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Submission to the Inquiry into Breastfeeding
House of Representatives Standing Committee on Health & Ageing

Ms Alison Sneddon MHlth BEd DipT AACHSE

I offer my opinion as an individual - not on behalf of my employer nor the organisations to which I am affiliated. However, my opinion is informed by:

- 16 years full-time work and professional development in the public health service, in areas of :
  - Perinatal & Infant, Child and Adolescent Mental Health services (past 5.5yrs)
  - Mental Health Promotion and Prevention – 10 years
  - Health Promotion – 16 years
  - City-wide multi-strategy community food programs

  working in project management and senior health service management positions – population health planning, service development, operational direction, management and evaluation.

- more than 8 years of this work has been in an area in NSW which is the largest populated (800,000), has the highest birth rate (more than 12,000 births pa), and is possibly the most socio-economically disadvantaged.
- 24 years membership of the Australian Breastfeeding Association, and almost 20 years as a Counsellor with that association.
- membership of childbirth education, parenting, school and community associations over the years.
- being a mother of 4 children now aged 14-23, each exclusively breastfed for 6 months and weaned in the vicinity of 2 years.
- experience as a breastfeeding mother in the full-time paid workforce in government departments of education and of health. I returned to paid work full-time when youngest baby was 3 months old, fully breastmilk fed until 6 months, and in a child-care centre – ie combined breastfeeding and working full-time for 20 months. I had returned to work after maternity leave with each of my other 3 children.

SUMMARY:

The benefits of breastfeeding and strategies to promote breastfeeding are well documented in research and Government policy, and can be demonstrated through the work of bodies such as the Australian Breastfeeding Association.

Issues

The most significant issues in my opinion are the:

- rate and the duration of breastfeeding, and the priority need to increase these at a population health level, through a range of commonwealth, state, local and individual care strategies.
- decision to breastfeed, and breastfeeding itself, may impact on the mother's/family attitude to nutrition and health more generally, to protection and prevention and their self-responsibility for their own health.
- ready availability and particularly the promotion of breastmilk substitutes ("formula") as an alternative, in advertising, information and published articles.
- marketing of "formula" and associated products by manufacturing companies, pharmacies and supermarkets to families and health professionals which is in breach of international agreements.
- role of the Government in monitoring and acting on breaches.
- accountability of health professionals – across every discipline and at team management and grassroots levels - in their responsibility to assist or appropriately refer women and in meeting health targets for increasing breastfeeding. This accountability should extend well beyond accredited Lactation Consultants, who are vital in health services.
- contrast between the philosophical and evidence based priority for good information and care in the perinatal period (eg antenatal care, midwifery care, Home Visiting, Mother support groups) and the reality in all health systems - which is symptomatic of low staffing resource levels, insufficient capacity for education of health professionals, and priority-setting directed towards acute health events.
- lack of consistent policy and practice in maternity units, intensive care and special care nurseries which support breastfeeding and feeding of breastmilk, as opposed to ready access and use of formula and soothers/dummies. The use of breastmilk from other mothers was a common practice in the early 1980s. I donated breastmilk to feed a neighbour's premature twins, after being approached by the nurse unit manager of the maternity unit suggesting this. Unfortunately, health scares about transmission of AIDS put an end to milk banks, without any real investigation into measures to protect transmission of HIV or the higher risks associated with formula.
- extent of professional education and training which is sponsored by companies manufacturing "formula" and associated products; and the culture that this is acceptable by health professionals organising such events. Employers and Governments should have responsibility to provide professional development, and not rely on private sponsorship by companies which jeopardise health. Would we allow a Cigarette or alcohol manufacturer to sponsor a health conference or education ?
- lack of education in health professional undergraduate training across all disciplines.
- cost of not breastfeeding – on the health system in general practice, emergency department, ongoing chronic and complex care, cardiovascular diseases, and the potential link to mental health which in itself is recognised as a burden; on the families themselves – economic, health and lost activity costs; and on society of the burden of illness as well as environmental factors in the manufacturing process and disposal of unnecessary waste.
- cultural attitudes towards breastfeeding, not viewing breastfeeding as normal, and accepting that "formula" can be as safe and healthy, as well as the "guilt

factor" which sometimes manifests as a backlash against breastfeeding and those who advocate it.

