoped that health professionals who know the companies' scores by reading the APMAIF reports, and who pay attention to the quality of the literature they receive from companies, will use this to guide their suggestions when asked by parents about which brands of formula to select. I believe that companies which behave worse than others, so undermining breastfeeding and infant health, should lose market share as a result. We do not want Code compliance to be associated with loss of market share, which to date has been the Nestle experience in Australia. This is one of the reasons why I cannot support any Nestle Boycott in this country.

Deterioration in infant formula industry compliance, 1996-1997

Thanks largely to social changes beyond industry's control, and despite the restrictions on advertising, the formula market here is growing slowly, and with it the companies' presence, and even the number of companies. In 1995 Heinz launched new products on the market, and with them a whole series of dreadful booklets aimed directly at parents; AMCAL, a major buying chain of pharmaceutical retailers, has recently launched its own brand, using Snow's Victorian factory as its supplier, and with that launch sent out the worst and most misleading comparative tables to be left on display in pharmacies everywhere, informing consumers that breastmilk lacked many of the wonderful nutrients in infant formulas. What is worse, AMCAL refused to sign the Agreement until heavily pressured by the new government, and in 1997 is distributing free formula at baby shows it has sponsored.

The new manufacturers' disregard for the APMAIF Agreement has not gone unanswered by companies previously not offending so blatantly. Australia is now experiencing major marketing initiatives by the US companies to provide materials aimed directly at parents. This had been outlawed by the Agreement, and had not happened for years. But now we have Wyeth booklets for parents and special ones for fathers; Mead Johnson materials teaching parents about reflux (what MJ wants parents to beleive about reflux, that is);

Is this provision of so-called "educational" materials for parents advertising and a breach of the Industry Agreement? Of course it is. Commonsense is all you need to assess that. But if proof you need: one simple acid test is this - does industry claim the cost of these materials as tax-deductible? If so, in the very critical judgment of the Australian Tax Office, the official agent of the Australian government, these materials are designed directly to promote the product, to make profit for the business, and are advertising. If they are not, they are not tax-deductible expenses, and the millions companies have spent on them over the years should not have been claimed as deductions. (Perhaps they weren't??) In fact, all these 'educational" materials will be paid for from the company's marketing/advertising/promotional budget. The materials are not the result of industry workers taking up charitable collections in the street so as to commission some educator to help parents with problems. They are slick expensive productions full of cute images and designed to promote the product. In addition, they are as fully educational as one might expect given their provenance. Let's look at some recent starters.

Take the Heinz Baby Programme book, distributed direct to mothers via the Bounty bags: it gives advice about breastfeeding that is full of subtle negatives, undermining language, and painful problems, with badly positioned babies, embarrassingly-exposed large sagging breasts, sombre-faced breastfeeding women without wedding rings: and the converse: reassurance that there is no need to worry or feel guilty if you bottle feed, no problems to deal with (well, not one is mentioned) so long as you follow instructions, smiling mother with highly visible

wedding ring and dads can share the feeding (as of course they all do, night in and night out), and everyone can achieve "the special closeness normally associated with breastfeeding" just by holding the baby close and looking at him. Incredible! The writer is clearly utterly ignorant about hormonal effects of breastfeeding on the infant and mother. The booklet also equates breastmilk and formula as far as weaning recommendations are concerned. False, misleading, unscientific, not factual; a breach of Australian advertising law, a breach of the Code and of the MAIF Agreement.

Or let's look at Wyeth's latest production: a whole packet of "Advice on baby care and feeding for parents who have chosen to bottle feed". In this, Wyeth tells parents about everything from infant development to immunization, with lots of advice about things that are none of an infant formula maker's business, all decorated with "Looney Tunes Lovables". Of course the material contains much that is unexceptionable, but also gems like those below:

- "Having made the decision to bottle feed you must be mindful that infant formula is the only product suitable for use until your baby is 12 months old." Curious how babies have survived so well on well-chosen family foods, whether including some mammalian milk or not, and water. And that included almost all babies before follow-on formulas so-called were invented.
- "feeding times vary from baby to baby, so it is best to work out your own schedule. [Schedule??] Usually babies are fed every 3-4 hours, in order to establish a good milk supply." What does that suggest to the young mother whose baby is feeding 10-15 times a day and doing very nicely?
- "Most experts agree that weaning should start at around 4-6 months." [Not if a baby is breastfed and thriving, they don't.]

Part of this package is "How to survive becoming a father: a collection of handy hints." It suggests fathers get a doctor if a baby "has more than 2 runny smelly motions" or "vomits more than once", which certainly ought to cause fathers to worry about a breastfed baby of the mother with plenty of milk. And it tells fathers to "take the baby out by yourself for the first time as soon as possible. The longer you leave it the harder it is." What a lot of codswallop. Why should it be harder for a dad to deal independently with a sturdy 4 month-old with head control and reasonable feeding intervals, than a floppy four-day old baby who may have almost continuous feeding needs? How subtly undermining this is of the mammalian norm, the deeply-attached breastfeeding mother who is reluctant to let anyone take her baby out of her sight, sometimes for months after the birth. Again, it is simply not the business of formula companies to write this sort of literature, which has been one of the key factors in the illogical western belief that feeding problems not seen in the exclusively breastfed baby of the non-allergic mother are universal and normal. And remember, this extensive giveaway literature can only be tax-deductible if it contributes to greater sales and profits: as indeed it does.

The infant formula industry should not be educating parents about infant feeding, much less normal developmental progress, immunisation, mothering and fathering. Full stop. The Code says it; the MAIF Agreement says it. Nestle and Sharpe are not doing it in Australia. Let's make sure that those companies that have once again begun to produce this nonsense are not benefitting from breaking the rules. If you are a healthworker, tell their reps what you think of this; tell them that other companies will get your support until they clean up their act. Complain to APMAIF. Write to the Minister and ask him to intervene. Why should industry be permitted to use the healthcare system to undermine breastfeeding, whether by bad information or subtle positioning of themselves, not as commercial vested interests that gain from every breastfeeding failure, but as philanthropists?

In my considered opinion there is no doubt that some of the companies have been getting bolder in Australia since the new government in 1996. The development of consumer information lines began before that date, and there is no problem if these are genuine consumer complaint lines: purchasers must have access to that sort of information for every product. But how many hardware or food or computer firms hand out their customer complaint contact numbers so freely, providing then as cute fridge magnets or tear-offs in ever shop? How many seek "complaints" and incessantly offer to be of help? APMAIF ruled in 1996 that these numbers should be promoted only to health professionals and parents already using the product, as on tin labels; that these lines should offer only information about the brand formula and not infant feeding generally; and that nothing should idealise infant formula. Wyeth bought the right to a Looney-Tunes (again, how apt) "Lovable" baby Bugs Bunny, who sits in nappies clutching a carrot toy, above a free-call number for their "Infant formula help line." (Though that should be the RSPCA helpline if bunnies are getting cows' milk.)

The fact is, a few years ago this blatant advertising to parents was inconceivable. No doubt these companies are trying to exploit the fact that the MAIF Agreement, like the WHO Code, theoretically allows for educational materials to be created by companies, and distributed according to government guidelines. This provision allows companies to educate about the use of their product, some of which are quite specialised, not to set themselves up as teachers on the subject of infant feeding and family life generally. That would be like the Dairy Board lobby running classes on the use of olive oil, or the Meat and Livestock Council telling us about the virtues of chicken: a clear and obvious conflict of interest exists and the information provided is bound to be slanted to suit the provider. The MAIF Agreement says categorically, "manufacturers and importers of infant formula should not advertise or in any other way promote infant formulas to the general public." Up until the 1997 Report there has been no discussion of this because industry had not been caught circulating these "educational" materials. Quite clearly industry feels that with the new APMAIF, the new Government, and the new de-regulatory climate in Australia, they can go for broke now and try to push through the barriers that have prevented them reaching parents directly. Add to this the widespread advertising of their so-called "help-lines" (well, they help the company) and it seems to me that they are positioning themselves to replace health professionals as the main source of information about infant feeding, whatever lip service they pay to the idea that parents should talk to such professionals. Will a free-enterprise government give away our babies into the care of the companies?

.

At the time of writing there were few signs that government will enforce the Agreement strictly, or put into writing that signing the Agreement is a condition for marketing infant formula in Australia. What will happen to APMAIF? What kind of consumer rep will be chosen? The Independent Chair plays a less active role now; the industry rep seems far less aware of the health consequences than his predecessor; the bureaucracy is once again losing experienced assistance: what kind of APMAIF will 1998 bring? The infant formula market is now worth over $100 million annually. Most of this growth is happening at the expense of breastfeeding duration. Yet the Health Minister seems genuinely concerned to protect promote and support breastfeeding. I will await his response to these matters with interest, just as ALCA has done to matters raised in ALCA Galaxy, to date without result. ACOIF is considering a proposal to publish its own Annual Report on company behaviour and APMAIF and Ministerial performance in 1998. Concerned readers can keep up to date on these issues by subscribing to ALCA Galaxy and watching for relevant reports. And readers can help us keep abreast of developments: the price of freedom from bottlefeeding as the social norm, a la the USA, is eternal vigilance. All the achievements of the last decade could be lost in a matter

of a year or two if ACOIF does not continue and strengthen its advocacy role, or if APMAIF is co-opted by industry. Constant ongoing committed advocacy is needed, not flash-in-the-pan heroics. We can never congratulate ourselves that the struggle is over and we can relax: then profit imperative drives each new generation of marketers. Those of us who care about babies and their mothers need to be just as persistent.

Bottles and Teats

But the formula companies were only one of the series of interlocking interests covered by the Code which, as stated above, Australia is implementing piecemeal. Bottles and teats are widely advertised here, and represent the most visible aspect of artificial feeding. After the June 1991 meeting, the companies involved in the import and distribution of these objects formed a Baby Products Association, and at the request of the FBCA, produced a draft voluntary Code. In later 1993 this was sent out for comment from concerned groups. ALCA's submission, made jointly with the-then IBFAN South Pacific representative,[121] was a highly detailed critique of the draft BPA Code, with a request that the FBCA facilitate a negotiation on these issues similar to the November 1991 meeting. Some of the key figures in the Baby Products Association have stated their willingness to abide by any Agreement negotiated by government and policed by APMAIF. Another draft Agreement was circulated in September 1995, and then again in December 1995. This latest is in the useful tripartite form used to negotiate the Formula agreement. Departmental re-organisation has slowed the matter, but a meeting in March 1996 went ahead despite the change of government.

The Baby Products industry is not willing to consider giving up the possibility of marketing directly to familes, seeing this as the only way to protect a brand name market and prevent all competition being based on price, thus encouraging a further flood of junk products, teats and bottles "made to Third World standards rather than of food grade materials". This seems a legitimate concern, but of course it could be addressed by making a Standard for Australian Bottles and teats and policing that standard, so that poor quality product was excluded as hazardous. Apparently only the UK has a Standard for these products. Discussions are ongoing.

Breastfeeding advocates do not anticipate that there should be any problem with the present Coalition government, as the protection of babies' health and the negotiation of industry codes of conduct are hardly party-political matters, and it was a conservative federal coalition government which originally voted to support the International Code in 1981. Moreover, this new federal Government has allocated $2 million for the promotion of breastfeeding. However, the recent serious cutbacks and erosion of support services for mothers and babies in Victoria by a State coalition government has left some breastfeeding advocates concerned. Breastfeeding certainly does need promotion in some niche markets, such as poor families, young and immmigrant mothers. But mostly in Australia, breastfeeding needs protection and support, not simply promotion.

The Baby Friendly Hospital Initiative has been a catalyst in this matter of bottles and teats, raising awareness of the need to alter marketing to pregnant women, for example, via agencies such as Bounty, a group that makes up sample bags for hospital patients. This group has recently made a commitment to end all provision of teats in their sample bags, and to omit discussion of bottle-feeding in the pregnancy booklet they produce. Full marks to them for

[121] By now this was Jan Mangleson, a very experienced breastfeeding counsellor who had pioneeered working with aboriginal women on breastfeeding; subsequently a co-founder with Grace Close and others, of ABBA, the Aboriginal Birth and Breastfeeding Association, and in 1996 President of ALCA.

this, even if they have a way to go with advertisements for teats in other publications. Whether this commitment will survive the sale of the Bounty Australia business to the parent group from the UK remains to be seen. ACOIF will be lobbying them to ensure that they do honour previous commitments such as this.

Free and low-cost supplies of breastmilk substitutes

The issue of free and low-cost supplies of breastmilk substitutes within the healthcare system is also under active consideration. In 1986 Australia had voted for WHA resolution 39.28, which urged an end to these in "maternity wards and hospitals". This wording was unfortunate as it allowed a semantic debate to develop over whether 39.28 covered all hospitals or merely maternity hospitals. Literalist governments and bureaucracies interpreted this as excluding other healthcare facilities, and were technically accurate in this legalistic stance, while advocates stated that it meant all healthcare facilities even if it didn't say so in so many words: a position incapable of sane negotiation. At the November 1991 negotiation of the Industry agreement, all parties, including ALCA, BFAG, and NMAA, agreed that this issue of free and low-cost supplies was not ready for negotiation and could not be allowed to delay the Agreement covering those items in the Code per se, not later resolutions: the Minister's instruction was to implement the Code, not all related WHA resolutions. But with continued pressure from ACOIF and Nestle Australia, and reminders that Australia did indeed vote for 39.28, the government began a process of consultation. The federal Health Department convened a meeting in November 1993 at which it was clearly stated that the question was not whether Australia would end the practice of free and low-cost supplies in maternity facilities, but how this would be achieved and what were the obstacles to so doing. There was considerable discussion of what healthcare facilities were included under 39.28, with breastfeeding groups arguing for a wide interpretation, including community private practice healthworkers. (WHA Resolution 47.5 in May 1994 was to render this obsolete by making it clear that all healthcare facilities were included. However, industry did not immediately signify its assent to this clarification of the original purpose of the 1981 Code, and their assent cannot be presumed without consultation, any more than the assent of breastfeeding advcates can be taken for granted if they are not involved in the process of negotiation. (We do not live in dictatorships, but democracies.) The Commonwealth Government agreed to consult the States and Territories on the issue, since they, not the Commonwealth, have control of public hospitals and some other healthcare facilities. A report was subsequently published of both the meeting and the replies received. It was immediately obvious that the situation around Australia is very varied, and some States are much more amenable than others. This issue was complicated by the Attorney General's written advice that it would be illegal to ask companies to set any minimum price on their product, as this constitutes price-fixing. Australia voted for WHA Resolution 47.5 in May 1994, and so stated that government policy is to end all such supplies within the healthcare system. The matter was then raised again between the Commonwealth and the States in October 1994. The companies have been reluctant to take action as no one wanted to go it alone, and so lose market share if any of their competitors continue. Unilateral action is likely to result in poorer profits, and managements and Boards of Directors have been sacked for less. ACOIF wrote to each of the companies to ascertain their intention in this area, and shared the replies with its constituent members. Nestle Australia was the only company to make any written commitment to ending all free and low-cost supplies everywhere in the healthcare system, and to give a date. Some others have agreed to end hospital supplies.

