Submission No.15
AUTHORISED: 14/2/07

From:
Sent:
To:
Subject:

Department of Health and Aging,
Canberra. ACT.

To whom it may concern

I am a child health nurse in metropolitan Perth working in a child health centre. Since 1968 I have had a lot to do with breastfeeding mothers and their babies, and in 1986 I became the first certified International Certified Lactation Consultant (IBCLC) in WA, and have been continuously certified since that time.

I am concerned that this is to be a 'breastfeeding inquiry' because – breastfeeding is not the problem!
Usually when there is an environmental pollutant, some authority measures it, then sets about determining how to get rid of it eg carbon, lead. For some reason this is not the case with formula. There are a lot of medical men/women who don't know much at all about the whole human lactation scene (4 hours in medical school), and their wives had a problem and had to use formula, so they get very defensive about suggestions that we should be able to decrease formula use and increase the amount of human milk ingested by our infants and young children.

Why is there no dedicated funding from the federal government for the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI)?
I was a member of the steering Committee here in WA from 1995. After a lot of hard work, fundraising, family dilemmas, headaches, heartache, 'blood sweat and tears', we managed to get 2 hospitals in WA accredited. It took 10 years to achieve that because we did not get Federal Government support. The State government was less than interested – wouldn't even give us 'stamped envelopes'! But, there were enough midwives who had a personal interest, that all the requirements for accreditation were met. Finally a year ago, the stress of it all got to me – hypertension – so I resigned from the committee, am no longer an assessor, do not review other assessments for BFHI National and have reduced my hours at work to 3 days. How was it that I 'cared' about the value of structural changes but the two Ministers for Health – did not?

In 1998 I was the Australian representative (ALCA) on the IBCLC exam Committee in Washington DC, and also visited the three breastfeeding clinics of Dr Jack Newman in Toronto. When I returned I used his suck training technique in my child health/lactation practice and in the last few months have found an 'answer' to much of the problem which confronts women in breastfeeding. **Women are not breastfeeding. Women are lactating. Babies are breastfeeding.** Some babies are unable to coordinate their suck-swallow-breathe cycle, which the occupational therapists tell us is the fundamental basis of all future coordination (a spiral model). When babies are checked for discharge from hospital – nobody actually checks this co-ordination. Apparently, it is done more in premature infants (there is a 5 day course in San Francisco), but mothers are going home with sore nipples and babies who do not suck-swallow-breathe efficiently. I am sure that the reason that we got so many sensory nerves in our nipples was so the baby can let us know when something is wrong on their side of the feeding team. I use a mechanical analogy to describe the problem to parents: just like the carburettor – if it is leaking the fuel does not flow into it – a vacuum must be created. Fathers understand this easily – one said "Oh, so he has a leaky gasket!" – exactly. It **is not** about how the mother sits in the chair – **it is suck mechanics.** Maybe we should be connected to the Institute for Sport – not the Health Department. Especially if this suck co-ordination is important in all future coordination.

In 1974/5, I was the NMAA president for Papua New Guinea, as well as working in a rural health clinic. That was educational!. There were no bottles in Port Moresby Hospital. If anyone wanted to buy a bottle, you had to get a prescription for it. Why don't we try that? Simple strategy and makes one think before buying a technological aid which has been shown to contribute to future problems. Infant feeding bottles are cultural artefacts, and are not essential for infant feeding – cups, cup and spoon are fine – just adults are 'lazy' and want 'fast food for their infants', and no milk spilt on the floor.

Journalists cause a problem with attitudes to breastfeeding because they mistakenly think they should present a 'balanced argument'. We don't really talk about the benefits of clean water, in Australia, but when the water supply is compromised (like that cow in Warragamba), it makes the national news. A 'balanced argument - presupposes that there is an 'equal choice'. The evidence shows that there isn't. All the research which documents a protective 'benefit' of human milk or

breastfeeding, conversely demonstrates that formula feeding is, a risk. WHO now says (?statement on young child feeding?) that infants who are formula fed from birth should be considered an 'at risk group by health professionals and carers'. Obviously, formula does not kill babies in Australia (education, safe water) but there is plenty of attendant morbidity. SIDS Foundation, asthma foundation, Diabetes Australia all neglect to inform parents about the association between formula and the conditions which they then have to manage. What chance do individuals have when the system is against us. It is very strange that there is no community support group for infants who have suffered or parents who are concerned about the effects of formula. I presume this is because when the child has repeated ear infections, needs grommets – it becomes a surgical issue and is not recognised as being precipitated by insufficient protection from the live organisms (white blood cells, macrophages, lactobacillus) which are present in human milk. I consistently ask these questions at professional education session provided by my employer (HDWA) and am continually surprised at the answers. It is also 'strange that feeding bottle do not come with any instructions for how to used them correctly, and in the current climate, health professionals in maternity units are not teaching how to use them correctly if the infant is biting on the teat.

When mothers come to my clinic with breastfeeding problems and challenges, I often ask them: **Did you get a call from Tony Abbott?** (or whoever the current health minister is). They usually just laugh or say, "Who?". "The Minister for Health in Canberra", I respond. Then I go on to say that it is Canberra who is setting the 'goals and targets' for breastfeeding. But they are not doing anything. It is not a PROGRAM. Why is *Drinksafe* and *Get the skin off your chicken* more important than the first food for all our infants. It does not receive dedicated funding – health promotion personnel say that "breastfeeding is not a program area, well, I suppose it's nutrition". There is no real plan for what we should be doing to fix this problem. BFHI is not required for ACHS accreditation. Why are there no milk banks for all infants who need human milk – football gets more money (ah, but they create an income for medicos and allied health – with all that falling over, punch ups, and strain injuries!!). Norway had a female prime minister – the problems got sorted very quickly (check their rates), seems like NMAA did such a good job for so long that there was no political will to change anything in the political arenas.