- changing family and workplace arrangements – increasing numbers of women returning to work part-time or full-time after having a baby; and workplace conditions and child-care arrangements that need to change to accommodate breastfeeding women returning to work.
- insufficient funding and advocacy support for a specialist not-for-profit organisation, namely the Australian Breastfeeding Association, which is a key to increasing breastfeeding rates and support.
- portrayal of breastfeeding and health in the media, and the profiling of self-promoting ill-informed and untrained "experts" .

Strategies for Change

I suggest the following strategies for Commonwealth, and acknowledge some may already be in place yet require reinforcement:

- Continued promotion of the health benefits of breastfeeding and the WHO guideline (up to 2 years of age) – through media and marketing strategy, client and professional health information, funded projects, web-based information; with the additional knowledge that "formula" is not an alternative and it raises risks.
- Active support of the Government to the Australian Breastfeeding Association, demonstrated through provision of funding, seeking advice, promoting the leadership and expertise of the Association, and providing information and consultancy to the Association where relevant.
- Alliance or forum at national level, bringing together Commonwealth, State, Australian Breastfeeding Association (as lead agency), and other key Associations/bodies interested (eg Australian Association for Infant Mental Health, Lactation Consultants Association, National Heart Foundation, Diabetes Foundation).
- Professional development strategy for the health workforce, targeting national and state professional organisations, universities and VETAB Accredited training providers; and acknowledgement of the training provided by the Australian Breastfeeding Association.
- Commonwealth and State Governments policy that does not support attendance of health professionals at conferences which are sponsored by companies that manufacture and market products that fall under the scope of the International Code of Marketing of Breastmilk Substitutes; and which provides guidelines to conference organisers restricting sponsorship by such companies.
- Policies and guidelines supporting breastfeeding and restricting the use of formula in hospitals, special care and intensive care nurseries; and supporting the introduction of milk banks.
- Policies and building designs which support women returning to the paid workforce to continue breastfeeding; and which support women to breastfeed in public places.
- Key performance indicator sets include requirement for states and any Commonwealth funded projects related to the perinatal and infant period to

include a focus on, and outcomes related to, the health benefits of breastfeeding.

- Monitoring of compliance to the International Agreement on the Marketing of Breast-Milk Substitutes, and penalties to those manufacturing companies and health services which breach the agreement.
- A Memorandum of Understanding with peak organisations – eg Divisions of General Practice, Pharmacy Guilds, AMA, College of Nursing, College of Midwives, etc – upholding their responsibility for increasing breastfeeding rates and duration of breastfeeding in the community.
- Commonwealth restrictions on the sale of "formula" in supermarkets, particularly those marketed for babies less than 12 months of age.
- A review by the NHMRC of guidelines for research and/or education of Ethics Committees such that research sponsored by companies with a commercial interest in encouraging artificial feeding, or where there is any suggestion that the research will be detrimental to breastfeeding rates, are not approved by Committees.
- Support for research and applied research and evaluation into the efficacy of interventions which promote and support breastfeeding which is consistent with WHO recommendations; and support for better information about side-effects of medications.
- Policy guidelines for Media releases and a memorandum of understanding with the Media about Breastfeeding, similar to the guidelines pertaining to reporting of suicide and also tobacco use.
- Targeted health promotion-community development initiatives in socio-economically disadvantaged communities, emerging communities (including CALD) and communities populated by Aboriginal and Torres Strait Islander people which are funded long-term to address cultural, health literary, and community support approaches to increasing rate and duration of breastfeeding.