Other means were subsequently tried. In May 1994, as part of a series of meetings arranged by the ACTU with key industries, Nestle Australia asked Martin Ferguson, then head of the Australian Council of Trade Unions (ACTU) to use his influence to resolve the free supplies

issue, the one outstanding matter that Nestle needed settled in order to be completely Code-compliant in Australia, in the widest interpretation of the Code. Nestle had earlier stated its willingness to end free supplies by the end of 1992, assuming that the government would co-ordinate this so that there would be no gain to any company; they had subsequently been accused of bad faith for not doing so unilaterally, and this was part of the reasoning given to justify the resumption in Australia of the boycott, in which some unions were involved. Despite its commitment to social justice, the trade union movement might reasonably be reluctant to campaign against a large Australian employer, since such a campaign, if successful, could result in more lost jobs for Australian workers. In October 1994 the ACTU asked BFAG (at this point still a part of CAA, Community Aid Abroad, which was then an ACOIF member) to organise a meeting to address this issue. ALCA was not permitted to attend this meeting; nor was ACOIF invited. The proposal re the supplies issue noted in the written record of that first meeting was clearly unacceptable to breastfeeding advocates: that the government provide taxpayers' money to purchase formula presently being "donated". This potentially both maximises industry's profits and legitimises their product! The second meeting a month later, which I attended with the formal support of the ALCA Council as ALCA's Code spokesperson, was a good deal more productive. A widening of the powers of APMAIF was called for, along with support for the Baby-Friendly Hospital Initiative (see below).

It was clear from comments in that second, November 1994, meeting that at least some representatives appreciated the commercial folly of any company acting unilaterally and advantaging its rivals, and also appreciated the difficulties inherent in legislation in the Australian context. It is unlikely enough that a law could pass in this climate of deregulation; even less likely that any court would enforce it; and counter-productive for consumer critics for this to be our avenue of complaint, since we can never match the money and influence of industry, and could not even criticise matters which are sub judice. However, the collective bargaining power of the ACTU meant that a further meeting with the then Labour Federal Health Minister resulted in May 1995, in which the Minister again reiterated that the problems were at state level and there was a limit to what the Commonwealth Government could mandate. The issue was again raised in the meeting of Health Ministers nationally. There certain State governments, notably Victoria, scuttled the idea of ending free and low-cost supplies. Agitation is needed at the State level, not the Federal. Indeed, the Commonwealth's refusal not to throw money at the problem is to be commended in this instance: it would not help breastfeeding for the Commonwealth to subsidise artificial feeding any further than it already does.

What is the situation as I write in late 1997? Nestle remains the only company to commit itself to ending all free and low-cost supplies everywhere in the healthcare system, with the exception of charitable supplies. Douglas Pharmaceuticals (Karicare) say quite openly that they need to provide these supplies anywhere they are wanted to gain market share. Mead Johnson and Wyeth say that they will not provide subsidised supplies to hospitals, but are silent on every other aspect of the healthcare system. Heinz is handing out free supplies in sachets. AMCAL will not sign the Agreement. Polls of healthworkers in teaching seminars indicate that almost all companies are still actively offering free or low-cost product to healthworkers, with - I hate to say it, as doing so causes me to be thought partisan, but truth should be told- markedly fewer reports of Nestle Australia or Sharpe Labs doing so. Douglas Pharmaceuticals formula brand is being bought by Nutricia, which has not signed the Agreement and which is providing advertising material to parents. In short, very little has been achieved in this area of free supplies at the level of government or industry, except to confirm

to industry that they can ignore the matter with impunity, and that taking it seriously leads to market share losses.

What are hospitals doing? We don't know. The Commonwealth Health Department paid BabyFood Action to undertake a survey in 1996, to see what hospitals officially claim to be the present situation in relation to free supplies. The survey caused some controversy as the names of a number of organisations were cited in the correspondence to hospitals without their prior knowledge, in some cases despite their statement that they were not part of any formal coalition other than ACOIF. The survey results also were hard to interpret: 243 hospitals responded, but what percentage this is of those asked is not stated. However, there was some good news: 75%of those self-reporting stated that they were abiding by a policy of ending subsidised supplies. This was a substantial group, covering roughly 60% of all births. Yet over 500 maternity units exist in Australia. One might also guess that those who replied had a rather more positive attitude to the survey than those who did not. So without knowing the response rate, and with no independent validation fo reports, it is unclear whether even half of Australia's maternity units have followed the Commonwealth government's urgings since 1993 to deal with this issue. The Health Department, which subsidised this survey, has apparently not been able to obtain the materials so no further analysis is possible. Powerful medical groups are opposed to any increase in hospital costs, and some have even openly expressed opposition to ending subsidised supplies. The Women's Hospitals' Association has gone on record as opposing this for financial reasons. The new independent Chair of APMAIF, recently appointed, Dr. Christine Bennett, is reported to be opposed to ending subsidised supplies. Again, what has been achieved here seems debateable.

The issue of ending free and low-cost supplies of formula is a publicist's nightmare. It can very readily be misrepresented as breastfeeding fanatics punishing poor families, causing bottle-fed babies to go hungry, and/or giving greater profits to industry. Some aboriginal women, strong advocates of breastfeeding, have said that it would be disastrous in some aboriginal communities to end the practice of providing free infant formula: parents would simply revert to using the Sunshine full-cream powdered milk they themselves were fed on as infants. And after all, why shouldn't industry give charitable supplies, say some. In fact, very few breastfeeding advocates want to stop that. The Code and subsequent WHA resolutions did not prevent the provision by conmpanies of truly charitable supplies, provided enough were given for the period of need. Companies can indeed give truly charitable supplies under tightly controlled circumstances. No one wants to see babies go hungry. But the wasteful distribution of endless samples, small quantities to healthworkers designed to get from them to a variety of families, not only undermines breastfeeding, but probably causes some of that hunger by jacking up the cost of infant formula at the retail level, where poor families must buy it after the free cans run out. Free supplies are not free, any more than any other industry gift to healthworkers. "Free" supplies are paid for by the families who buy formula. Why should these families, in Australia among the lowest socioeconomic groups, subsidise health institutions which are supposed to be funded by the taxpayer? Why should those institutions go on wasting product which they do not attempt to audit because it is free or cheap? Once they have paid the company for the formula, healthcare institutions can indeed choose to give it to families: supplies paid for can be given away. But maternity hospitals should not do so when breastfeeding is till a possibility, and will not be accredited as baby-friendly if they are misusing formula. Controls on the use of infant formula in healthcare institutions need to be as strict as those of any other potentially dangerous product. What other substance do healthworkers blithely give babies, without parental consent, without recording its administration, when that substance can not only lead to decreased milk production in the mother, but dramatically transform infant gut flora, leaving babies more susceptible to

infectious, allergic and inflammatory disease? How many deaths from necrotising enterocolitis have been the result of needless formula-feeding?

The ACTU's laudable 1994 efforts on the matter of free supplies were resumed after a break of two years, with a third meeting of what is now being loosely referred to as a coalition to end subsidised supplies, in August 1996. The personnel of what had been BFAG[122] acted as the secretariat. This meeting, with a few new players and many absentees from the previous list,[123] decided to seek an interview with the new Federal Health Minister. Other groups have not had a report of this meeting to date. The situation with supplies remains largely unchanged, and it is BFHI and professional education which is having a positive effect on this (see below p.)

Other Code issues

Other Code issues still to be acted upon are Guidelines for Retailers, which both ACOIF and APMAIF have worked on; and a Code for those making babyfoods and drinks. Another area of concern is the role of pharmacy in promoting artificial feeding inadvertently or otherwise, and the role of healthworkers. More anon.

The initial APMAIF draft retail guidelines did allow for price promotion of formula, as required by the Trades Practices Act. This means it is OK to state that Product x is selling at x dollars, and to allow enough stock to be present for likely demand. There are differences in the way companies respond to these retail guidelines: I have seen very highly-visible promotion for Wyeth, Mead Johnson, and Karicare products. If the cans are made less drab, more decorative and more obviously for babies, the sheer weight of visibility will serve to promote the normalcy of artificial feeding, and APMAIF may have to review its guidelines allowing such retail displays: now that Wyeth has switched from pharmacy only to supermarket sales, the retail area is highly competitive. (Although still not very price-competitive.)

Another new initiative is in the area of working mothers. Both government and the unions have been active here. In 1996 the ACTU published a Mother-Friendly Workplace booklet, as an extension of its "family-friendly" policies. Although the first list of resources at the back is seriously defective (consult NMAA or ALCA for overlooked local contacts) the booklet is a useful resource. For a copy write to the ACTU or contact your local union rep. And in 1997 the Commonwealth government has allocated some part of its $2million grant for the provision of information in this area: as yet unseen and so unable to be evaluated. But these schemes are tinkering around the edges of the problem of employed mothers of young children. What would help here would be far more serious re-arrangements of social priorities: adherence to ILO conventions allowing breastfeeding breaks for working women; shortening of hours of work for parents as in Sweden; and major reforms such as reasonable periods of paid maternity leave: a minimum of six months paid and preferably another 6-18 months unpaid leave as well. Even better would be to allow women at home to receive the substantial amounts of money the government will pay for their children if put into other people's care. And I would suggest that any government which runs "work for the dole" schemes should immediately classify as "working for the dole" all low-income mothers who have young children under the age of three and who train and serve as NMAA peer counsellors.

Other Interests and the Code

---

[122] As of about the end of July 1996, Rae and Greg Perry and CAA "mutually decided" to wind up BFA.

[123] These absentees presumably are still supportive of the initiative, as their names were still publicly being used to lend credibility to the coalition.

The work of breastfeeding advocacy never ends. All sorts of vested interests can act in ways that are inimical to breastfeeding, for their own reasons, and the same small batch of volunteers has to respond. In the last month NMAA has been involved in protesting to groups as different as AMCAL re their provision of infant formula at baby shows, and Greenpeace over an irresponsible fund-raising campaign in which they labelled breastmilk poison as a way of attempting to generate concern about environmental issues. Yet Greenpeace no doubt supports breastfeeding in theory: it's probably just that this ad campaign was so successful at raising money in Europe that it seemed like a good idea to try it here. I have to hope it failed, that those who support Greenpeace were as outraged as I was by this unscrupulous nonsense. Unintelligent, poorly informed, and divisive breastfeeding "advocates" are harmful to the cause of breastfeeding in any country, just like the powerful vested interests which are so often blame for breastfeeding failure.[124]

But as the rest of this book should make clear, what commercial interests do is not the sole or even major reason why Australian women are having difficulty succeeding at breastfeeding. And here we should stop to acknowledge the Commonwealth Health Department's greatest achievement in this area: the formulation and passage in 1984 by the NH&MRC of guidelines to promote breastfeeding and implement the WHO Code. By concentrating on the whole range of practices impinging on the breastfeeding mother, and emphasising the need for improved education of health workers, these guidelines have done more to help Australian women, than would any control of industry practice (though the latter is also necessary). In many ways these guidelines justified the revision and improvement of postnatal practice that was the hallmark of the 1980's in Australia, preceding the BFHI by some years. Again, they arose form direct consumer pressure: in 1981 NMAA and I had recommended in written submissions that the NH&MRC or some designated body should 'formulate and circulate rational policies of hospital ante-natal education and hospital management of the new baby, as well as a programme to educate medical professionals'. The response was these 1984 Guidelines, which were well ahead of their time, but naturally have dated. In 1994 a process of revising these began, which culminated in revised Guidlines being published in late 1996 and ***the launch in 1997 of a companion document for use with mothers. Yet again the process of consumer consultation by these health channels was far from adequate, the committee was heavily dominated by healthworkers, and NMAA was not represented. As a result some criticisms of the final Guidelines are justified. (Its medical approach to and disproportionate emphasis on gastric reflux, for example, could not have been more timely for Mead Johnson!) Still, the overall effect has been very positive, and revision of details is always possible in due course. Copies are available from any AGPS bookstore or from ??? NH&MRC materials can be obtained by writing to the NH&MRC, P. O. Box 100, Woden, A.C.T. 2606, Australia.

The Baby Friendly Hospital Initiative

Another major boost to the promotion of breastfeeding world-wide was the development of the Baby Friendly Hospital Initiative. At the UNICEF-convened meeting in New York in February 1991 which led to the formation of WABA (World Alliance for Breastfeeding Action), the suggestion was made of formal recognition for hospitals which provide appropriate care for breastfeeding women and babies. James Grant, then UNICEF's Executive Director, announced in May 1991 that UNICEF planned to recognise hospitals which were "Baby-Friendly" because they followed the Ten Steps to Successful Breastfeeding first enunciated in the Joint WHO/UNICEF Statement of 1989, Protecting Promoting and

[124] It is for this reason that every country needs one good solid working coalition of breastfeeding advocates, such as we have achieved in ACOIF. But given human nature, it will probably not be long before a more radical group, one which refuses to be accountable to the wider breastfeeding community or to work together with ACOIF, develops here again.

Supporting Breastfeeding. The idea had been spelt out; a programme had to follow. Dedicated work followed, by the Wellstart[125] team in San Diego, together with WHO Geneva input and that of an international team[126] created by Helen Armstrong, a UNICEF New York consultant working from Tufts University Nutrition faculty in Boston, who had been one of the founding mothers of the influential Kenyan Breastfeeding Information Group. Thanks to Grant's commitment and UNICEF funding, and building on earlier Wellstart work, Global Assessment Criteria and evaluation tools were ready by February 1992, when hospitals in the first 12 lead nations were assessed, after receiving significant UNICEF funds to enable them to prepare for this process. I was fortunate enough to be asked to go to Nigeria- at ten days notice!- to assess hospitals there, and so had access to these global documents. Not surprisingly given the haste involved in their drafting, these first documents, while generally very sound indeed as a basic programme, had some minor problems both of content and of tone. After returning from Nigeria with the BFHI documents and this experience of national hospital assessment, I approached Margaret Peters, then President of the UNICEF Committee of Australia, and a Taskforce was set up to investigate the feasibility of BFHI implementation in Australia. This consisted of representatives of the Association of Directors of Nursing Inc., the Australian College of Midwives, the Australian College of Pediatrics, the Australian Lactation Consultants Association, the Royal Australian College of Obstetrics and Gynaecology, the Australian College of Hospital Administrators, the Private Hospitals Association, the Nursing Mothers Association of Australia, and the Maternal and Child Health Section of the Victorian Health Department.

