7

Regional, remote and Indigenous communities

Overview

7.1 In general, living in a rural or remote area translates to limited access to medical and health professional facilities. Women may not have any choice about how they can deliver their baby, they will have to travel large distances and when they return home and they are unlikely to have services nearby which can help them with breastfeeding. In remote areas, these problems can be even more severe.

7.2 Women in rural and remote communities where there is a high level of breastfeeding support such as supportive health staff, a volunteer breastfeeding counsellor or an International Board Certified Lactation Consultant (IBCLC) can find breastfeeding highly successful. Community acceptance, family support and community expectations are relevant in any community and breastfeeding rates are likely to rise according to people's knowledge, expectations and acceptance of what is a normal process.[1]

7.3 The health status of the disadvantaged, Indigenous and remote communities within Australia is known to be of a lower standard than the general population. For example, Indigenous Australians have a life expectancy 15 to 20 years shorter, and higher incidences of

1 David Q, sub 37, pp 1-2.

all chronic illnesses such as diabetes, heart disease, kidney disease and acute chest infections.[2] The committee considers that breastfeeding needs to be promoted within Indigenous Australian communities as a preventative health measure and that support should be provided to enable successful breastfeeding.

7.4 Many of the issues and actions required in relation to the provision of health services in regional, remote and Indigenous communities were beyond the scope of the evidence that the committee received as part of this inquiry. However, the committee acknowledges there is a real need for breastfeeding support services in these communities and adds its voice to that of a mother from regional Australia, Rebecca Ferluga:

> …acknowledge that there is a lack of support which must be impacting on breastfeeding rates in rural communities; that there is not a 'one-size-fits-all solution' across city and country; and that we need specific solutions and increased Government support to fill the gaps so rural mums and babies don't miss out on the professional and community breastfeeding support they need.[3]

Factors influencing breastfeeding

7.5 Women in regional and remote communities do not have the same level of breastfeeding support available as women in urban areas. Factors such as distance, lack of health care options, isolation and lack of community breastfeeding support services all have an impact on breastfeeding. Additionally, the factors which impact on the initiation and duration of breastfeeding may vary slightly between rural and urban populations (see Table 7.1). Younger mothers were more likely to breastfeed if they were in a rural area compared to an urban area; however, younger mothers in general were also more likely to cease breastfeeding no matter whether they were in a rural or urban environment. In rural areas the influence of the maternal grandmother was not as strong, compared to urban areas.

2 College of Lactation Consultants Victoria Inc, sub 142, p 2.

3 Ferluga R, sub 108, p 8.

Table 7.1 Factors associated with the initiation and duration of breastfeeding in a rural population compared with an urban population.

Factors associated with the decision to breastfeed	**Factors associated with risk of ceasing breastfeeding**
In a Rural area, breast feeding was more likely if:	In a Rural area risk of early cessation of breastfeeding was higher:
● fathers preferred breastfeeding; ● mothers were younger; ● mothers decided pre-pregnancy to breastfeed; ● mothers were primiparous (first pregnancy).	● in younger mothers; ● in mothers who planned to breastfeed for less than two months; ● where fathers did not prefer breastfeeding; ● in mothers who did not decide to breastfeed before becoming pregnant; ● in mothers whose infants received complementary formula feeds in hospital.
In an Urban area, breast feeding was more likely if:	In an Urban area, risk of early cessation of breastfeeding was higher:
● fathers preferred breastfeeding; ● maternal grandmothers preferred breastfeeding; ● mothers decided pre-pregnancy to breastfeed; ● mothers were primiparous; ● mothers were born in Australia, the United Kingdom, Asia, the Middle East or North Africa; ● husbands were professional or administrators.	● in younger mothers; ● in less educated mothers; ● in mothers born in Australia, New Zealand or the United Kingdom compared with mothers born in the Middle East or Africa; ● in mothers who planned to breastfeed for less than four months; ● when maternal grandmothers were ambivalent or preferred formula feeding; ● when mothers received conflicting advice on infant feeding while in hospital

Source: National Health & Medical Research Council, Dietary Guidelines for Children and Adolescents in Australia, (2003), p 9

Regional and remote communities

7.6 The Australian Rural Nurses and Midwives argues that the social fabric of rural communities has changed. They consider there has been a change from the extended family networks previously seen, leading to people becoming socially isolated. If family support is not available and if it cannot be supplemented with professional support then these communities face a double disadvantage.[4]

> Parents may have limited support from family and friends if they have recently moved to a rural area for work or lifestyle reasons. Parents are likely to have to travel further for both specialist and essential health services (especially those that

4 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 3.