My plan for the way forward – Interglactica.
I deal with the mothers and babies who are in pain every day and cannot feed because of it. We need to stop dealing with the problems caused by dysfunctional suck and deal with the cause of the problem. **The baby 'is the problem'**. You do not get sore nipples if you do not let a baby who is not feeding properly attach to them. When I look at the baby there is a sequence I follow to exclude all the problems which will stop baby from feeding comfortably.
1. Ask the mother if she is in pain. Midwives do not have x-ray vision and cannot tell by looking from the outside, if baby is sucking correctly.
2. Check for ankyloglossia (tongue tie) – refer to surgeon as appropriate.
3. Check for positional turn (which leads to positional plagiocephaly); explain the exercises to parents and demonstrate the positions for baby.
4. Conduct a suck assessment; the teach the parents to correct the suck. Explain facial exercises
5. Explain about Developmental Issues: insufficient production of lactase, and laxity of cardiac sphincter in infants under 12 weeks of age (gastric reflux). Discuss strategies to improve infant comfort.
6. Talk about issues of Lactation Management: hand expression of milk, use of pump, storage and use of milk; stress management; sleep deprivation; stupid myths propagated by 'anyone' eg 'can't eat chocolate!
7. Monitor infant growth parameters, intelligently. WHO recommends that three measurements are used for this. The current recommendation is that only weight is used unless 'there is a concern'. A lot of health professionals do not really understand the standard growth charts and the concept of 'normal range'. The mathematical concept of 'average' also presents us with problems. Paediatricians often say that babies put on 250 gms each week – but those on the 3rd percentile and those on the 97th percentile – don't. One puts on about 100gms and the other about 300gms. Parents worry unnecessarily. This process takes about 60-90 minutes to complete and costs the parents $5 (because I am paid by HDWA and it is part of my 'usual child health practise'). I ask them to ring back in 2-5 days if the problem is not improving. Very few need a follow-up appointment. This is a very cost effect strategy and restores parents confidence and self esteem.

When I do these suck efficiency assessments, I need long feeding tubes, so you can see what is happening – I buy them myself. A consultation with a private IBCLC costs about $60 or more – OK if you have private cover, but what if you don't? They usually get better (develop a coordinated suck in about 2-5 days, if we see them before 6 weeks). Fathers can feed the baby and help develop the correct suck, using the right muscles. The suck-swallow-breathe cycle is established. Sometimes I need to refer a persistent problem to the Child Development Centre – there is a significant waiting list, and confusion about the line of referral, because I mentioned the work 'breastfeeding'. I was hoping to do a PhD on this but have been too busy at work, solving problems, to actually do it, yet!. It has taken me 40 years of nursing education and practise, 20 years of being an IBCLC, 13 years of personal breastfeeding (5 kids) and 8 years of practising and refining the suck training technique in my daily work (these years are obviously concurrent) to get to the understanding I have today. **The light dawned on me last November – it is so simple – nobody really checks for efficiency of the suck-swallow-breathe cycle prior to discharge or in the first 2 weeks at home.** Most of the problems experienced by the mother are caused by a 'dysfunctional baby'. When we train the baby the maternal issues recede: Dysfunctional suck (tongue not over gum or biting action) causes sore, grazed, bleeding nipples, mother becomes stressed may not want to put baby to breast, milk is not removed from the breast causes blocked ducts which if not treated becomes mastitis (antibiotics, abscess, surgery) and baby needs formula. Candida infections usually only occur after the nipple integrity is interrupted. Baby who does not suck well, does not drain brain, milk is not replaced, baby not settling finally loses weight. We can spend a lot of time blaming the mother for having the wrong demographic at attitude or we as health professionals can start to include real suck assessment in the first 4 weeks of life.

Last year we had a planning meeting at work, because 'breastfeeding' was a KPI. Everything thought it was a good idea to have 'evidence based practice'. Well, yes,....but....if the **current evidence based practice WAS WORKING, then it would**

not be a KPI. We need to do something different, **we need new evidence**. We need to talk to mums, assess infant suck correctly and monitor infant growth and development.

Don't let doctors test infants < 12 weeks age, for reducing substances (on Medicare) – they are all positive at this age – then they suggest "lactose free formula for a week". Lactase is not secreted sufficiently till about 12 weeks. Those formula company sales reps did a good job. Why doesn't your department pay people like me to go talk to the GPs for the same amount of time that the multinational reps get to talk about the 'you beaut new formula' (playing catch up again}. Lets talk about the 40,000 year field trial conducted on human milk. Sure formula is better than it was 40 years ago but it is still lacking (see list in Dietary Guidelines). When we are calculating the cost, of premature introduction of formula, we also need to include the earlier need for contraceptives. It is not co-incidental that the multinational drug companies who make popular formula also make popular oral contraceptives. **Is formula a loss leader for oral contraceptives?**

I am on annual leave for 2 weeks tomorrow, but I would be happy to supply further formal information if it is required, or if you want to discuss the possibility of funding for the production of a film about how to do suck training and how to help parents relax about the 'whole breastfeeding thing'. If this format is considered as a 'submission' – I am quite happy for this to be used or published.

Yours sincerely

Ailsa

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