Its first task was to evaluate and then revise the Global documents, making them suitable for an industrialised democracy where women are free to make even the wrong choice. There was a need to distinguish clearly between the hospital's responsibility and the mother's prerogative to decide, even if the staff or BFHI assessors wished she had decided differently. This was more a matter of language than of content: indeed the Australian version of BFHI was strengthened by including some additional aspects overlooked or not then deemed relevant in the developing country context, such as the staff's use of nipple shields, and an explicit investigation of the free and low-cost supplies issue.

This process took most of 1992, as committed professionals met to examine all the UNICEF documents in great detail and re-write passages that would be counter-productive in the Australian context. Until her departure for the USA, Dr. Pat Lewis worked closely with me on this project, together with representatives of the Australian College of Midwives (Lorraine Wilson), Royal Australian College of Obstetrics and Gynecology (Christine Tippett), the Association of Directors of Nursing (Netta McArthur) and the Victorian Department of Health and Community Services (Liz Scott). By early 1993 it was decided to hold a two-day workshop to introduce key national professional organisations to BFHI. Together with Jan Edwards (Geelong Hospital) and Neil Campbell (Director of Neonatology at the Royal Children's Hospital) I updated this key national group about the importance and management of early lactation, and introduced them in detail to the BFHI documents and process. The

---

[125] Wellstart began as the San Diego Lactation Programme in 1981 and evolved into a huge programme supported by USAID, which among other things educates selected teams of healthworkers from around the world. The vision of Dr. Audrey Naylor and her co-worker Ruth Wester have contributed greatly to the global breastfeeding revival, and they will be recognised as major pioneers in the field of improving healthworker knowledge and skills, even if Australians have had minor reservations about some aspects of that clinical teaching.

[126] I had strongly urged Australian participation in the final workshops and recommended midwife Suzanne Murray when asked for suggestions. Suzanne was thus the only Australian with direct input into the Global BFHI documents. Despite my subsequent suggestion, seconded by Pat Lewis, that Suzanne be co-opted to the BFHI Taskforce, she was not.

group agreed that the process and programme, Australia's first independent postpartum Quality Assurance Programme, was worthwhile. The Australian BFHI Steering Group, the national authority for BFHI was then set up. This was convened by Margaret Peters, by then the immediate Past President of UNICEF Committee of Australia and still on the UNICEF Australia Board of Directors. It included the previous representatives and new nominations from the Royal Australian College of GPs, as well as the Australian Association of Paediatric Teaching Centres, the Public Health Association, the Australian Nursing Federation, and Community Aid Abroad. The Royal Australian College of Obstetrics and Gynaecology was no longer represented, however, though it had been on the Taskforce, where Dr. Christine Tippett had made a valuable contribution. Given the impact of obstetric practice on breastfeeding difficulties, this is a serious omission.

The National Steering Group's task was to oversee the further development and continuing administration of BFHI in Australia, setting up State Administrative Bodies and creating guidelines for their operation and all aspects of the BFHI process. (Core groups that may always be represented in the State Administrative Groups were NMAA, ALCA and ACMI.) The National Steering Group worked as a largely independent group reporting to UNICEF Australia but developing its own programme and funding. UNICEF support for the first printing of the revised documents came via the far-sighted Regional Representative, then Anwarul Choudhury, who visited Melbourne and was impressed with the structured manner in which the NSG was proceeding; this grant was later repaid, and indeed in 1994 some profits were remitted to UNICEF New York. The programme was a matter of considerable interest to overseas groups for whom large ongoing UNICEF or government grants were needed to achieve a less integrated programme.

An assessment programme requires trained assessors. In November 1992 the the first assessors' workshop was organised in Melbourne. Under the conditions set by the National Steering Group, those who wish to organise these UNICEF-approved 10-hour workshops must agree to the terms of a contract covering content and financial obligations, such as the substantial levy per registrant to support the National BFHI. Those conducting other educational courses were encouraged to ask for a copy of the contract to consider, though until a member of their team had completed an accredited 10-hour course the group was unable to offer the official 10-hour programme. This was because those who are educators themselves need to have considered all the possible subtleties of interpretation and understand the spirit underlying the documentation. Where education about BFHI takes place by those without such understanding, negativity towards the programme is likely to be the result, and hospitals will not be attracted to consider it. This chain also means that the BFHI national authority can rapidly amend and update any information or documents being distributed, as the educators talking about BFHI in the community will all be on file. And of course it means that BFHI benefits from its own intellectual property, the documents UNICEF New York spent thousands of dollars creating and the National Taskforce many hours adapting for Australia. Here in Australia, BFHI was created by the Taskforce and the NSG to be a self-supporting programme, and only approved educators were to be given all the official documents for use in approved 10-hour workshops, all of whose graduates will be eligible to be considered as assessors. This did not prevent shorter or more informal information sessions being conducted, but attending these did not qualify anyone for consideration as an assessor, or provide anything like the depth of understanding of BFHI needed for implementation. Nor did any profits from sessions other than the formally-approved workshops contribute to support of the national BFHI programme: profits were retained at local levels. Some levy on these should be considered in future.

Hospital assessments began in 1993. A team of four donated their time and expertise to conduct a pilot assessment programme at the Royal Women's Hospital in Melbourne over two days in late July. This tested the workability of the documents and agreed procedures. Not until 1994 however, were any hospitals formally assessed and accredited as Baby-Friendly. Mitcham Private Hospital in Melbourne, in March, and the Royal Women's Hospital in September, have both attained this distinction. Around Australia, scores of other hospitals are working towards this assessment, and many are almost ready to apply. Perhaps BFHI's greatest impact has been through getting hospitals to consider submitting to an external assessment: no one wants to lose face by failing, and so strenuous efforts have gone into re-thinking attitudes and practices, arranging in-service, and so on. BFHI has lent credibility and authority to those many voices calling for change from within: it has empowered midwives and breastfeeding mothers alike. Without the existence of the assessment process it would be very easy to ignore those voices.

The Baby-Friendly Paediatric Unit

Work in late 1993 resulted in Guidelines being developed for the Baby-Friendly Paediatric Unit. These 11 Steps to Optimal Infant feeding in the Paediatric Unit were approved by the National Steering Group in April 1994, and key paediatric units are now testing the concept. Christine Minogue, at the Royal Children's Hospital in Parkville, was Chair of the sub-committee developing these. Since by 1996 UNICEF New York had not evaluated these for global distribution, they have been published in Breastfeeding Review, and so made available globally. A quick reading will show that a complete assessment programme could be contructed from these for very little outlay, but in the absence of UNICEF interest or any financial support this seems unlikely. The BFPU Guidelines are appended (see page).

Another BFHI Sub-Committee, ably headed by Dr. Lisa Amir, BFHI representative of the RACGP (Royal Australian College of General Practice) on both the National Steering Group 1993-1995 (and National Advisory Council 1995-7) set up a most successful August 1995 International Scientific Conference designed to introduce doctors to the benefits and management of breastfeeding. This was combined with an ALCA-Vic Branch initiative: a 2-day national conference on human milk banking, fractionation, and use for small sick infants. The $25,000 profits from this 1995 conference are now being used to support the BFHI in 1997, as UNICEF's promised matching grants have not been received by ACMI.

Of course all this voluntary activity required some national co-ordination. In 1992, Andrea McGinlay, an education officer working for UNICEF Victoria, was given the task of assisting the Taskforce, and did so ably and enthusiastically until her contract expired. The part-time position of National Co-ordinator was then advertised, and Lisa Donohue was appointed in September 1993. A research-based midwife with experience in family planning and other women's issues, Lisa was doing research at the Centre for the Study of Mothers' and Children's Health, and represented the Public Health Association on the National Steering Group ; she proved to be an ideal choice. Her commitment and willingness to work long hours were to be tested to the limits by the full-time demands of a part-time job, but she succeeded not only in holding together a national initiative with state-based administrative groups, but in making it profitable, so that UNICEF New York received some thousands of Australian dollars as a result of the BFHI work here in Australia. Lisa's skills were recognised globally when she was asked to fly to China to assist in that country's implementation of BFHI. To her surprise she found that Australia's Paediatric Guidelines preceded her; it was not at all surprising that they were highly esteemed! Unfortunately her contract was not renewed at the end of 1994, and the absence of any National Co-ordinator allowed failures of communication with the States to develop throughout 1995.

What Australia had done about BFHI to the end of 1994 was truly remarkable. A small volunteer group of representatives of national associations, meeting monthly, shaped a national strategy and structure such that BFHI was proceeding in every State of Australia. With no handouts or grants, this volunteer group had done more than has been achieved in some other countries with huge injections of government funds or other sponsorship.

Yet even though BFHI had been largely self-funding, within UNICEF Committee of Australia's Executive Board there had always been ambivalence re a "domestic" project which promotes breastfeeding in a culture where bottle-feeding is not a death sentence. This curious attitude has been reflected in the language used by some UNICEF employees around the world, and in the way breastfeeding is presented in UNICEF appeals: as late as 1997 in Australia, the only mention of breastfeeding in one appeal was as a reason for greater need for food supplementation in women. Breastfeeding is not as obviously and immediately urgent as child prostitution or sanitation or iodine deficiency.... Such ignorance is perhaps understandable among those chosen by UNICEF for their expertise in public relations or management or other areas than breastfeeding. But surely some education of all UNICEF staff and volunteer committees would be in order, when over a million babies die every year for want of breastmilk, and breastfeeding advocates worldwide recognise that the elites in poorer countries take much more notice of what we in rich countries DO than of what we say,. The best way Australia could encourage breastfeeding in less affluent nations where UNICEF devotes resources, would be to model a breastfeeding society to those countries. By omitting positive images of breastfeeding women from their myriad cards, calendars, and other visual and written depictions of women, UNICEF says unwittingly that breastfeeding is not a central or valuable female activity. By saying that the BFHI is not their business in rich countries, UNICEF is unwittingly saying that elites in poor countries can ignore it: it's just for poor people. "Poor people" don't like being patronised, and can smell a double standard a mile away: in Nigeria a wonderful market woman challenged me in front of others at the MCH clinic as to whether breastfeeding was promoted so heavily in my country, or whether doctors were just trying to make Nigerian women breastfeed because they couldn't afford formula. I was glad to be able to say that I had breastfed all my children for years, the youngest for almost four years: she was more impressed by that than anything else she'd heard. Breastfeeding is an issue about which there can be no double standards. By accepting earlier industry propaganda that "it doesn't matter that much what we do in Australia, but of course poor women should breastfeed" we are in fact acting as global promoters of artificial feeding. So "domestic" breastfeeding promotion is in fact international action for the One World of which we are an integral part, and it's about time UNICEF Australia, and America, realised that. (And of course every year hundreds of white affluent babies die for want of breastmilk.)

Stasis in BFHI 1994-6

UNICEF, quite properly as an auspicing body, had not intervened in any way in the creation of the BFHI National Steering Group. The national role of the National Steering Group and its thrifty self-funding policies were apparently not understood by some state-based BFHI workers, who wanted (NSG-paid-for) State representation on the national committee. Without such state-based representation it was not seen as national by them. Obviously the NSG could not spend money on paying for airfares, and had taken the rational course of asking for fully-supported representatives from the national organisations which wanted to be involved in BFHI. Naturally this meant that the organisation was centred upon one state, where national organisations chose representatives who cost them very little. That state was Victoria, where NMAA, ALCA, ACMI all had their national offices and where Margaret Peters was located. The NSG unanimously agreed that BFHI money should not be spent on interstate

representation, although of course any organisation could choose its representative from any state and pay their costs. Monthly NSG meetings thus cost nothing except the time of volunteers and their expenses, absorbed personally or by their organisation.

It became clear that key NSW midwives were not happy with being unable to attend NSG meetings, and it was (and still is) discussed in language that suggested interstate rivalry was alive and well. This misunderstanding must be seen as a failure of communication by representatives within the organisations concerned, as well as a failure of the NSG to take such concerns as seriously as its many other BFHI tasks. (To be fair to the NSG, most feedback it received from around the nation to the end of 1994 did not reflect any such concerns, but was focussed on BFHI work. And to be fair to the organisational representatives, some people may not listen if the communication is not what they want to hear!) Partly due to lobbying of UNICEF Board members and expressions of dissatisfaction with the NSG within NSW, the issue of UNICEF Australia's involvement with BFHI in this country was again discussed at UNICEF Australia's November 1994 Board meeting. An options paper was commissioned. There were some surprising omissions in the consultative process: the Sydney-based consultant interviewed members of the NSG and just two outside persons in NSW who had expressed dissatisfaction; and she interviewed the National Co-ordinator only very late in the piece. UNICEF did not permit the NSG to continue key aspects of its work over this time of review. New restrictions kept on being communicated verbally via the Chair, some of these (such as the decision that no further accreditation be conducted) months after a UNICEF Australia decision. UNICEF never consulted the NSG before taking such decisions. A number of proposed or ongoing NSG projects (e.g., the breastfeeding teaching doll; distinctive Australian artwork for the Award; the Baby Friendly Paediatric Unit project) were shelved as the NSG waited for UNICEF Australia's decision after the review. They have not been revived as yet.

In April 1995, UNICEF Australia agreed to provide some funding ($5000) towards making the initiative an independent incorporated body, as well as providing a small matching grant ($10,000 for two years). This was exactly what members of the NSG had proposed in writing and had begun work towards. Groups represented on the NSG were asked to ascertain the willingness of their organisations to commit themselves to an equal share of the needed matching $10,000, and a collaborative bid was envisaged and discussed by all active members of the NSG. It was minuted that NMAA, ALCA, and two other groups had formally expressed willingness to meet their fair share of the matching grant from UNICEF, and the NSG was led to believe that ACMI would be an equal partner; the NSG also assumed that, as per the usual lines of communication, this bid would be communicated to UNICEF on behalf of the NSG by the Chair.