> reside on outlying agricultural properties). Additional demands may be present including lack of financial security (for example the impact of drought and industry deregulation on some primary producers) and commitments to livestock (i.e. poses problems for travelling where others are not available to monitor stock).[5]

7.7 Bush nursing communities still operate in some areas in Victoria; however, there is a trend for services in rural and remote areas to be cut back with staff doing less travel out to those remote areas. There is an expectation that rural people will travel in to the services, which can mean that some people become quite isolated, if they do not have the means to enable them to travel.[6] Breastfeeding problems, such as mastitis, that could be treated quickly and effectively if a service was close, can often escalate with a time delay in treatment, a travel component and associated expense.

> A woman from our community could have to travel over 200km round trip to access ultrasound – after referral from her GP (if there is a GP in her town!!) whilst suffering from debilitating infection accompanied by fever, rigors, exhaustion and at least one very unhappy baby. This is very emotionally distressing and would required a very strong constitution not to "give up" breastfeeding and use artificial formulas.[7]

7.8 Rural towns are not always seen as being 'breastfeeding friendly' by mothers. In a breastfeeding study in rural South Australia, 92 per cent of breastfeeding mothers in the study stated that breastfeeding was not well supported within the community.

> There are excellent places available in Adelaide but all my breastfeeding friends agree, it's impossible, facilities in [regional town] are practically non-existent.[8]

5 Western Australian Country Health Service – South West Dietitians, sub 308, p 1.

6 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 6.

7 Willis R, sub 193, p 2.

8 Stamp G and Casanova H, 'A breastfeeding study in a rural population in South Australia', *Rural and Remote Health* (2006), vol 6, issue 2, article no 495.

Staff workforce and workplace issues

7.9 Staff workforce issues are a major factor in the provision of services in the medical and allied health areas in rural and remote areas. The Australian Rural Nurses and Midwives noted that there are difficulties in the recruitment and retention of midwives to rural and remote areas. A particular issue is ensuring midwives have access to continuing education and professional development. This is often difficult, primarily due to the lack of available staff to backfill core staff.[9] Additionally, it can be difficult to gain access to a wide enough variety of experiences because midwives are not able to practise across their scope of practice.

7.10 For childbearing women in rural Australia the provision of maternity services continues to be hampered by shortages of GP obstetricians and midwives and closures of smaller maternity units with 130 units having closed in the past ten years. This is despite recent studies showing that birthing in small, rural Australian maternity units is not associated with adverse outcomes for low risk women or their newborn babies.[10]

7.11 Continuity of care in rural and remote areas is not always available (see chapter 6). Many women do not have the option of giving birth in their local community hospital as obstetric services have been centralised in major centres. This results in some mothers being discharged back in to their local community, away from the health service staff with whom they may have developed rapport through their involvement with the birth and in the initial stages of feeding, and often before breastfeeding is established.[11]

Advice

7.12 People who live in more remote areas may not have any choice in the health services they can access. If they are having problems or need some advice on a breastfeeding issue, they may only have one place where they can access help or advice. It can be quite difficult and expensive to seek a second opinion, so they may simply follow the advice given. If this advice is to supplement or change to infant

9 Australian Rural Nurses and Midwives, sub 299, p 4.

10 Australian Rural Nurses and Midwives, sub 299, p 4.

11 Western Australian Country Health Service – South West Dietitians, sub 308, p 1.

formula, they may not be advised of the effect upon their milk supply and premature weaning may be the unintended result.