Specifically Addressing the Criteria in the Inquiry's Terms of Reference

a. The extent of the health benefits of breastfeeding;

There is substantial and well documented international evidence for the health benefits of breastfeeding for the baby, mother and family – related to nutritional, immunological, mental health and economical aspects.

Emerging evidence of the importance of "bonding and attachment", nutrition in early brain development, as well as the interaction between physical, social and psychological health, suggests that breastfeeding, and mothering practices associated with it, has an important role not only in physical health but in mental health and in the general health and wellbeing of the family.

Governments are, thankfully, adopting and advocating in policy the WHO recommendation of exclusive breastfeeding to 6 months. However, further advocacy of the benefits of longer-term breastfeeding is warranted and the full WHO recommendation must be promoted.

In my observation, the health benefits of breastfeeding have been translated to most regional or Area health authorities and most are developing strategies to promote and encourage breastfeeding. This is encouraging, and must have continuing support.

The challenge is to ensure that the broad health workforce has the capacity to, is aware, and also importantly that they believe in and advocate the importance of breastfeeding to the health and wellbeing of mothers and babies. And that they provide care across all hospital, community based, and primary care – medical, pharmacological or psychological treatment, advice and support – that is informed practice which does not compromise breastfeeding.

I have experienced many examples of health professionals – within publicly funded health services, general practice and key specialty groups (paediatricians, psychiatrists, medical) - where "formula" is upheld as a suitable alternative to breastfeeding and often encouraged. This extends to premature babies, mothers and infants having medical, surgical or pharmacological treatment; as well as in response to normal breastfeeding adjustment and child health problems.

Behaviour and management strategies and treatments are often inappropriately applied to normal parenting and breastfeeding problems, and are often not based on current good practice.

Of further concern is that health professionals' advice to mothers and expressed attitude is often based on their own personal practice or decisions. A large cohort of health professionals currently giving advice have personal experience gained during a period a heavy marketing of "formula" was common and subsequently breastfeeding was less common. System support for appropriate professional development and values clarification could be substantially improved to address this.

Smart strategies are required to affect culture change – both education and legislation, and most particularly for health workers to be accountable at all levels of the organisation, through performance management and the necessity for demonstration of how they have met and contributed to the key performance indicator of rate and longevity of breastfeeding. Some health professionals are already highly motivated in this respect – the systems need to support them and also support others to change.

Over the years, I've observed in the many families with whom I have come in contact that a higher level of awareness and interest in healthy food and childhood development is often demonstrated where breastfeeding is the norm, or where an effort has been made to gain information about and breastfeed baby. Suggesting that an acceptance of and effort to breastfeed, may have a flow-on effect to other values and practices related to nutrition, health and wellbeing.

b. Evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;

Working in the south-western Sydney Area (eg Liverpool-Green Valley-Miller, Campbelltown-Macquarie Fields-Ingleburn-Minto; Fairfield; Bankstown; Picton to Bowral) with some of the most socio-economically disadvantaged families and the highest urban indigenous population, I have seen data which demonstrates very low breastfeeding rates and can see evidence of this when I move around the community. Rates drop dramatically on discharge, and many women are only in hospital for a very short time due to short-stay practice, bed demand and the need or expectation for them to be home to look after other children or family members.

Low rates in disadvantaged communities can be attributed to many factors – health literacy, family history, limited health resources comparative to the population and very high birth rate; and ease of access to "formula".

In my opinion, breastfeeding rates are exacerbated by the dislocation and relocation of many families, lack of community connectedness, large numbers of medical centres (many families don't have a family GP) and the gathering of people in large shopping centres where I and they:

- see many displays of "formulas on special"
- see advertising brochures for supermarkets and chemists with "specials"
- get free baby-care products, or special deals on other products if tins of formula are purchased
- pick up free magazines which openly promote formulas through ads and articles.
- witness large numbers of babies being formula fed such that it becomes the norm.
- are made to feel uncomfortable about breastfeeding a baby in public; or where inadequate facilities are provided for women who prefer to feed in private for personal or cultural reasons.