At this stage it was thought that there would be little money in BFHI other than that contributed by professional organisations and grant bodies or governments. All that changed in late May 1995 when Bounty Australia approached the NSG with an offer of at least $10,000 for at least two years, provided it could be linked with BFHI.[127] The NSG talked with Bounty, and outlined their concerns about that company's links with bottle and teat advertising as well as the content of its sample bags to hospitals, in relation to the International Code of Marketing of Breastmilk Substitutes. The NSG acknowledged that Bounty had made some significant changes (e.g., had decided not to allow bottle and teat advertising in their booklet for pregnany women) and were grateful that Bounty expressed its willingness to consider others if the NSG would consider the sponsorship offer. The NSG therefore advised that it

[127]Minutes of NSG meeting 25/5/1995

would recommend that the incoming BFHI authority would consider this matter of sponsorship generally, and create guidelines applicable to all sponsors. This was because the incoming BFHI body would be responsible for dealing with any adverse publicity such commercialisation of BFHI might generate, and would need to write the terms of the agreement with Bounty very carefully. It was explicitly stated in NSG Minutes that this would be dependent on Bounty's willingness to further consider its position in the advertising of bottles and teats."[128] Naturally representatives on any committee making such a serious decision would have to be authorised by their association to do so in its name. NSG members had believed in May 1995 that UNICEF would soon create an incorporated successor body, and so the NSG might not be in existence long enough to get such feedback before making the decision. NSG members would not allow any hasty decision as some still had grave reservations. None of these were insuperable, and it should be stated that the reservations did not arise simply because Bounty Australia was involved: there was a prior policy decision to be made as to whether any commercial interest should be allowed to link its name to BFHI, and if so, on what terms.

Bounty clearly believed that "UNICEF Australia's requirements of the successor body meant it was possible to establish a sponsorship relationship".This was news to some NSG members. Bounty's firm position that they would not go beyond "reasonable levels in the matter of bottles and teats" clearly needed to be explored: what is reasonable to breastfeeding advocates is the International Code, accepted globally. NSG members knew that Bounty had not considered this reasonable in the past, and was still a strong proponent of advertising of bottles and teats. Indeed, Bounty person Arthur Bateman was the founding President of the BPA, and one of the most vocal in meetings on this issue, although he made no baby products but instead gained revenue from those who did and wanted them advertised. So the issue was two-fold: commercial sponsorship generally, and then Bounty Australia in particular. I would stress that it was perfectly proper and appropriate for Bounty to make this offer on their terms; it was simply necessary for BFHI partners to consider their response collectively and carefully.

I was coming to the end of a full term on ALCA's National Council, and ceased to be ALCA’s BFHI representative in late May 1995.[129] At the very next meeting, June 1995, the NSG, which had been expected to continue "in place until the successor body is formed," was persuaded that its meetings " should be put into abeyance" as from June 30, 1995.[130] Some NSG members at the time felt they had little choice but to agree to this, although a protest by key member groups might have averted this shutdown. However, ALCA was not even aware of what had happened, as its South Australia-based representative did not attend this crucial meeting. Apparently no one was too concerned (except about the unnecessary delay) because the NSG had been repeatedly assured that it was to be succeeded by an independent incorporated collaborative body[131] and all NSG members assumed not only that their collective matching bid had been faithfully communicated to UNICEF, but that UNICEF would see the value of continuing with the democratic collaborative cost-effective approach already pioneered by the NSG.

There is no doubt that UNICEF Australia's ambivalence, its review process, and its failure to maintain the role of the National Co-ordinator after December 1994, had slowed momentum

---

[128] ibid.

[129] Endacott to NSG Convenor date unknown, NSG convenor to Minchin 30/5/1995; Minutes June 1995 NSG meeting.

[130] Minutes June 1995 NSG meeting.

[131] NSG Convenor's letter to LIFE and other collaborative bid partners, 18/7/1995.

since the second half of 1994 and confused and discouraged many people. It did not help that a Melbourne-based committee was being administered from Sydney from January 1995, by individuals who were frequently at pains to tell BFHI enquirers that they had so many more important things to do. Materials taken to Sydney without the knowledge or consent of anyone on the former NSG seem to have been completely mislaid, for example. Finally in August 1995, on the very eve of the scientific conference that the NSG conference sub-committee had gone on producing, UNICEF announced that BFHI would continue in future under the auspices of the Australian College of Midwives Inc. (ACMI). This was a surprise to all other NSG members. After all, they had been requested by the midwife chair of the NSG to seek collaborative matching funding from their organisations to set up an incorporated body. ACMI had been reluctant to commit itself publicly to any financial support of BFHI.[132] It was only with this UNICEF announcement that other ex-NSG members discovered that after June 21, 1995 (when the NSG was closed down) ACMI decided to tender separately for total control of BFHI nationally. It remains unclear whether UNICEF ever was made aware of the collaborative bid, other than via the Minutes of NSG meetings. It is also unclear what if anything the NSG Chair knew of the College's internal processes, as she was not the ACMI representative. Breastfeeding advocacy organisations which had committed to the collaborative bid as requested felt a great deal of concern about such behind-the scenes manouevres without consultation of other BFHI partners. Such concerns were in part allayed when former NSG members were assured in August 1995 that ACMI intended to set up an autonomous national body of the various interest groups willing to contribute time, money and expertise to the furtherance of BFHI in Australia. The reality since is that ACMI has taken full control of the Initiative, insisting (despite the advice of at least one BFHI state group) on the title of "governing body" as if to underline that point. It has not set up an autonomous national body, but a National Advisory Council which is responsible for advising on BFHI policy and content matters, but not for the employment of the Project Officer, or decisions about money, staffing, budgetting, or other key aspects of autonomy.

So from August 1995 UNICEF Australia devolved responsibility for BFHI in Australia into the hands of the Australian College of Midwives Inc., in a process that from the point of view of other BFHI stakeholders has been far from ideal. The reported loss of many records unexpectedly taken by UNICEF Sydney staff from Melbourne to Sydney in 1995, for example, has been said to have hampered ACMI's ability to manage the initiative and created needless work. Former NSG members have spend time on re-creating records that should never have been lost. And the failure to make public the UNICEF-ACMI agreement whereby reponsibility for BFHI has been transferred has caused concern. It is difficult to advise when basic terms of reference remain unknown.

Also of great concern to some in December 1995 was the reported willingness of ACMI to accept Bounty sponsorship money for BFHI and for midwifery scholarships, thus making a far-reaching policy decision before creating the promised independent body, or formally consulting its putative BFHI partners, State Administrative Bodies, or even adequately consulting ACMI Branches, some of whom objected strongly to the idea of a Bounty-sponsored BFHI. Although the Bounty decision was evidently reversed, and no Bounty money has been taken for BFHI, the failure to consult undermined confidence in the process.

New beginnings 1995-7

---

[132] NSG Minutes indicate that in March 1995 the Australian College of Midwives had queried the financial viability of the project; in April it had sought further information; in May and June it had yet to consider the issue.

However, in late 1995 the Australian College of Midwives did eventually invite some selected groups to participate in a policy-making body to advise the College, which now describes itself as the BFHI "governing body".[133] NMAA, ALCA, and RACGP accepted the invitation, despite some concerns about the structure, powers, and finances of this new entity, concerns shared by some State BFHI groups. This new National Advisory Council finally met in late August 1996, then again in February 1997 and April 1997. It consists to date of representatives of ACMI (Chair and one other), ALCA, NMAA, RACGP, and State delegates, many of whom have been unable to attend meetings because of the cost. It is still hoped to secure representation from the Australian College of Paediatrics, the Dietitians Association of Australia, the Public Health Association, and other interests besides midwives.[134] All members of the National Advisory Council are committed to getting national progress underway after this hiatus, and have worked very hard to review and create all the necessary new documentation for the Initiative nationally. The Initiative was administered 1996-7 by a Brisbane-based National Project Officer, Rowena Chapman, employed by ACMI. BFHI partners do not know what plans the College is making for the period after December 17, 1997, when she ceases employment.

For all those who care about breastfeeding, it has been very hard to watch BFHI development slow nationally in the period 1994-1997, and interstate differences of interpretation emerge for want of national co-ordination, while enthusiasm and progress at the state and grassroots levels continues unabated. For much positive work has continued at the State level, using the guidelines written for these groups, set up by the outgoing National Steering Group, and the BFHI materials developed for Australia by the NSG. I believe strongly that the processes of decision-making must be more transparent and collaborative than they were in the period 1994-7, or support of other breastfeeding advocacy groups for BFHI at state or national level may not be maintained. ALCA has invested literally thousands of dollars into BFHI at both state and national levels, and to discover in April 1997 that UNICEF Australia has still not paid its matching $20,000 is somewhat disillusioning, to say the least. Those breastfeeding advocates in Australia, mostly midwives and mothers, who have given so much to BFHI cannot know what the future holds, but can be proud of what has been independently achieved at state and national levels.

From what is said above it is evident that I believe that UNICEF Australia has little to be proud of, in the way it has auspiced BFHI in this country. There is a legacy of disillusion which has undermined support for UNICEF among breastfeeding advocates. This should be said publicly, because for UNICEF globally to similarly dissociate itself from the BFHI project would be catastrophic for its own credibility, for the process of change it has set going so widely, and for its ability again ever to harness volunteer support for UNICEF breastfeeding projects. Indeed, the fear that UNICEF might not support the project long-term was a real one for many Australian volunteers initially, and some put their credibility on the line by assuring others that of course UNICEF realised that this was not a flash-in-the-pan project, but a sustained long-term educational process.

---

[133] UNICEF Australia had originally been seen as the auspicing body and the former NSG, in which power was shared equally between a variety of organisations, had been seen as the governing body, right up until UNICEF Australia decided to set a review in place.

[134] At the first BFHI NAC meeting 10 of 13 representatives were midwives, and of these a majority were on the ACMI National Executive or held office at State Branch level of the College. While some over-representation of midwives is inevitable given their role in relation to breastfeeding, this is hardly a hugely diverse or catholic coalition of all the Australian interests involved with breastfeeding.

Similarly, of course, the National Executive (as distinct from State branches) of the Australian College of Midwives has some repair work to do on relationships with national breastfeeding advocacy organisations, and must build their trust in its ability to work transparently, democratically, and accountably. It cannot take co-operation for granted on any terms it chooses to impose. Only the commitment of those other groups to the Global BFHI process has kept them working with the College after the events of 1995-1996. It seems likely that they will have no qualms about breaking with the College if it should ever seem that ACMI is not supporting the Global standards.

Yet to be fair to the College, some of those events were outside its control. And it should also be said that in fact ACMI at every level has played an extremely important part in breastfeeding advocacy in this period. The 1984 ICM Declaration on Breastfeeding was the beginning of a decade of increased awareness among midwives that breastfeeding did matter, and that they needed skilling in this field. It may have been largely ALCA and NMAA which were bringing the radically new knowledge to midwives' notice, but this translated into support by ACMI at state and national level for virtually all breastfeeding initiatives. ACMI responded to members' criticism of formula advertising in its journals by banning such advertising. And in 1991 ACMI became the first professional group to write a policy about formula sponsorship of its conferences, strengthened in 1995. While occasionally less than well-informed articles on infant feeding may emerge in state ACMI journals, ACMI's partners have no concerns about the present National Executive's commitment to breastfeeding. And midwives have been the spearhead for much of the change discussed in this chapter, particularly that within hospitals. For that matter, it is mostly midwives who go on to become lactation consultants, and around 55% of the ALCA Council are midwives! Critical evaluation of certain actions of an organisation is occasionally needed (and any truthful record must be critical) but that does not detract from the achievements of that organisation elsewhere, whether we are talking of ACMI, ALCA or UNICEF.

To end this section on BFHI on a positive note: before 1997 had ended assessments were once again proceeding, and in the period from August to December 1997 ten Australian hospitals have been declared "Baby-Friendly." Wangaratta and District Base Hospital in Victoria was the first rural hospital to achieve this status; Knox Private Hospital in Melbourne, and John Flynn Maternity Hospital at Coolangatta, along with St. John of God Hospital Geelong, and ??? have all attained the standard. They are accredited for a period of three years and join the two existing baby-friendly hospitals (Mitcham Private and the Royal Women's Hospital in Melbourne). There is a backlog of hospitals to assess in most states, and 1998 should see many more hospitals receiving the award.

BFHI and the Supplies Issue

As stated earlier, the Baby-Friendly Hospital Initiative, or BFHI, has been quietly having a very positive effect in this issue of free and low-cost supplies. A question was written into the 1992 Australian version of the Global documents, although the original Global BFHI Assessment tools did not formally include it, and so the National Steering Group felt it could not make rejection of free and low-cost supplies mandatory for BFHI accreditation at that stage. However, the NSG immediately re-defined "low-cost"supplies. The initial UNICEF definition was "less than 80% of retail", which effectively forced hospitals to pay full market price and guaranteed company profits. Australia saw no reason not to adopt usual commercial practice and reduce the companies' profit margin in return for guaranteed sales to a good customer. We are not in the business of guaranteeing industry profits, and some competition is essential to keep prices down. I have been told of a company representative charging a hospital full retail and saying that BFHI has mandated this, creating ill-will towards BFHI

quite unjustly, while maximising profits. Caveat emptor: In Australia definition of low-cost supplies is less than 80% of WHOLESALE, if you want to be recognised as Baby-Friendly.

When in 1997 hospital assessments began again, one of the gaps immediately identified by experienced assessors was the treatment of this issue of free and low-cost supplies. While the question is asked in the Global and Australian programmes - does the hospital accept free or low-cost supplies? - there is no formal outline of what this means for, or how this is assessed in, hospitals. The CEO and Supply Officer must state that the hospital pays for its stores, but there should also be a detailed visual and verbal check that the many other areas of the hospital (paediatric wards, dietitian, NICU's and many more) are not quietly being serviced by reps who drop off cans and materials in many places in some hospitals. Assessments to date have shown that some hospitals have no idea just who industry reps are talking to, much less where they leave samples and supplies. Senior staff have been astonished that what they thought was hospital policy, that no such supplies be accepted, was routinely breached by persons unaware that to accept such gifts was any problem for the hospital's BFHI status. This finding casts further serious doubt on the accuracy of answers to the BFA 1996 self-reporting survey on this issue. In 1998 ACOIF will be proposing to the BFHI NAC a formal protocol for "supplies" assessment.

It should of course be noted that ending free and low-cost supplies is in the interests of industry, which had found this policy an increasing financial burden in many markets. Achieving cessation of free supplies is one of the easier tasks once companies have judged them ineffective as a marketing tool. I am very conscious that the end of free supplies was inevitable once midwives in Australia were better educated and therefore supplies were not being misused as they were in the 1970's. Health professional education and conscientisation achieves many ends.

Other Governmental Initiatives.
Each state of Australia could list a variety of initiatives in relation to breastfeeding, but very few have spent serious money over this period to protect, promote or support breastfeeding. Some notable policies have emerged that are worth mentioning briefly: NSW's official policy that no child should be given a so-called "complementary" feed without the mother's written consent; ????

The Queensland Government has given substantial assistance to BFHI, with funding to hospitals to create change, and the employment of a co-ordinator for a period of a year. To date in this country, they are the only government to give any money to BFHI, although the previous Commonwealth Health Minister provided some financial support for the BFHI conference in August 1995, and Dr. Wooldridge, our present Health Minister, believes that in funding a consortium consisting of the ACHS, ACMI and CHAS for the development of standards of postnatal care he is supplying support to the incorporation of the BFHI standards in all Australian Hospitals. (This of course means that all Australian BFHI partners will expect to be consulted in any process of developing such standards, as ACHS standards might not match the BFHI standard.)