7.13 Even quite straightforward solutions such as the Australian Breastfeeding Association's helpline can become more complex and expensive in rural and remote areas. It may require two STD phone calls to reach a counsellor and then with the call being timed, it becomes expensive.[12]

Indigenous health status

7.14 The origins of poor health for Indigenous people can in part be traced to early life. Poor nutrition during pregnancy and childhood is a determinant of poor health and social outcomes in adulthood, including chronic disease, poor school attendance and reduced learning. Low birth weight, growth failure and iron deficiency are indicators of poor nutritional status which have shown little improvement over the past decade. According to the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) they are a salient reminder of the increasing health disparity between Aboriginal and non-Aboriginal populations.[13]

7.15 The poor health status of Aboriginal and Torres Strait Islander people indicates that they are the most disadvantaged population group in Australia[14] and the committee was particularly interested in gaining more information on the rates of breastfeeding amongst the Aboriginal and Torres Strait Islander people.

Breastfeeding rates in Indigenous populations

7.16 The latest Indigenous breastfeeding statistics were obtained in the 2004-05 National Aboriginal and Torres Strait Islander Health Survey. It found that the majority of Indigenous women, 84 per cent, aged 18-64 years who had had children reported having breastfed them. This rate was higher in remote areas, (92 per cent) than non-remote areas

12 Ward K, sub 56, p 4.

13 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 2.

14 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 2.

(80 per cent).[15] Traditionally, breastfeeding babies was normal practice for Indigenous women and breastfeeding was thought to continue until the child reached several years of age. Breastfeeding has been a normal part of Aboriginal culture and mature Aboriginal women living in remote and rural parts of Australia tend to follow more traditional lifestyles and breastfeed more often and for longer.[16]

7.17 Breastfeeding rates in Indigenous populations are likely to vary depending on rural, remote or urban setting. The South Australian Government noted that studies conducted in several different states of Australia have shown breastfeeding prevalence by Aboriginal women decreases by increasing proximity to urban areas and is similar to that for women of low socio-economic background.[17]

7.18 The Northern Territory Government noted that a small number of studies have been conducted to measure current breastfeeding rates in Indigenous populations. However, like many current studies, comparison of data is difficult due to variations in breastfeeding definitions and sampling methods. Anecdotal evidence suggests that the rate of breastfeeding amongst Indigenous women in the Northern Territory may be decreasing.[18]

7.19 The committee considers that any significant improvement in the rates of breastfeeding in Indigenous communities will require at the very least, the collection of Indigenous breastfeeding data as part of a national monitoring system. This will enable an accurate measure of the current state of breastfeeding in Indigenous communities and allow for the development of appropriate breastfeeding promotion and support.

Recommendation 19

7.20 **That the Department of Health and Ageing provide leadership in the area of monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas.**

15 Australian Bureau of Statistics, *2004-05 National Aboriginal and Torres Strait Islander Health Survey* (2006), cat no 4715.0, p 20.

16 Government of South Australia, sub 274, p 8.

17 Government of South Australia, sub 274, p 8.

18 Northern Territory Department of Health and Community Services, sub 334, p 3.

The critical importance of breastfeeding

7.21 The protection of breastfeeding is one health promotion activity that has potential for short and long-term improvements in Indigenous health. Breastfeeding should be encouraged, promoted and supported in Indigenous populations as it will result in substantial benefits to the health care system.[19]

7.22 Indigenous communities are already marginalised in terms of health status, and breastfeeding is one way to ensure that health benefits are passed onto children. For example, rates of recurrent otitis media in Aboriginal children are ten times higher than in the general population as the NSW Centre for Population Health Nutrition indicates.[20] Recurrent otitis media leads to hearing problems in children which can lead to learning difficulties - perpetuating a cycle of disadvantage. The evidence that breastfeeding provides protection against otitis media is very strong (see chapter 3). For this reason alone breastfeeding should be encouraged in Indigenous populations.