Indigenous elders in outer metropolitan areas are less influential than in remote communities, and most families do not consider these outer metropolitan areas "home". Strategies need to take into account the fragmented nature of many communities, and their experience of multiple very short-term funded projects; rather than a long-term commitment of resources necessary for change.

Culturally and linguistically diverse families are also at risk, particularly the second generation which most actively wants to assimilate into the "mainstream" Australian culture and marketing influences; become less connected with traditional cultural norms.

<u>The marketing of breast milk substitutes is cleverly aimed at:</u>

1) mothers and families, through:

- "specials"
- "follow-on formula"
- key messages that "it's the next best thing" if you can't breastfeed
- claims of nutritional and/or functional equivalence of these products with breastmilk or breastfeeding often via specific mention of individual
- sales inducements such as gadgets and products such as free plastic shake containers, spoons, growth charts, etc;

2) health professionals, through
- free samples of formula or other infant feeding products
- products such as pens, post-its and other desk accessories
- cleverly written "health information" which doesn't indicate the risks
- significant sponsorship deals for conferences and professional development.

The reliance on sponsorship from companies which market products which fall within the scope of the International Code of Marketing of Breastmilk Substitutes, to support professional development, conferences and seminars is a most significant problem

which is accepted as common practice and ethically unsound. While other sponsors exist, the most generous benefactors and most ready to sponsor are commonly the companies with an interest in encouraging women to abandon breastfeeding.

Media Portrayal of Breastfeeding and Infant Management

Apart from inappropriate advertising in print media, portrayal of breastfeeding and "formula feeding", as well as feeding practices in television and radio shows, and in the print media.

There are no controls over untrained self-promoting advocates who give advice contrary to policy and accepted evidence. Examples include a high profile individual from overseas, with no relevant training or qualifications, giving advice about solids from 4 months, babies sleeping 12 hours through the night from 8 weeks of age, and rigid feeding and sleeping routines; a 'parenting expert' from another overseas country with very rigid teachings on discipline and routines from an early age. These practices often result in distressed babies and mothers, reductions in breastmilk supply, breastfeeding problems and levels of parental anxiety about breastfeeding. Methods such as "controlled crying" and unresponsive parenting are not supported by Australian leaders in the fields of mental health, parenting and breastfeeding.

Similar problems experienced in the context of alcohol, smoking and suicide resulted in the Commonwealth Government stepping in with controls over the media portrayal. I strongly recommend similar measures in relation to breastfeeding as protective and "formula" as a real health risk.

c. The potential short and long term impact on the health of Australians of increasing the rate of breastfeeding;

Impact is evident in the literature, and is well-known in the fields of public health, health promotion and preventable disease, particularly in relation to obesity, asthma and other allergies, cardio-vascular disease and diabetes.

Mental Health is a health priority which also needs to be considered in relation to breastfeeding. Emerging research on Attachment in the perinatal period clearly demonstrates the impact on mental health both short and long term, of the impact of nutrition and smoking on the child's developing brain in utero and after birth. Advocates of breastfeeding clearly understand the relationship between breastfeeding and attachment; and between breastfeeding and smoking rates.

d. Initiatives to encourage breastfeeding;

Australian Breastfeeding Association

The leadership and strategies undertaken by the Australian Breastfeeding Association, formerly the Nursing Mothers' Association of Australia, have been fundamental in encouraging breastfeeding rates in Australia, through:

- mother-to-mother support
- regular newsletter and informative magazine
- website
- local opportunities for meeting other parents – group meetings, social events, visits to maternity hospitals, information sessions

- breastfeeding education classes for new parents-to-be – run through ABA and also by ABA counsellors and community educators at hospital antenatal classes
- access to breastfeeding information through a volunteer telephone counselling service 24 hours per day 7 days per week across Australia.
- high quality training of mothers as Breastfeeding Counsellors and of females and males as Community Educators
- health professionals seminars, and conferences
- promotion and administration of the Lactation Consultants examinations and accreditation
- Breastfeeding Research and Information Centre
- links with other organisations, internationally such as the La Leche League, nationally and locally such as PANDA (post-natal depression), maternity alliances, Public Health Services.