Among other initiatives of Australia's Commonwealth government in this period was the 1983 preparation of a pamphlet designed to encourage prospective mothers to make a decision to breastfeed; and the 1989 circulation of 5000 copies of the Royal College of Midwives Successful Breastfeeding, the first really modern breastfeeding guide for health professionals, which handsomely acknowledged and incorporated the new clinical information from Breastfeeding Matters. Australia's 1982 Dietary Guidelines (unlike other Western countries)

included 'Promote Breast Feeding'; regrettably, in a 1992 revision, this first Dietary Guideline was demoted to number nine on the list, on the peculiar basis that it applied only to a small segment of the population. (Since we were all infants once, from one perspective this was the only truly universal and primary dietary guideline.) Dietary Guidelines for Children were also developed and passed by the NH&MRC in June 1995; "Encourage and support breastfeeding" was naturally the first. And in 1988 the official Health for all Australians report set a goal for the year 2000 of 80% of all infants breastfeeding at 3 months: a goal we are unlikely to reach without drastic social change or serious government action to halt the erosion of breastfeeding.

Commonwealth reviews of the Australian implementation of the International Code have also occurred, as part of Australia's responsibilities to the World Health Organisation. In 1991 a Committee was set up "to assess actions taken in Australia to give effect to the aims and principles" of the International Code, based upon the WHO Common Review and Evaluation Framework sent out to selected countries. Being composed largely of healthworkers with epidemiological skills[135], this Committee was dissatisfied with the WHO CREF as it then stood, and developed a number of strategic questionnaires as part of its task, reporting in 1993. Subsequently WHO went on to commission Ros Escott, the APMAIF Community Representative, to develop the CREF utilising responses from the countries involved in this first pilot project, and the WHO published in 1996 The International Code of Marketing of Breastmilk Substitutes: A Common Review and Evaluation Framework (WHO/NUT/96.2) which now provides an epidemiologically credible way of assessing national compliance with the International Code. National monitoring using this WHO technique will not attract the criticism that less "scientific" consumer monitoring inevitably does, as so is more likely to convince policy-makers that a country has a problem it should attend to. Just as both qualitiative and quantitative research techniques are valid but different, there is room for both types of surveys and reports: one hopes that the consumer advocacy movement will read carefully and then promote this extremely useful tool, as well as continue to submit its own research protocols to such epidemiological scrutiny. In my view, to ignore or denigrate this WHO document is show oneself to be unaware of the realpolitik of healthworkers and politicians in "advanced" western countries where science has been deified.

Important too in Australia in this period has been the review of standards for Infant Formula. Until 1991 the NHMRC (National Health and Medical Research Council) had responsibility for Infant Formula standards. In 1986 the NH&MRC adopted Standard R7 for Australian Infant formula, subsequently revised so that it closely paralleled the Codex Alimentarius standard and also attempted to incorporate the labelling requirements of the Code. (These requirements in 1985 were made mandatory on relevant exports from Australia.) Consumers strongly criticised the mandatory labelling of any infant formula as "Suitable from birth" but this was not listened to at the time, when so many of those involved in the revisions had no problem about lending their credibility to the preposterous statement that any artificial substitute is "suitable" for all infants from birth, despite the evidence that it leads to allergy, diabetes, even anaphylaxis in some infants. Times change: it seems likely that in the next revision of Australian formula standards no such guarantee of suitability will be given; the formula will simply be labelled "may be used from birth" or "...from six months", though I believe the latter should be labelled "not safe for infants under 6 months", since that is the problem we now face!

---

[135] Involved were Dr. Margaret Dean (Health Dept.), Dr. Pat Lewis (NMAA LRC), Dr. Dorothy Mackerras (Uni. Of Sydney), Margaret Miller/Yong Sook Kwok (ACA), Stephen Fox (FBCA, A-G's Dept), Denise Drane, and Cathy Meyer/Sue Jeffreson (Nutrition, Health Dept.). I also did a great deal of work on drafts of this report, although in an unofficial capacity!

So-called “special infant formulas” were covered by the Therapeutic Goods Administration throughout the 1980’s. With the changes in the TGA, including changes in the definition of what constituted food, and the process for establishing that a therapeutic claim could be made about a product, these special infant formulas needed to have a food standard developed for them. In August 1991 the National Food Authority (NFA) had been established, and it was given responsibility for this. A review was commissioned which recommended that before any standards could be set for so-called special infant formuals, it would be important to revise the 1986 standard for regular infant formula. The process has been ongoing since. In late 1996-early 1997 significant progress was being made, then cutbacks, the re-organisation of the NFA into the ANZFA (the Australian and New Zealand Food Authority) as from July 1996, and the loss of the expert staff person involved with the process, have delayed matters until more urgent issues were dealt with. It is anticipated that 1998 will see a further process of consultation in both Australia and New Zealand, and a joint food standard for infant formula set for both countries. Although at present a great deal of money has been made available for contracting out tasks such as this, ANZFA has rightly retained this crucial task for its own staff. There can be no more important or sensitive food standard: infant formula is the sole source of nutrients for the most vulnerable class of human beings for a long period of time, a time of maximal brain growth and physical development. To be solely reliant on a single food violates the usual norms of dietary safety: diversity and moderation. If infant formula provides too much or too little of any nutrient, an infant has no way of balancing that ingredient from other components in its diet. Hence ANZFA staff are working carefully and consulting the best scientific authorities for the latest research to determine an acceptable standard for both countries. And that national standard must be scientifically defensible, since countries can be accused before the World Trade Organisation of a breach of the GATT (General Agreement on Trade and Tariffs) if they set a standard higher than the lowest-common-denominator, industry-dominated Codex Alimentarius world standard for infant formula (currently also in the process of revision) and then refuse to allow the import of products which breach the ANZ standard but meet the Codex one. There is little real risk of this, since almost all the major formula-exporting companies have huge influence on the development of standards in every country: in fact, standards are usually written around the parameters of existing formula. Only the naive believe that regulatory agencies can lightly disregard powerful vested interests and tell them to re-formulate. Consumers’ trust in all such agencies needs to be tempered by realism.

ANZFA, like every other government instrumentality, has been put on notice that it is to reduce rather than increase regulation of the food industry. There is no time to go into this in detail, but I strongly suggest that readers interested in the quality of Australian food keep a careful eye on developments. The ANZFA Website is excellent; look for it at http://www.anzfa.gov.au??? ANZFA has a highly professional staff and so crucial issues like infant formula have not ben outsourced, but it is almost morally certain that in a country with such a small population and industry base, that some food reviews will be being conducted by those with direct links to the industry involved: that is where the expertise is. Consumer input will be more needed than ever before.

State governments have undertaken a variety of projects in this period, but none that I am aware of have been of national significance, while the overall effect of many other national and state government policies has not been supportive of breastfeeding. Women forced back into the workforce by economic necessity are less likely to feed their babies for the WHO recommended period, although if they were allowed to claim from government for the full period of lactation, the amount available as childcare subsidy if they were to leave their babies

in care, many might. One thoroughly positive development has been a number of complaints by women discriminated against for breastfeeding in public: under Equal Opportunity laws forbidding sexual or racial or other discrimination, this is now considered a cause for complaint and remedy. There will always be antediluvian restaurateurs who oppose such freedoms for women and their children, and they can always count on mobilising some support if they are noisy or obnoxious enough, but these fly in the face of social opinion. However, to keep each generation comfortable with seeing breastfeeding in public and so to maintain such freedoms, women need to exercise them, so I actively encourage brazen breastfeeding. Ignore the baby rooms (except for change purposes) and liberate a lobby!

Lactation Consultancy

In this last decade too, Australia has benefitted from the uniquely American concept of Lactation Consultancy. In the early 1980's, largely as the result of far-sightedness on the part of LLLI and key professionals such as Chele Marmet and Ellen Shell, Ruth Lawrence, Audrey Naylor and Ruth Wester, America pioneered the concept of professional education about lactation and breastfeeding. The creation of the International Board of Lactation Consultant Examiners (IBLCE) in 1985, and the increasing number of lactation consultants and training institutes are the result. ILCA, the International Lactation Consultant Association, developed too in 1985 to provide a professional association for IBCLCs and other health professionals interested in lactation. While standards of competence in this new field of professional assistance to breastfeeding women are presently very variable around the world, a great deal of useful information is beginning to be generated and recorded in professional journals. The task of reviving breastfeeding as the 'community norm' is intrinsically more difficult in the United States than in Australia or Britain, but there is immense enthusiasm for the project in some circles. And major American initiatives, such as IBLCE and ILCA, have had enormously positive consequences in other countries.

Australia was involved with both groups from their beginnings. ALCA, the Australian Lactation Consultants Association, was set up with support from NMAA in 1986-7. Nationally incorporated in 1987, its constitution differed significantly from ILCA's, in that ALCA made the IBLCE certification the definitive entry standard for membership. This committed ALCA to slower growth, as potential membership was obviously confined to then number of successful candidates. But in the "British" world all the newly-forming national associations (as distinct form local or regional grouops eager for sufficient members to be viable) realised that credibility as a professional association would not last long without a credible and defensible minimum entry standard. So in New Zealand, Canada, South Africa and other countries such as Israel, membership of the national professional association is limited to International Board Certified Lactation Consultants, or IBCLCs (Ibclicks, to some!). Quality, not quantity, was the motto. Not surprisingly, in 1997 ILCA itself has voted to move to an IBCLC-only voting membership structure.

ALCA has been and still is a very significant part of world development of the profession. It negotiated the right for ALCA to send a representative to the IBLCE Examination Committee, in recognition both of its status as the national professional association for LCs, and the role of ALCA in encouraging candidates for the exam. Australia actually has the highest per capita ratio of International Board-certified Lactation Consultants. This universally-recognised qualification is the only valid guarantee of a minimum standard of basic competence in lactation consultancy. Only those who do not understand just how expensive and difficult it is to create and maintain an independent health professional certification process in the United States would seriously propose that ALCA or any other professional body for lactation consultants should recognise any other credential for membership entry. Major midwifery

bodies certainly appreciate IBLCE's standard: the Royal College of Midwives has a representative on the IBLCE Board, and has been involved with the IBLCE Exam Commitee for some years.

Obviously there are those in many countries who for a variety of reasons consider that successful completion of a local course (sometimes one they or their friends are associated with) is as good as successfully passing an international exam. ALCA allowed for future developments in its constitution by permitting membership of persons who had passed the IBLCE exam "or an equivalent assessment process approved by the ALCA Council." But as yet there is no equivalent assessment process, and the task of judging "equivalence" would be huge. ILCA's Education Committee has considered for years the problem of professionally assessing educational offerings for equivalency with one another, despite the bureaucracy, problems of confidentiality, and costs this would involve, but no one has seriously considered setting up any other examination.

Yet to accept course graduates as the equivalent of an IBCLC for membership purposes was proposed to National Council by the executive of ALCA NSW branch in 1993. ALCA put this idea to its membership, and feedback was almost universally negative. That Branch executive subsequently went on to create a new organisation in which such equivalence is given; indeed, in which any health professional with an interest in lactation may be a full member. In a number of states some course graduates are now calling themselves Lactation Consultants, while recently another new organisation was set up for "qualified LCs" which does not recognise the IBLCE qualification as a standard for membership, adding that the person must also be a "recognised" health professional or NMAA Counsellor; while any Counsellor or health professional with no lactation qualification whatever can be an "associate member". It seems to me unwise for any volunteer Breastfeeding Counsellor to be considered or to consider herself a Lactation Consultant: the volunteer NMAA Counsellor is explicitly forbidden to give medical advice while the Lactation Consultant is a health professional who is obliged to do so. Yet if a Counsellor or healthworker is introduced as a member of a "college of lactation consultants", or a "lactation college", one might expect her to be competent to give full medical advice re lactation. NMAA may well find that difficulties arise from members of the public dealing with NMAA Counsellors who are members of a self-styled college of lactation consultants.So the waters are becoming muddied indeed about who and what is or is not a Lactation Consultant in Australia, as a few locally-powerful doctors and nurses sit in judgment on the worth of the IBLCE qualification as a stand-alone credential.[136]

In a field such as breastfeeding, where many of the pioneers of education were mere mothers, like myself "not even a nurse", this medical bias seems not just quaint but truly sad. It first emerged in America a decade ago among doctors and nurses, who wanted to have organisations that were "medical professionals only". Of course the territoriality is understandable, and it does simplify things to be able to presume some basic medical knowledge. As well, the elitist nature of medicine means that there are some health professionals who will not take seriously any organisation which is not exclusive, and there is no doubt that many people love discriminatory barriers that make them feel part of a special enclave, even when it is demonstrable that one does not have to be a doctor or nurse to

---

[136] I would be the last person in the world to maintain that passing the IBLCE exam is proof of equal competence or senstivity or skill. IBCLCs will be as variable as doctors, nurses or any other group. But at least there is a an impartial, financially disinterested guarantee of basic competence at a given point in time, which no other process can give. The IBLCE credential is legally defensible. I am sure course attendance and performance cannot be, when the assessment process is in the hands of the paid educators. Separating education from assessment is fundamental to legally-defensible credentialling in the US.

understand lactation better than many such persons ever will. But creating ghetto organisations can also have major drawbacks. In my view it is destructive of the unity and cross-disciplinary skills needed to keep nurses and doctors in particular from medicalising breastfeeding and developing tunnel vision. And the contribution of highly trained health professionals in a more catholic groups can be extremely valuable in raising standards of knowledge generally: this is lost where such persons seek out their own rather than interact with others. So too is the unity and increased advocacy power of the profession as a whole, when it is divided into competing chunks. I look at the Academy of Breastfeeding Medicine, a doctors-only organisation, and lament the diversion of such resources and talent from ILCA, which would be far more effective world-wide with it. And the drug remedies are more likely to multiply where doctors discuss problems. In division lies weakness.