Barriers to breastfeeding

7.23 The Australian Rural Nurses and Midwives indicated that two of the main barriers to breastfeeding are the lack of support services in remote communities and the breakdown of the social structure. Where breastfeeding would have been traditionally modelled and supported by the community, social breakdown in remote Indigenous communities means that breastfeeding is less prevalent and less supported.[21]

> That is an issue that was raised with the women yesterday. They talked about the impact of not having mothers—of mothers either dying or being from the stolen generation—and how that has affected them. They talked about the lack of support that they have had and how they have looked to the community for support.[22]

7.24 As noted in chapter 5, the length of postnatal hospital stay has significantly decreased over the last decade in Australia, despite evidence to support links between quality postnatal care and sustained breastfeeding. The NSW Aboriginal Maternal and Infant

19 NSW Centre for Public Health Nutrition, sub 178, p 9.

20 NSW Centre for Public Health Nutrition, sub 178, p 9.

21 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 4.

22 Hall J MP, transcript, 4 April 2007, p 22.

Health Strategy (AMIHS) considers that discharging women home early does not have to be an issue if there is effective, sustained home visiting by qualified health professionals and family support for the woman. The barriers to breastfeeding for Indigenous women are similar to non Indigenous women;[23] however, the difficulties can be magnified if Indigenous women do not have a supportive environment.[24]

The marketing of infant formula

7.25 On its visits to two remote Indigenous communities in Queensland, the committee saw no evidence of direct marketing of infant formula; however, the committee acknowledges this was not a representative sample of communities in Australia.

7.26 The community store in Pormpuraaw, which is the main provider of formula, stocks three brands and sells an average of two tins of each brand every month for a population of 700 people in the town of Pormpuraaw and the 12 Homelands Outstations. Feedback generated during the 2005 Northern Territory infant feeding guidelines project, however, indicated that the use of infant formula in remote communities was becoming more common, particularly amongst young mothers.[25]

7.27 Formula was more expensive in remote communities than urban environments; however, the cost of infant formula did not seem to be a barrier to its use. For people on lower incomes, infant formulas are very expensive but whilst it may seem to equate to the fact that breastfeeding is an attractive option in lower socioeconomic groups, it is not always the reality according to the Australian Rural Nurses and Midwives.[26] Queensland Health noted that in Aboriginal and Torres Strait Islander communities, correct information regarding breast milk substitutes should be provided to families as misinformation can accompany the marketing, making the promotion of these products highly successful and commonly used.[27]

7.28 Additionally anecdotal evidence from health practitioners in Queensland and the Northern Territory suggests the regular use of

23 Government of South Australia, sub 274, p 8.

24 NSW Pregnancy & Newborn Services Network, sub 171, p 2.

25 Northern Territory Department of Health and Community Services, sub 334, p 2.

26 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 5.

27 Queensland Health, sub 307, p 5.

alternate products to infant formula in Aboriginal and Torres Strait Islander communities. This includes cow's milk, reconstituted powdered milk and soft drink via infant bottles in infants less than 12 months of age and highlights the need for additional strategies to promote breastfeeding.[28] Evidence indicates that Indigenous mothers are also more likely to introduce unmodified cow's milk before 12 months of age than non-Indigenous mothers.[29]

Education

7.29 The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) considers there is a need for further antenatal education for mothers and their support network. Some women are unable to breastfeed due to pressure from families and males who do not understand the benefits for mother and baby.[30]

> Education and support is also required from other members of the health care team including General Practitioners. GP's find it easy to switch to bottles as everyone knows what they are getting. Many women are unaware of implications of bottle feeding and partners are unsupportive due to perceived 'ownership' of woman's body.[31]

Cultural factors

7.30 The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) Training and Support Unit (TSU) noted that Aboriginal community culture can play a part in decision-making about how an infant will be fed as the infant belongs to a large family from birth.[32] If the grandmother of an infant did not breastfeed she may encourage the mother to bottle feed as this allows the grandmother to have control of the infant and gives the mother the freedom to go out.[33]

7.31 The committee noted that on the site inspection to the remote community of Kowanyama, the male members of the committee were asked to leave a gathering of women discussing breastfeeding.

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28 Queensland Health, sub 307, p 5.