Support and validation of this Association as the leader and experts in breastfeeding and related matters by the Commonwealth and State Governments is paramount.

Families First and Home Visiting

Home Visiting by trained health professionals and trained volunteers has been demonstrated to make a difference in breastfeeding rates, family functioning, mental health, and baby/children's development. Government financing of home visiting has occurred, but substantially needs to be increased along with the quality of the information provided.

The Families First strategy was an exciting whole-of-government initiative which has made some small gains, but has never been resourced sufficiently to effect the required strategies and achieve outcomes. Specific departments, eg the health services, require additional resources to provide the necessary training of volunteers and health workers and to provide the necessary level of care and occasions of service. Involvement and financial support of groups such as the Australian Breastfeeding Association, to enhance capacity for counselling, groups, information meetings, pamphlets and web-related information, is another factor which has not been explored sufficiently in the strategy.

Health Literacy

Quality of health information provided to the community and to health professionals must be consistent - and all government funded initiatives should be required to uphold the key health messages consistent with WHO and Commonwealth recommendations.

Much quality information about breastfeeding and breastfeeding management already exists, and has primarily been developed in Australia by the Australian Breastfeeding Association or people associated with it.

Health Practices, Evidence Base and Accountability

Performance indicators and funding of Mother-baby residential services, such as Karitane and Tresillian, should include breastfeeding targets as with all maternity and early childhood services.

A review of practices is also warranted – particularly widely held routines promoted and actively taught by some mother-baby services, eg feed-play-sleep, sleep training and

variations of "controlled crying", which have no evidence base and may be detrimental to successful breastfeeding. This extends to privately operated services, but is more difficult to monitor and guide.

Generally, all maternity, perinatal and infant, and early childhood services which receive public monies should be required to be accountable for the efficacy and quality of their practices, and report on outcomes, of which breastfeeding rates and duration is one.

e Effectiveness of current measures to promote breastfeeding;

Performance Indicators

Key performance indicators which make health services, and funded organisations, accountable for the rate and duration of breastfeeding are paramount.

Monitoring and Acting on the Marketing of Breastmilk Substitutes

Effective monitoring and action against breaches of the Agreement on the Marketing of Breastmilk Substitutes must be a priority.

Public Health experts have long found that monitoring, exposing and penalising breaches is fundamental to ensuring protection of public health – for example with food hygiene, legionnaire's disease and under-age smoking.

From a public health perspective, I recommend similar penalties on breaches of Marketing of Breastmilk Substitutes and associated products.

f. The impact of breastfeeding on the long term sustainability of Australia's health system.

There is significant evidence of the impact of breastfeeding on health, and it is a key and acknowledged protective factor in the prevention of a number of diseases and conditions.

Cost-benefit analyses by health economists have been prepared in the preparation of State Strategic Plans for nutrition and breastfeeding; and I understood that a paper on this was prepared by an officer employed within Commonwealth Treasury about 6 years ago.

The cost to Australia's health system in the medium and long term of not increasing rates and duration of breastfeeding will be in the demand for treatment of:

- obesity related conditions
- diabetes
- cardio-vascular disease
- asthma, other respiratory diseases, and allergies
- post-natal depression
- childhood and adolescent mental health problems related to early attachment
- hearing (related to glue-ear) and dental (dental caries)
- minor health problems related to immunology – eg number of visits to GP

This will be exacerbated by the impact of the "baby boomers" on the system, many of whom sadly were not breastfed themselves because of the culture and practice of post-war health services which promoted rigid "4 hour feeding schedules", strict routines and "scientific" and medical models of parenting.

As a taxpayer and responsible citizen, I do not wish to bear this cost.

Close.

Thankyou for the opportunity to submit to this inquiry, and particularly for undertaking a much needed inquiry of this nature.