A sociologist friend recently commented on the propensity for women, and nurses in particular, to weaken their own cause by not dealing with disagreements appropriately. She noted that powerful dissident figures tend to form their own little splinter groups rather than work together for a single coherent powerful national body. Regrettably such a split occurred within ALCA in the period 1995-1996, for reasons that were both political and personal.[137] New local "colleges"[138] were created after ALCA dissidents were defeated in a deeply-divisive and damaging May 1995 national ballot. Even more regrettable was the less than professional behaviour in the setting up of some of these new organisations.[139] Most of the colleges are presently led by IBCLCs and former ALCA office-bearers, and have been built up over time with the national support of ALCA, which has educated via ALCA News, and funded national tours to all states of outstanding speakers, etc. Thus there is no doubt that these new groups, now organising themselves into a network, should continue to provide good education and local support for professionals interested in breastfeeding. Of course if ever there are too many non-IBCLCs in these new groups, (and at least one is providing heavy financial incentives for every conference attendee become a member) standards may eventually diverge from the globally recognised ones: the current office bearers must move on eventually and may be replaced by non-IBCLCs, or IBCLCs with no national or international connections or awareness. It is to be hoped that in the future, when tempers cool and office bearers are in charge who were not involved in the events of 1995-6, some reunification between professional LC groups will prove possible, for the sake of breastfeeding families and LCs themselves, as well as breastfeeding advocacy in Australia. After all, there are only around ??? IBCLCs in Australia. For them to be split between one national and 6 separate state organisations seems farcical. As for two rival national organisations, when only one has sufficient resources to employ a national co-ordinator, and that part-time: whatever motivates that, it's hard to imagine that it's either commonsense or any desire for effective national advocacy for LCs or breastfeeding. If East and West Germany can hazard reunification after decades of separate development, this hope is surely not too ambitious!

---

[137] If any sociology department has a PhD candidate searching for a spectacular case of organisational politics and pathology, I shall be very happy to provide access to documentation of this issue, but the time for a definitive history is not yet.

[138] Being a member of a College is not usually attained by paying to attend a conference and agreeing to support Rules one has not seen. In health professional terms it usually signifies recognition of a set standard of achievement, considered to be a high one by all members.

[139] e.g., gross misrepresentation to state-based ALCA members of the national situation, with no opportunity for another perspective given; breaches of branch obligations; some financial and other ALCA records still not returned to the national office despite repeated requests; improper disbursement of ALCA funds, in some cases to the new breakaway organisation; retention and use of ALCA mailing lists.

In face of this split, widely and misleadingly advertised by certain vested interests, and with publications and numbers of the new groups even advertised over Lactnet,[140] ALCA has again chosen, in my view appropriately, not to play such games, but to continue to restrict membership to IBCLCs (the only legally defensible global qualification for LCs), and in no other discriminatory or arbitrary way.[141] In December 1996 ALCA strongly reaffirmed its commitment to the IBLCE certification as the gold standard for Lactation Consultancy. NMAA found it necessary to do so at the same time. ILCA has also made such a commitment, and so despite misleading published claims as far back as 1995[142] that ILCA affiliation of the new groups was in process, all attempts to gain ILCA affiliate status failed until one of these state groups made its Rules less discriminatory. Unless ILCA changes its policy of supporting IBLCE, applications for ILCA affiliation should always fail where membership qualifications exclude any IBCLC, or portray the IBLCE certification as equivalent to local courses.

ILCA itself has played a very positive role around the world and in Australia, and From the beginning ALCA has influenced the development of ILCA. There have been numerous interactions, from ILCA's re-wording of ALCA's aims and objectives to ALCA's re-working of ILCA's then Recommendations and Competencies into ALCA's Standards of Practice.. which have since been re-worked into ILCA's Standards of Practice! The input has been through an exchange of people as well as ideas and documents. Australia has had a representative on ILCA's Board for most of ILCA's lifespan[143] to date, although it was surely time that New Zealand was represented, and so in 1997 ALCA, jointly with NZLCA, has endorsed a NZ candidate, Heather Jackson. Then ILCA President Jan Barger was a guest at ALCA's 1992 conference, Dr. Savage[144] (another former ILCA International Delegate) at the 1994 conference in Adelaide, and the outgoing ILCA President, Karen Kerkhoff-Gromada, attended ALCA's 1996 conference in Hobart, just as the incoming President Marsha Walker has been invited to attend the July 1996 National Conference. As Australia's ILCA National Affiliate, ALCA offers its members access to the world of Lactation Consultants. Every year in July ALCA is officially represented at the ILCA conference, an astonishing learning fest where much is gained by networking.

Such international affiliations are important to developing the profession world-wide, even if the benefits are not immediately obvious. However, ALCA may be forced to re-consider its official ILCA affiliate status now that ILCA has decided to eliminate the separate categoru of National Affiliate, and to demand that at least 25% of all affiliate members must be also paid-up ILCA members. ILCA membership is expensive for Australians, many of whom have arranged for subscriptions to the ILCA *Journal of Human Lactation* to be taken out centrally, and for whom there are no other real benefits of ILCA membership. (A conference discount of a few dollars is irrelevant when travel costs thousands.) How 25% joint ALCA-ILCA

---

[140] But with numbers of IBCLCs not stated. Lactnet is a US-based global chat-line for health professionals, and can be accessed at ???

[141] Such as a policy that a member of the present committee must sign a candidate's application form.

[142] Birth Issues,

[143] Jan Edwards was ILCA South Pacific delegate 1993-1997; I served a term as International Delegate 1989-1991, resigning from the PAB to do so, at a time when the affiliate criteria and Position Paper and much more was drafted, and ILCA began to seek NGO status with the World Health organisation (since achieved thanks to James Akre[143] [143]and Felicity Savage).

[144] Felicity Savage too has done and continues to do wonderful work for breastfeeding, Now employed by the CDD Unit at WHO Geneva, she has created an excellent training programme, and her simple book for healthworkers in developing countries, Helping Mothers to Breastfeed, is a classic which has been translated into many languages. Her earlier "collaboration with Nestle" over the video referred to earlier has in no way affected her zeal for breastfeeding, any more than mine has.

membership can be achieved or monitored by national organisations such as ALCA is completely unclear. It would seem likely that ILCA will reconsider this provision, as it will certainly lose affiliates, or find itself confined to very small elite groups of affluent members. Is ILCA supposed to check this? How? ALCA cannot provide membership directories to other organisations without the explicit consent of every ALCA member in the Directory. Is ALCA meant to do the work of checking, having been supplied with the ILCA Directory? Is ILCA going to accept assurances from former affiliates without proof? This doesn't seem like a very workable decision. Yet advocacy at national and international levels requires unity, or we duplicate efforts and reinvent the wheel repeatedly. So I am assured that ALCA will continue to support ILCA, despite growing concerns about how little ILCA does for affiliates outside the USA. That support could continue even if ALCA decides that in future there is little justification for spending members' money to remain an ILCA affiliate, now that ILCA has decided to treat a national fully-democratic organisation of IBCLCs as no different from an interested group of parents in a small town.

ALCA acknowledges that professional education is one key to a better future for infants. If health professionals were truly professional in their knowledge and skills about infant feeding, and vigorous in political advocacy, many more women would be breastfeeding, and industry would not be a problem. The task of community education is huge, and around Australia many groups have been tackling it with enthusiasm. Breastfeeding education in Australia is now a growth industry, ranging from university-based nurses-only courses to innovative free-standing and correspondence programmes, the most influential of which have probably been the ALMA courses in Melbourne since 1986, and Australasian Lactation Courses, set up in Adelaide in ???. Australians are even educating overseas: a group called LIFE (Lactation and Infant Feeding Education) Inc. has pioneered teaching in Asia, while numerous Australian educators have taught in New Zealand and America. ALCA's own Biennial National Conferences have been enormously important in introducing to Australia major international speakers such as Dr. Mike Woolridge, Miriam Labbok, Felicity Savage King, Tony Williams, Jack Newman, Tom Hale and in 1998 Ruth Lawrence, Gro Nylander, and Kerstin Uvnas-Moberg, to name a few of many. In every state ALCA members past and present have been key players in this task, many supported by ALCA in overseas travel and networking: ALCA Vic Branch has been outstanding in the range of topics and speakers it has showcased since 1986. So too has NMAA, via its massive International Conferences in 1988 and 1997, Health Professional workshops (many in conjunction with ALCA) and regularly via the outreach of the Lactation Resource Centre, which since 1991 has been collaborating with ALMA in a 28 hour teaching programme. Membership of the LRC is strongly recommended to anyone dealing with breastfeeding families. NMAA's LRC maintains a database of courses and educational offerings around Australia, and should be the first port of call for any interested person. So too does ALCA, although not all courses provide materials to either centre.

Midwives undoubtedly have been the group most responsive to new information to date, as breastfeeding is "their" territory if it belongs to any one professional group predominantly. The 1984 ICM statement[145] was a wonderful inspiration for this decade of change. It is to midwives and mothers that I give credit for most of the positive changes within the hospital system. Almost without exception, they have paid for their own education and set about implementing what they have learned, challenging everything from breastfeeding management to formula procurement. General practitioners are also beginning to respond and quite a

[145] Appropriately enough, this developed in response to an IBFAN protest at the 1984 ICM meeting, where I went around and collected advertising material from all the companies present (except Nestle) and pinned it up under a heading "Code violations at this conference". Nestle was not included because none of its material breached the Code: that was 1984!

number have sat the IBLCE examination. Probably South Australia has the highest number of GP IBCLCs, although Victoria is not far behind. This is of course a gain, so long as GP practice can be re-structured to give women the time a proper breastfeeding consultation involves, or else GPs employ Lactation Consultants to do so for them, a practice pioneered in SA.[146] And the first course offered by the Pharmacy College in Melbourne in 1995, a spin off generated by the involvement of Simon Appel of the Pharmacy Guild on the BFHI NSG, indicates that the need for infant feeding knowledge is recognised by this professional group: over 90 pharmacists enrolled! The course has continued since and is being offered again in 1998. Work is also continuing towards a Best Practice Infant Nutrition scheme for pharmacies, recognising those that handle these issues appropriately. Draft guidelines for pharmacies were approved by ACOIF and are now being discussed with pharmacy interests; in late 1997 Dr. Peter Hartmann is working with some pharmacy reps in WA on this issue.

Halting the erosion of breastfeeding is more than controlling industry.

Despite all the deficiencies, a good deal that is positive has emerged, all around the world. But that so much has been achieved, what remains to be done? This is where the work begins, not ends. It is the major re-structuring western society has undergone and is undergoing which poses the greatest threat to breastfeeding. This is discussed in chapter 13, and will be dealt with at greater length in my next book. Industry is one part of that western social mixture which is eroding breastfeeding. Eighty years ago it was a key force in eroding breastfeeding in some communities. In others it still is.

Previous criticisms of infant formula may create the impression that I see all formula manufacturers or their employees as wicked or criminal. I do not. But nor do I see industry as altruistic philanthropists working solely to support health professionals and help children. Industry is industry, with its own legal duty to make profits for shareholders. The shareholders' appetite for profit may be boundless, and this ensures that ethical standards cannot be such as to put the company out of business, or evens eriously reduce profits. I agree that industry's product is currently necessary, and I do not consider industry solely responsible for the decline in breastfeeding, much less all infant mortality and morbidity. Neither do I consider industry guiltless, as the evidence for its involvement in the complex processes leading to lactation failure, past and present, is simply overwhelming. I have considerable respect for industry's ability to create a need for a second-rate product by advertising their belief in a first-rate one, namely breast milk. The formula industry's marketing strategies have been among the smartest known. Industry's ability to create diversions by labelling their opponents Marxists or opposed to free choice for women[147] is really amazing, as is the way they have become an accepted adjunct (a partner, even) to the medical profession. That most rewarding of liaisons has a very long history by now, and it can be difficult for professionals to step back, view themselves dispassionately, and accept that such a liaison has shaped their assumptions, attitudes and beliefs, as well as their clinical practice, and that they will need to re-think much that seems normal after long acquaintance with industry information.

Can breastfeeding advocates work with industry?

---

[146] It is however worrying to find GPs doing more and more breastfeeding work because MCH centres are under-staffed, when the GP knows little or nothing about breastfeeding: but can claim a rebate where a community midwife visit would cost money.

[147] Yes, it is factually a biological failure not to breastfeed one's own child adequately, just as it is a biological failure not to conceive or safely bear a child. This does not mean the woman is a failure as a mother or a person. But all biological failures do have an emotional impact that can be very important to one's sense of worth as a person, and we ignore them at our peril. Failure to breastfeed causes many women great distress and grief.

Despite all that, I believe that it is both possible and necessary for health professionals such as myself[148] to shape a working relationship with industry which does not threaten the integrity of either party. At the present time some of us do have to deal constructively with industry: we can hardly ignore it while it controls most healthworker information and resources. While trying to generate additional independent information[149] it is necessary to have input into what will reach professionals from industry.

There are simple ways of reducing the real risk of co-option through association. For example, if you want to make sure written material is not harmful to breastfeeding, agree to review it on condition that:
• if your name is attached to the material, you will have the right to edit every version until the final print is done;
• you will not be paid for doing so;
• your name will not be attached to it in any promotional way, or
• if your name is attached a strong disclaimer is also there to say that you agreed to assist to help women and this should not be construed as endorsement of the company or any of its products.
Then add in strong information about the risks of artificial feeding if writing for a formula company; or the benefits of low-cost technology rather than high tech if dealing with breast pump literature. If they won't publish what you have written, they are not genuine about wanting to help women breastfeed and you can later publish a factual (not emotional) account of your dealings with them which makes that clear. In general they'll choose to publish and honor the terms you've set.

If you are asked to speak at an industry-sponsored meeting, consider the target audience and likely good you can do. If it will be a waste of your time, don't accept. If you feel you can reach even a few people via practical topic that will ensure that the audience is better skilled at helping women afterwards than before, then say yes; and make sure that in developing the presentation you document some of the harms that are done by artificial feeding as a process and a product. You might like to begin with a thank you to the organisers for the invitation, and also to the artificially-feeding families of Australia who are subsidising the conference through the cost of the product they are purchasing; along with a reminder that your presence should not be taken as an endorsement of any commercial interests visibly associated with the meeting. Then or later in the presentation you may wish to go further and state that you accepted the invitation because you wished to let attendees know that independent education is available inexpensively, and ask them to think about the realities of company-sponsored meetings; that you are accepting no payment for being present, and not eating the expensive lunch usually provided, but donating your time and bringing lunch, so as to minimise the cost of your own presence, since it is poor families who bottle-feed in Australia and you feel uncomfortable with the idea that companies over-charge for a product in order to have an advertising budget that allows healthworkers, not the poorest people in any society, to enjoy lavish lunches and subsidised education. The adage that "there is no such thing as a free lunch" is familiar and effective; a very good Argus poster illustrates this.