29 Binns C, sub 86, p 5.

30 NSW Pregnancy & Newborn Services Network, sub 171, p 1.

31 NSW Pregnancy & Newborn Services Network, sub 171, p 2.

32 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

33 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

7.32 The South Australian Government notes that Aboriginal women also tend to be younger mothers than non-Aboriginal women and adolescent Aboriginal mothers may be less inclined to breastfeed their first child as breastfeeding impacts on their freedom, body image, social interaction, education and lifestyle choices.[34]

> The issues we see are; young mothers too shy to breast feed in public but their social life is at the local shopping centre.[35]

7.33 Societal pressures and changes also play a part with health workers identifying the ease of bottle feeding from a young woman's perspective.

> Aboriginal women like to be out and about doing other things and feel that it is much easier to make a bottle and take it with them than to spend the time breastfeeding it just takes too much time.[36]

Housing

7.34 The committee noted when undertaking a site inspection in the remote communities of Pormpuraaw and Kowanyama, that the lack of housing was an issue. Anecdotal evidence indicated that there could be up to 25 people living in the one house. The Royal Flying Doctor Service (RFDS) consider that environmental factors such as overcrowding in houses have a huge impact.

7.35 Young Indigenous women are often shy about their bodies and it may be impossible to breastfeed in private in overcrowded conditions. An overcrowded house does not provide a place where a new mother can breastfeed in a clean and safe environment, and thus may be a factor in why a mother may choose not to breastfeed.

Travel

7.36 In many instances women from remote areas of Australia are required to travel long distances for the birth of their babies and this can cause financial hardship and social disruption. Typically, pregnant women will leave their communities between 36 to 38 weeks gestation to await birth, usually alone, in a regional centre. The facilities in these settings vary but are often very simple. Mookai Rosie in Cairns,

34 Government of South Australia, sub 274, p 8.

35 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

36 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

provides accommodation support services, health support services and advocacy to the mothers and women that travel from remote communities to Cairns for prenatal, antenatal and medical services. At Mookai Rosie the health workers educate and encourage the women to breastfeed, by talking about the positive benefits and how it is the best way to care for the baby.

> As a health worker, I take care of clients' appointments and their education on whatever it may be: breastfeeding, nutrition, diabetes. I also do their dressings, I will escort people to appointments if they need me there and I will be with them in the birth suite. Anything that they need me to do, I will do for them.[37]

7.37 Women may have to leave other children behind while they are away giving birth. This can lead to high levels of anxiety as there may be social issues in the community such as domestic violence and alcohol abuse which can lead to a mother having very valid concerns about her children who remain in the community.[38] Women may also be concerned about not being able to give birth 'on country'.

7.38 The Patient Assistant Travel Scheme (PATS) is a Commonwealth program which is administered locally with the states and territories.[39] It provides financial assistance for people who need to travel for medical reasons. Women from Cape York communities in Queensland who are required to travel to give birth are also able to be accompanied by an escort of their choice paid for by PATS. Other states have different rules for escorts. This leaves Indigenous women in the position where they may not have any support during the time before and after the birth which may impact on breastfeeding. Mothers from the remote community of Kowanyama indicated to the committee that escorts were very important and should be available to all women who need to travel to give birth.

Low birth weight – compounding issues

7.39 Under nutrition and poor growth among Aboriginal infants is well reported within remote communities. More Aboriginal children

37 Simpson B, Mookai Rosie Bi-Bayan, transcript, 4 April 2007, p 12.

38 Yates K, Cairns Base Hospital, transcript, 4 April 2007, p 35.

39 The committee notes that the Senate Community Affairs Committee is currently undertaking an inquiry into the Patient Assistant Travel Scheme. Information can be found at the Senate Community Affairs Committee website, viewed on 30 July 2007 at http://www.aph.gov.au/Senate/committee/clac_ctte/pats/index.htm.

present with low birth weights (12.5 per cent) than non Indigenous children (6.2 per cent).[40] Despite widespread and prolonged breastfeeding by Aboriginal mothers in remote areas, their infants have poor growth patterns after six months and suffer recurrent infections.