I can live with those whose principles will not permit them "to sup with the devil", even so circumspectly as this. To stay clean and undefiled by commerce with industry is one understandable way out of major dilemmas. But I think that babies will be worse off if **everyone** adopts that policy of "purity" and isolationism, and it is babies (and their mothers)

---

[148] WHO would define someone who is paid to educate health professionals in breastfeeding management as a health professional, even if some doctor or nurse-based groups might not!
[149] As I do, inter alia via my role as ALCA Vic seminar programme co-ordinator.

we are working for. Too often those with such principles cannot talk without judgmental outbursts about those of us with more pragmatic views of working with industry. I know that holier-than-thou attitudes on this issue of industry liaison are NOT persuasive to the unconverted, who are the audience we need to reach. Like them, it makes me angry to have it insinuated that I am a simpleton who is unaware of the risks of co-option, or to hear others tell me what they think is ethical in ways that are profoundly disrespectful, often while those same people behave in divisive or aggressive ways which I think grossly unethical. I know it makes industry reps very angry to be insulted and stereotyped, and that this discredits our cause. So does assuming venal motives for the involvement of healthworkers with industry: many provide their services for free. Ranting about the evils of formula salespersons is just tacky and stupid. They are people and deserve courtesy and respect (and education about infant feeding, which can have some remarkable results).

Health professionals are becoming far more more conscious of their interaction with industry. It is heartening to see that in 1997 the Australian College of Paediatrics has developed an excellent draft statement on industry sponsorship of research. Copies are available from Dr. Karen Simmer, Flinders Medical Centre, Adelaide. It is to be hoped that the College adopts it and goes on to strengthen its stance on these issues, and that other reputable organisations follow suit.

Of course in this regard I have been addressing questions of interaction with vested interests who profit from breastfeeding failure. Healthworkers also need to interact with those who seek to help breastfeeding succeed, whether by supplying pumps or nipple devices or other paraphernalia for breastfeeding. Here the dilemmas are less severe. If a product helps mothers and keeps babies breastfeeding, it is useful. It may be over-priced: let's say so. It may be untested: let's say so. It may be a good idea but a bad item, made of unsafe materials or poorly designed: let's say so. It may work for some mothers and not others: let's say so. (Indeed, let's try to identify those for whom it is likely to work and recommend it discriminatingly.) But let's not fall into silly Luddite denunciations of all technology or gizmos or creams as automatically wicked because they make money out of lactation, or are not scientifically proven. For goodness sake, doctors, nurses, lactation consultants, midwives, and the rest make money out of breastfeeding: and they are not wicked because of that fact per se! And as for treatments needing to be scientifically proven: yes, this would be good, but if doctors or midwives only did that which has been proven to be safe and effective, there would be no call for the development of evidence-based medicine. Every day medicine acts on the basis of experience and empirical beliefs, not just randomised double blind controlled trials...And for my money, if NMAA tests a product and gets positive feedback from intelligent breastfeeding mothers who say they liked it or it was helpful, that seems a reasonable basis for giving any product a go if its design does not offend basic principles of safety or science. Common sense at times seems a most uncommon virtue in the breastfeeding world. People who make breast pumps are commercial entrepreneurs, just as are people who make infant formula, but there are serious differences between the two. If there is a baby to be fed, the one is useless once lactation ceases; the other benefits when it does.

Controlling artificial feeding industry marketing practices is necessary, and important in efforts to prevent further erosion of breastfeeding in this country, but will not fix all our infant feeding problems. Breastfeeding rates will not rise simply because industry stops advertising. History will discredit us if we say that it will. This is not a simple issue. Simplistic solutions create problems and do not always have the desired result, which is better health for babies. To value one's perceived purity (yes, the word is even used by some) over what helps women and children seems to me narcissistic, self-indulgent and foolish. So what if a few people

misrepresent or misunderstand things? Anyone doing anything worthwhile will be criticised by someone. The only way not to be criticised for one's actions is to do nothing, to make no waves, to upset no cosy vested interest. Our life's work will not be judged by who we worked with, or what rude names we were sometimes called, or by whom, but by what positive improvements we were able to bring about for the world's women. We should not be buffaloed by purists, but by all means take care to avoid co-option: by refusing payment, insisting on full control, and so on as outlined earlier; working only on our terms, not those either of industry or industry's critics.

The next chapter: what?

We are all writing the next chapter of change in infant feeding history. Only if our analysis of the real problems in our particular situation is correct, based on solid information, and our strategies well thought out, can we hope to protect promote and support breastfeeding effectively. Frankly, I think our advocacy strategy remains behind the times, as it always has been. Industry is not the only key element in Australia. And hospital-based healthworkers are better than ever at supporting breastfeeding. Yet breastfeeding rates are no better and in some places worse. Why?

What we are doing about industry and hospitals is good, is useful, is necessary to stem the tide: but is increasingly less effective as the century rolls on. Look at our society. Look at the social structures changing. Westpac Bank gives women 6 weeks maternity leave: write those women off as breastfeeders. The ACTU has negotiated just three months paid leave: formula company profits will grow as mothers get their babies established on the bottle before going back to work they are now afraid to give up. Six months unpaid leave would have been less harmful to breastfeeding, but the ACTU was not advised by people who know about breastfeeding, it would seem. Case-mix formulas derived from America throw women out of hospital on day two or three or four after birth: watch the rates of mastitis and early weaning increase as unsupported women struggle to manage their milk supply. (We are already reading of "breastfeeding malnutrition" in Pediatrics.) A conservative (actually "radically destructive" would be a better title) government privatises MCH services in Victoria: watch the development of commercial services for women who can afford them, while breastfeeding slowly declines despite those hospital improvements and much greater community awareness of its importance than ever before.It is in this context that formula companies are beginnning to make hay by direct advertising to parents: a need is being created that they will fill. (Badly.)

The evidence of a reaction against breastfeeding promotion is everywhere in the media, because breastfeeding does not fit into the lives women are being forced to lead by our ad hoc social restructuring, in which breastfeeding or babies are simply not a consideration. So we now see more and more destructive articles and books by good feminists and failed breastfeeders who go on to blame breastfeeding advocates for making them feel bad, rather understand the causes of their failure[150] and deal with both their feelings and the objective social circumstances that make breastfeeding failure almost inevitable. We have two mutually exclusive choices here: we can say, "Breastfeeding is often impossible in society as we have it, [true] so we must not make too much of it or we upset those women who truly cannot breastfed, and a choice not to try is rational." Or we can say, "Breastfeeding is often impossible in society as we have it, and breastfeeding is so important - to babies, to women, to

[150] Yes, it is factually a biological failure not to breastfeed one's own child adequately, just as it is a biological failure not to conceive or safely bear a child. This does not mean the woman is a failure as a mother or a person. But all biological failures do have an emotional impact that can be very important to one's sense of worth as a person, and we ignore them at our peril. Failure to breastfeed causes many women great distress and grief.

families, to nations, to the environment, to humanity- that it is society which MUST be changed to make it possible."

Only if we can weld concerned parents and professionals into an effective political lobby to halt the changes most detrimental to women and children can we expect to improve breastfeeding rates. It is pointless telling a mother to breastfeed when her employment demands that she is back on the job six weeks after birth and there is no on-site childcare. Yes, some women manage quite well in this situation. Some women can succeed regardless of anything. But most women will not. Most will soon be feeding their babies bottles of formula. This is already the norm for three month old babies, not breastfeeding. Breastfeeding can't be delegated (until the re-birth of wet-nursing as a paid profession, anyway.) And breastfeeding is so important to women that it shouldn't be delegated, any more than intercourse and orgasms should be given up just because IVF is a modern option for the wealthy. Anthropologists are right to emphasize that women's infant feeding actions are determined by their sociocultural context, and that telling them what to do or how to manage breastfeeding is pointless where breastfeeding cannot fit into the context of their lives. Women frequently have no choice. And the cost of failure to breastfeed is high, for families and society.

Breastfeeding advocates need to be united in re-structuring Australia according to a blue-print that includes breastfeeding as central. We need to write a charter for breastfeeding women that empowers them to breastfeed, not tells them to. Decades ago we allowed companies to alter the market, and noticed only decades later. We allowed healthworkers to enshrine authoritarian practices, and unravelled them decades later. Will we now allow Australia to be re-structured on the American model, without support for women at home as well as work, and then decades later wonder why breastfeeding has become a forgotten art, a quaint minority activity, faintly disgusting or embarrassing to most, as it is in America?

Sadly, despite all the hard work of so many, despite all that has been achieved in Australia, we are still at the beginning. Artificial feeding fits well with a society that has disempowered women, that defines women as objects of sexual desire and docile workers needing to be separated from their infants, that sees them and their infants primarily as consumers, as units to be exploited -milked?- for economic benefit, that denies an infant's need for frequent physical closeness and considers institutionalising babies in creches to be acceptable care, despite the increased sickness and sorrow such babies manifest. Breastfeeding is always going to be a struggle in societies where women of reproductive age are wanted in the paid workforce, where mortgages demand two incomes, where those who are no longer sexually attractive are discriminated against in employment. When women cannot choose to work or to stay at home, women have won, not freedom, but another emotionally and physically exhausting form of servitude. And so many in this generation of wage slaves believe they must sacrifice breastfeeding. Progress??? Feminists need to see infant feeding as a paradigm of what patriarchy had done to women: dispowered them, convinced them that they are readily replaceable, that they have no unique value as women, that men can perform any of their tasks as well as they can.

If this trend continues and reaches critical mass, eventually our Australian consumer protection and health agencies will also be busy "reassuring parents that formula is safe because Australian society depends on bottle feeding" as the US FDA, and an Irish consumer magazine, and so many more suposeldy independent groups with consumer intersts at heart, routinely do. Our consumer protection authorities will be confiding to industry that it is in their interests that no ???AOAC

These are political problems. They demand political solutions. It is impossible to be apolitical when you care about women and children. Not party political necessarily: but policies advantaging women and their babies need to be at the forefront of every party's policy thinking. It will not happen easily.

What can you do? Will you keep silent while strident American and Australian accents accuse breastfeeding activists of being fanatical "lacto-nazis", of not caring about women, of restricting the god Free Trade, and all the rest of that inimitable bulldust? Or will each of you urge your organisation, whatever it is (church, community, overseas development, environment, feminist, professional) to join ACOIF[1] and work actively for OPTIMAL infant feeding in Australia? Help us to help Australian families: support NMAA and ALCA, get active in ACOIF or Maternity Coalition, report Code breaches to APMAIF, talk to people about breastfeeding, brazenly breastfeedin public and congratulate mothers who do, whatever. You can know exactly what is happening in these "political" matters: subscribe to ALCA Galaxy (formerly ALCA News) and the NMAA Newsletter, as these two magazines are committed to letting you know all that is going on in Australian infant feeding circles. Join your local college of lactation consultants and work towards reunification of professional breastfeeding advocacy. And look to see where support for breastfeeding is needed in your organisation, community, workplace, church, school, home....None of us can do everything, but we can all do something. Lao Tse was right to say that "The journey of a thousand miles begins with a single step".

Supping with the devil?? A personal addendum made necessary by international gossip by the unscrupulous or unaccountable.

The vexed question of healthworker interaction with industry will be the subject of a complete chapter in a later book, but here I want to record two examples of what I personally found possible. My readers can assess whether my judgment on these issues has been affected. I am not suggesting that only my course of action is right: I believe in trusting my conscience and the judgment of my colleagues, while accepting that we will all make mistakes, and so extend that courtesy to others. The important principle is to be open and accountable. I am writing of these issues here because I have been the subject of vicious gossip by the less scrupulous.[151] I don't really care what such individuals think, but I am very concerned that good information might not reach good people because its source has been slandered as tainted.We should all remember that McCarthyism was effective and evil, even if with hindsight good people regret having been taken in. And we should insist on the individual's right to reply to any allegation.

Firstly, after giving a presentation at a major teaching hospital interstate, I was asked by the staff to make an educational video for the hospital to use for its other staff and to sell. I agreed, and was later informed (at the suggestion of the company) that the Educational Resource Centre which would like my talk on positioning the baby as part of that series of videos had a grant from Nestlé to make the series. Obviously this would be a useful video, and money for making such things is virtually non-existent. So I enquired as to the degree of freedom the Resource Centre had in its choice of topic, content and speakers. This was total. I enquired as

[151] I have no objection to any honest mistake, as made by a naive BMAC worker who reported the gossip on Lactivist and so gave me a chance to clear my name, and who apologised for his mistake very promptly. But I believe we are all remiss if we allow gossip about individuals to be published covertly without the subject of the gossip being told of it and being given an equal opportunity to respond. And I would urge readers not to trust any person who is willing to pass on such gossip as fact in private mailings or circulars.

to the control of sales, and where profits from sales would go: this was to the hospital, and they retained full rights over the film once made. (Nestlé simply could get so many copies free for distribution to professionals, and thereafter had to pay for copies if wanted.) This ensured that the film could not be made difficult to obtain, as seems to have happened to Helping Mothers Breastfeed, another excellent film Dr. Felicity Savage[152] and Chloe Fisher made, with an independent producer, but for Nestlé Switzerland's ownership and distribution. So I agreed to participate, provided that it was agreed in writing that I had total control of content, complete right to change and edit and to refuse permission to proceed if things were going wrong; that Nestlé had no such rights; that I was paid **nothing** beyond the cost of travel and accommodation in the time needed to make the film. (This clause is necessary to avoid financial dependency: if I can earn money doing other things, but earn nothing from working with industry, there is no danger of gradually finding that I am dependent on industry!) The film was made. Along the way it acquired a very strong introductory piece about the hazards of formulas and bottle feeding per se, before the material on positioning. It was made in 1986, when no-one but myself talked publicly of formulas "lacking the fatty acids needed for proper brain growth after birth." I gather it was heavily copied in Manila at the IBFAN Forum in 1989, and is creating discussion in many places in the world at the moment, as well as generating independent income for the hospital's resource programme.[153] And as one Director of Nursing said, "You know, I never would have believed what you said about infant formula if it hadn't had the Nestle logo on the video: we show it to all our pregnant mothers and our breastfeeding rates have gone up."

So was it worth doing? I think so. Did it help Nestle Australia look like good guys? Probably, with a few people: those who did know and respect me would not have seen it as anything more than sound advertising by Nestle, while for those who did not know me as the author of Breastfeeding Matters, the association with me would have meant nothing to Nestle, and it might even have made my words believable! Do I repent of doing it? Not at all, because the Nestle logo on the video meant more babies got breastfed. What do I care for the opinion of anyone whose actions and rhetoric sometimes suggest more emotional concern about controlling a single multinational company, Nestle, than controlling the whole of industry in developed nations and so helping mothers and babies? Very little, frankly.

When the Nestle Boycott was revived again in 1987[154] many long-term breastfeeding activists in Australia and overseas had concerns. I was consulted about this by a key member of IBCoCo, and suggested instead a co-ordinated global year-long appraisal to identify the worst offender in each market, then a co-ordinated international boycott targetting the worst in each market: which would have allowed us in Australia to target a company other than Nestle, and

---

[152] Felicity Savage too has done and continues to do wonderful work for breastfeeding, Now employed by the CHD Unit at WHO Geneva, she has created an excellent training programme, and her simple book for healthworkers in developing countries, Helping Mothers to Breastfeed, is a classic which has been translated into many languages. Her earlier "collaboration with Nestle" over the video referred to earlier has in no way affected her zeal for breastfeeding, any more than mine has. And certainly no one who knows Chloe Fisher considers this video compromised her care for mothers!!!

[153] Called Latching-On, the key to Successful Breastfeeding, it is available from the Education Resource Centre, Adelaide Women's and Children's Hospital, Fullarton Rd., North Adelaide, S.A. 5006, Australia.

[154] By an American group in 1996 publicly outcast from IBFAN for a liaison with a US company, how justly I cannot assess as yet. Did this liaison exist earlier and influence the decision to set the Nestle Boycott going at a time so convenient for US companies? Or was it a recent development, as the result of working in a confrontational style and eventually realising that the solution ot complex problems must involve industry? Historians of this issue in the United States will have some interesting trails to follow.

still be part of the global movement. That year of evaluation could have caused a great deal of change world-wide as no company would have wanted to be targetted. The reasons given to me for rejecting this were less then convincing, although the time is not right to publish these openly. I suspect that careful historians may find that the principal, presumably unintended, effect of the 1987 US revival of the Nestle Boycott was to assist the US companies fight Nestle's attempt at US market penetration. If this is so, it indirectly led to direct advertising to the public, as Nestle were locked out of the lucrative institutional contracts by good people trying to save babies. Should I be pleased with a result like that? Should I be pleased that the principled unwillingness of myself, ALCA, and NMAA to endorse the Boycott 1987-1991 led to subsequent destructive overseas interference in Australian affairs, so that a professional association was manipulated into breaking the laws against defamation, in ways that led directly to division of breastfeeding advocacy in this country? I think not.

I'm still feeling quite comfortable about my decision both to make that Nestle video and refuse to support the revived Boycott in Australia despite the hassles this has caused me since, again better not recorded in this book. Integrity is not in the eye of the beholder but in one's actions and one's motives.

The second example of personal industry liaison was also a useful experience. I was asked to write an article on the WHO Code for Nursery News, a free handout produced independently, but paid for by Nestlé and given to maternal and child health nurses and others. I agreed to do so on condition that
* what I wrote was not edited without my consent;
* I was not paid for this;
* Nestlé had no right to change what was written;
(All these conditions go down in writing and are signed by the person I am dealing with, or we do not proceed.) In the end, the article was not printed: too long, they said. However, the company later asked permission to run the article in Australian Doctor Weekly, another of their free publications funded by general advertising, which goes to every doctor in the country. As a result I had quite a number of requests for Protecting Infant Health, the IOCU Guide to the Code for healthworkers. So it was worth the time it took, and my integrity was not in question.

Yet I have had some unpleasant flak about being prepared to associate with Nestlé (or any other formula company) even so indirectly as this, as well as flak about being prepared to question or criticise in-house (as I have done) whatever I see as counter-productive, unjust, wasteful or undemocratic actions by some breastfeeding advocates. I have been libelled on Lactivist and elsewhere by fellow IBFANers as having sold out to the companies. Some of these consider the above Nestle "link" explains what they say is a change of strategy or policy by me. Some have responded, not with answers to my questions or criticisms of my actions, but with denunciations of my character and speculation as to my psychological state. When reason is replaced by vituperation I feel certain that there is something to hide, and my questioning was truly justified. An independent critic's task is to be independent and a critic, not the propagandist for any group. Good guys with good intentions, myself included, can make dreadful mistakes and need to be held to account. The expert who says African women never have breastfeeding problems is harmful to the cause of breastfeeding and women's health, no matter what his intentions may be; he needs to be told so. The group that spends $350,000 of UN money for worldwide breastfeeding promotion in a year needs to explain to all of us in predominantly women's breastfeeding groups starved for funds, especially in developing countries, why $70,000 of it ever went to an American university and so much seems to go to men, relatively speaking. Who has been paid what and why? Who determines

the priorities? What democratic processes put those people in power and how may others attempt to join them? Such questions need to be asked and answers need to be documented. Accountability is not a virtue only infant formula companies should practise.

Clearly anyone who thinks I've changed in essentials never read the first edition of Breastfeeding Matters carefully, and noted my even-handed criticism of any behaviour that I consider damaging to the cause of breastfeeding. Breastfeeding Matters criticised healthworkers at least as much as it criticised industry, as the Royal College of Midwives was mature enough to recognise. I am aware of the potential dangers of industry liaison, but also of benefits flowing from it. The genuine willingness of Australian industry to consider our proposals and negotiate has been a crucial aspect in the development of all these initiatives in Australia, and seems notably absent in some other countries. That willingness to negotiate only comes in a climate of respect, in which people are not categorised as White Hats and Black Hats automatically just because they claim to be breastfeeding advocates or are working for industry. Of course I have also worked with industry via my role as Consumer Alternate on APMAIF 1992-1995, and in many other situations. While industry remains co-operative this is essential. But I think my ongoing, entirely self-funded voluntary work and its results should persuade all but the most irrational that I have not sold out to industry. If I'm wrong about that, too bad. What others think of me personally cannot be allowed to influence what I do, or I am of no value as an independent critic. Of course I invite reasoned argument and debate, and remain willing to be convinced on any point that I am now or have been wrong. I just don't care much for those whose response to differences of opinion on strategy is to call it heresy and excommunicate fellow believers. If I and others like me are not members of IBFAN (as one long-term IBFAN paid staffer circulated) because we refuse to follow suggestions where to do so would harm breastfeeding, IBFAN is a sect and not a network of those who care about breastfeeding.

There may be suggestions that I have misused the title of IBFANer, which I am proud to claim for anyone of the vast numbers of Australians who have worked so long and hard for breastfeeding in this country. IBFAN is a loose network not an organisation. This is a strength in that no one can target the whole easily; reprisals against individuals are less likely. It is a weakness in that the self-perpetuating governing group, a small centralised clique called IBCoCo, or the IBFAN Coordinating Council, can make pronouncements for which it cannot be held accountable by membership. Even within IBCoCo there is an even smaller rapid response group which may not consult all IBCoCo members before doing so. Too often only these people can speak for IBFAN; too often the rest of us are claimed as IBFAN when numbers and credibility are needed, but disregarded as "not really IBFAN" when we ask questions about money and power in IBFAN, or seek to make change. Ordinary IBFANers have very little power or opportunity to join these inner circles, and are unlikely to be invited if they are critical of existing policies (such as "the Code must be made law".) But IBFAN's basic principles make anyone an IBFANer who observes them. They are:

I dedicate this chapter with love to my fellow IBFANers everywhere who are working to improve maternal and child health: and to create more democracy and accountability in IBFAN as in the rest of the world. And I invite your critical response.

AUSTRALIAN POLITICS OF BREASTFEEDING TIMELINE, 1981-1997

1981 Submissions by NMAA and MM re hospital practices and breastfeeding promotion
International Code of Marketing of Breastmilk Substitutes: Australia voted for
Health and Primary Industry depts negotiate with industry to create "code"

1982 *Food For Thought*:: first published chronicle of western formula disasters
Australian Dietary Guidelines formulated
1983 Conservative Labour party forms government.
Australian industry "Code" signed; revised 1986....
1984 ICM Congress in Sydney: ICM Declaration on breastfeeding
End of Nestle Boycott worldwide negotiated by US group
NH&MRC Guidelines for Healthworkers on implementing the Code
NMAA's 20th anniversary
1985 *Breastfeeding Matters*: "a milestone in breastfeeding history" (January)
Inaugural meeting of IBLCE in Washington (March)
Formation of ILCA, the International Lactation Consultant Association
1986 WHA Resolution 39.28 re free supplies; Food Standard R7
First independent educational course for healthworkers on infant feeding, at Prahran College of TAFE, Melbourne (after 1991 at Monash University jointly with NMAA LRC)
1987 *Successful Breastfeeding*: Royal College of Midwives
Formation of ALCA, the Australian Lactation Consultants Association
Nestle plans to enter US Market; different US group revives boycott
Australians previously involved decide not to participate in boycott
1988 Australian Code illegal: TPC consultation process begun
NMAA International Conference in Melbourne
Health for all Australians report
1989 ALCA submission re Marketing of BMS; ACOIF formed
1989 Joint WHO/UNICEF statement: *Protection, Promotion and Support of Breastfeeding*: the Ten Steps to Successful Breastfeeding
1990 Innocenti Declaration; World Summit for Children
Infant Feeding: the Physiological Basis (WHO) published
TPC Report on implementation of the Code
Creation of ACOIF (Aust. Coalition for Optimal Infant Feeding)
1991 Creation of National Food Authority
WHO CREF (Code review and evaluation framework) committee
Feb. 1991 Meeting that led to formation of WABA and idea of BFHI
Bestfeeding (Renfrew, Fisher & Arms) first BF book with accurate pictures
May 1991 James Grant announcement of BFHI (no programme at this stage)
Nov. 1991 ACOIF in negotiations re Australian implementation of WHO Code
Wellstart San Diego development of BFHI assessment programme
Feb. 1992 First BFHI assessments in 12 countries
1992 Australian Dietary Guidelines revision
Formation of Australian BFHI Taskforce; priorities:
*adaptation of Global Documents
*workshops for assessors; national database
*development of BFHI educational resources
*creation of administrative infra-structure
May 1992 Signing of Australian Agreement, negotiated in November 1991.
Nov. 1992 Creation of APMAIF: Advisory Panel on Marketing in Australia of Infant Formula
1993 Publication of CREF committee (1991) report
Feb. 1993 a National BFHI workshop for professional groups: agreed to proceed and create national initiative with their support.
Creation of National BFHI Steering Group
Aug. 1993 Appointment of Lisa Donohue as co-ordinator
Pilot assessment of Royal Women's Hospital

Availability of UNICEF 18 hour course kit
Establishment of assessment process; criteria for assessors; call for State Administrative bodies (regional auspicing groups, responsible to a wider group in each state.) (Groups created in every state over time.)
Establishment of Baby-Friendly Paediatric Unit working group.
Nov. 1993 Consultation on ending free and low-cost supplies (hospitals+)
Jan. 1994 Assessment of Mitcham Private Hospital: successful
Mar. 1994 The 11 Steps to Optimal Breastfeeding in Paediatric Units finalised by NSG and sent to UNICEF NY for comment.
Mitcham Private Hospital assessed and declared Baby-Friendly.
May 1994 WHA Resolution 47.5
Sept. 1994 Assessment of Royal Womens Hospital Melbourne: successful
Nov. 1994 Announcement to BFHI NSG of review process by UNICEF Australia; National Coordinator job to end at end of year; NSG action limited
Jan 1995 Federal consultation on ending free and low-cost supplies (community)
Nestle reiterates they will end them, but are waiting for agreed timeline
Feb. 1995 UNICEF Executive Board proposal to be created; uncertainty re future delays further assessments and BFHI work
Mar. 1995 End of federal consultation on Guidelines for Healthworkers...
July 1995 National Steering Group comes to end of term. Still no leadership for BFHI
Aug. 1995 Breastfeeding: an International Scientific Conference, NSG's project.
UNICEF gives BFHI responsibility to ACMI, who are to consult with NSG partners
Aug. 1995 BabyFriendly Victoria created; runs workshop at PANCH
Second APMAIF report: Keeping an Eye on the Market
Draft 1.7 of Agreement covering bottles and teats circulated
1995 Australian Dietary Guidelines for Children published
1996 The International Code of Marketing of Breastmilk Substitutes: A Common Review and Evaluation Framework (WHO/NUT/96.2)
March 1996 Conservative coalition parties win government.
June 1996 Nestle date for end to all free supplies in healthcare system
July 1996 NFA (1991) becomes ANZFA, begins work on revising R7

SOME FACETS OF THE AUSTRALIAN APPROACH

* Piecemeal and negotiated approach rather than legislative mandate: uniquely Australian and of great interest globally, because it works- provided it can generate widespread community support.

* Government commitment and leadership at federal level (resistance at some State levels) has been crucial. Ministers have mandated the implementation of the Code in conformity with Australian law. Thus we are limited by provisions of Australian Trades Practices Act, but not seriously, provided there is government commitment. A less willing government could put endless obnstacles in the way or refuse to resource progress or even APMAIF.

* Industry co-operation essential and unlikely to have been achieved without Sharpe/ Nestle Australia leadership: very different attitudes evident in advertising and discussion from some overseas companies, particularly the Americans.

* Multi-factorial problem: multi-dimensional strategy imperative

* Huge potential for backlash: need for real skill in presentation

* Enormous power in the hands of every healthworker, but rarely utilised

* Industry issues are only a small part of the whole and over-emphasis to the detriment of major structural issues (e.g., women's workforce participation; the destruction of free community health services and other supports) can be totally counter-productive

* Controlling unethical marketing has NOT limited and will not limit the growth of the infant formula market in Australia. During 1980's, growth of total market, of numbers of producers and importers. This leads to more brand competition which means more advertising in subtle and not so subtle ways. Some companies are notable for not pushing the boundaries of the APMAIF interpretations of the Australian Agreement/Code; others are notorious for doing so. Each of you can make an independent judgment on which, and try to use your own power to prevent the worst from prospering from their actions.

* Individual consciences need to be respected: there is room for valid disagreement about strategy and personal actions. Name-calling helps no one. Insulting people as industry stooges makes them more likely to sympathise with industry, not less, and less likely to work with you. Raising awareness is not readily done by the self-righteous: while they may appeal to the gullible or like-minded, they more often raise anger among the unconverted, their target audience. Be subtle; be smart; be respectful; ALWAYS.

* YOU have a lot of power in a small market. USE IT!

FURTHER RESOURCES

• Australian College of Midwives Inc., suite 23, 431 St. Kilda Rd., Melbourne. Vic 3004. Tel: (03) 9804 5071.
•Australian Lactation Consultants Association (ALCA) Victorian Branch, 1st floor, Queen Vic Womens' Centre, 210 Lonsdale St., Melbourne 3000. Tel/fax: (03) 9650 5397.
•Australian Lactation Consultants Association (ALCA) National office: PO Box 192, Mawson, ACT 2607. Tel/fax: (02) 6290 1920. E-mail: alcagalaxy@interact.net.au
•Nursing Mothers' Association of Australia Lactation Resource Centre (NMAA LRC), PO Box 4000, Glen Iris, Vic 3146. Tel: (0309885 0855; fax: 9885 0866. E mail: nursingm@vicnet.net.au

[1] *Food Chemical News*, Jan. 4, 1982, p. 18.

[1]Called Latching-On, the key to Successful Breastfeeding, it is available from the Education Resource Centre, Adelaide Women's and Children's Hospital, Fullarton Rd., North Adelaide, S.A. 5006, Australia.