7.40 Low birth weight (LBW) is an extremely important factor in infant mortality. US data indicates that only 0.5 per cent of babies born with normal weight die in the first year of life compared to 10.2 per cent of babies born under 2500g and 45.3 per cent of babies born under 1500g. Besides its impact on infant mortality, LBW is associated with increased childhood ill health including that from respiratory illnesses, impaired growth after birth and brain development problems. Although these complications increase in frequency with decreasing birth weight, even children at the upper end of the LBW range, who require no intensive care, have poorer outcomes than children with normal birth weight.[41]

7.41 In October 2005 rates of underweight children under the age of five years in remote communities across the Northern Territory (NT)were reported to be between eight per cent and 18 per cent (compared to an expected rate of three per cent). Across the NT, nine per cent of children were recorded as wasted, with some regions recording rates of up to 14 per cent. It has been said that international relief agencies regard a prevalence of wasting of children more than eight per cent as a nutritional emergency. Poor growth is a serious problem among Aboriginal infants in remote communities across Australia. Within this context breastfeeding provides protection against infections and the cycle of growth faltering.

7.42 However, the importance of appropriate solids introduced at an appropriate time to complement breast feeding should not be overlooked. Although breastfeeding helps to protect against infection such as gastroenteritis, it cannot be expected to completely prevent such infections in the context of poor living conditions and food insecurity. Continued breastfeeding is beneficial for Aboriginal infants and their health would probably be much worse if they were bottle fed on infant formula in unhygienic living conditions.[42]

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40 The Royal Australasian College of Physicians, sub 174, p 5.

41 Australian Medical Association, sub 358, p 8.

42 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, pp 3-4.

7.43 The RFDS noted that solids are often not introduced at the recommended six month mark. Either breastfeeding continued beyond six months or infant formula was introduced but no solids were introduced. This can lead to issues of anaemia and failure to thrive, especially at seven to eight months old and onwards.[43]

Successful strategies to encourage breastfeeding in Indigenous communities

7.44 There are programs that are working in Indigenous communities. A significant achievement of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) has been the inclusion of 'nutrition' as a core unit in the new national Aboriginal and Torres Strait Islander Health Worker competencies, which form part of the Health Training Package released in February 2007. This means every Health Worker undertaking the 'practice' stream at a Certificate IV level around Australia will study nutrition as part of their training. There will also now be the opportunity for Health Workers to specialise in nutrition within the new national competencies at the Certificate IV and Diploma levels.[44]

7.45 Queensland Health has developed a package called Growing Strong for Aboriginal and Torres Strait Islanders. The 'Growing Strong' resources provide information about nutrition during pregnancy and early childhood, with a specific focus promoting breastfeeding and supporting mothers with common breastfeeding issues. Regular in-service training targeting community based Aboriginal and Torres Strait Islander Health Workers is delivered by nutritionists in partnership with Aboriginal Nutrition Promotion Officers.[45]

43 Felsch J, RFDS, transcript, 4 April 2007, p 3.

44 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 7.

45 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 8.

Figure 7.1 Extract from "Young Mums - Growing Strong: Feeding you and your baby"

Being pregnant and having a baby can be challenging times for all mothers, especially young Mums. It is good to ask for help when you are pregnant and after your baby is born and while your baby is growing up.

Source *Queensland Health, exhibit 10, p 2.*

7.46 In response to requests from remote store managers and health centre staff, the NT Feeding Guidelines project of 2005 developed a set of guidelines to selling infant formula in remote stores. The guidelines suggest that stores do not promote infant formula and bottles, and stock only one type of both. Stores are encouraged to stock and promote a range of infant feeding cups.[46]

7.47 NATSINSAP recommends that there needs to be more family focussed nutrition promotion, resourcing programs and disseminating and communicating 'good practice'. In this context

46 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 4.

'good practice' as defined by the community and health professionals, includes understanding community priorities, family, culture, preferred methods of communication and learning, in addition to an up-to-date knowledge of the prevention and management of diet related disease. However, across Australia identification and dissemination of 'good practice' nutrition and breastfeeding information currently occurs in an ad hoc manner and resources to implement this important area have so far been limited.[47]

7.48 Given the proven short and long-term health benefits that breastfeeding provides, the committee considers it crucial that the Commonwealth Government take a lead role in promoting breastfeeding within Indigenous Australian communities.

Recommendation 20

7.49 **That the Commonwealth Government promote breastfeeding within Indigenous Australian communities as a major preventative health measure.**

47 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 10.