My name is Sally Eldridge. I write this submission as a mother who has breastfed two children, now 7 and 5, and as someone who, as a result of this experience, has become a passionate advocate of breastfeeding. I also write as a volunteer with the Australian Breastfeeding Association. Since qualifying as a community educator with the association in 2003, I have spent on average about ten hours a week, but often far more, focusing largely on supporting women to combine breastfeeding and work through the Breastfeeding Friendly Workplace Accreditation program (BFWA). In reality I have spent more hours doing this work over the last four years than I can, or would like, to calculate, though my spouse would readily tell you it was way beyond what is reasonable as a volunteer.

MY BREASTFEEDING HISTORY AND LESSONS LEARNED

I come from a family of breastfed children. I have long known that to breastfeed, my mother had to go against the advice of numerous health professionals, to stand her ground from day one with each baby, to demand her rights and protect those of her babies. With me, it was to get assistance to establish breastfeeding at the hospital in the United Kingdom, where formula had been given without consultation. Later she had to defend her right to breastfeed me on the plane to Australia (she was migrating, and I was four months old). With my sister, it was to stand up to the child health nurse who screamed at her "I won't take any responsibility for that child if she dies" – because my sister was a small baby and mum would not do as the nurse wanted her to and add formula to the baby's diet. With my first brother it was for the right to have her husband with her at the birth, to have her baby with her in the room (not kept in a nursery and fed formula without permission), then later to be able to breastfeed in public while studying at university.

With my youngest brother, who was adopted in 1971, Mum defied conventional wisdom that it was impossible, as she went about preparing to re-lactate and breastfeed. I am old enough to not only remember his arrival and the lengths Mum went to, but the joy of her success. Having learnt so much about breastfeeding since becoming a mother myself, I now realise how groundbreaking Mum's actions were. With little information available, Mum had told the social worker what she was planning, only to be told she was mad. It is no surprise to me that after this sort of response, she says she was too scared to approach her GP. Sadly, I don't think things would be much different now – friends of mine who have adopted have been stunned when I tell my mother's story; they have no idea that adoptive breastfeeding is even an option.

Despite having such a positive role model, I realise now how little I actually knew about breastfeeding when it came to having my own children. Essentially, I thought that breastfeeding was something you tried to do because it was good for your baby and which you did for a maximum of nine to twelve months. I had few friends that I had watched breastfeeding, I had seen little in the way of breastfeeding in public and I heard virtually nothing about breastfeeding from the health professionals I came into contact with during my pregnancy.

While breastfeeding my children has been an overwhelmingly positive experience and a highlight of my mothering to date, establishing a successful breastfeeding relationship with my first child almost seemed to be in spite of some of the health professionals, rather than because of them. Due to the fact that I was overseas on posting at the time, my pregnancy was monitored by an Australian embassy GP and I was not linked in to the usual ante-natal programs. When I returned to Australia at 36 weeks, I met my obstetrician and attended a catch-up program of ante-natal classes that my sister, a paediatric nurse, had arranged at

the hospital where I was to deliver. Information in the classes focused heavily on labour choices, birth plans, pain management and the like, but I cannot recall anything being said about breastfeeding. If it was, it was clearly in so marginal a way as to make no impact.

Fortunately I benefited from what my sister had learned from the misinformation and lack of support she experienced when trying to breastfeed her first baby. She directed me to a lactation consultant before my baby arrived so that I could discuss strategies that might assist me with my planned early return to work. When my baby arrived, neither the delivery nor breastfeeding went according to plan, so within days my baby and I were having significant problems with breastfeeding. Illness, pain, tiredness and stress from my fear that breastfeeding might not work out compounded the situation. Things were not helped by the fact that advice about breastfeeding was varied and ad hoc. To get the assistance I felt I required, I insisted on staying in hospital longer than they wanted me to, and until my lactation consultant was available after the weekend. In hindsight I realise that this surprising level of assertiveness on my part, at a time when so many women are vulnerable and ready to accept anything to fix the problems, was the saving of me.

With the support and encouragement of the amazing lactation consultant, Sue Cox, who I now know is at the forefront of her profession, I was able to return home to Indonesia and gradually address the breastfeeding issues. Armed with the options she offered me, and the "permission" she gave me to follow my instincts, I successfully returned to work full-time when my baby was seven weeks old. With the support of my incredible partner, my boss, my colleagues and my staff, I was able to combine breastfeeding and work. I expressed my breastmilk for my daughter through all manner of instability in Jakarta, such that she received breastmilk exclusively until she was six months old.

We then returned to Australia and a new workplace, where, fortunately, similar support was available. My daughter continued to breastfeed until she was 18 months old, when I weaned her while pregnant with my second child. Although I am very proud of our breastfeeding relationship and how much we achieved, it is with some regret that I think back to this forced weaning and the tears and emotion that surrounded it. While I knew by then that tandem feeding was possible, I knew no one who had done so and had too little information to make a truly informed decision.

With my second baby, I was better equipped to deal with the different breastfeeding difficulties we encountered. I was also able to take maternity leave and extended leave from work to stay at home until my child was nearly four. While many questioned me, I continued to breastfeed until my child told me, at the age of 3 ½, that he was a big boy and didn't need any more. The feelings I have about the way this breastfeeding relationship came to a natural conclusion are far more positive.

Lessons learned

- Ours is not a culture that embraces breastfeeding, promotes it as the norm for infant feeding and supports women to breastfeed longer term and in line with the infant feeding guidelines put out by the World Health Organisation or Australia's National Health and Medical Research Council (NHMRC);
- The cultural chain of breastfeeding knowledge has been broken in our bottle-feeding society. Breastfeeding is spoken of little in the story of our babies, it is seen little, such that women approaching a birth have often only got broad/unformed ideas about breastfeeding;
- Because of this and because breastfeeding is actually a learned skill, women need far greater education and information about how to breastfeed and what they can realistically expect of newborns and beyond;

- far too little emphasis is placed on breastfeeding in antenatal education;
- While many health professionals support breastfeeding, far fewer have detailed knowledge of breastfeeding management;
- Resources to promote and support breastfeeding are woefully inadequate;
- There is a very real shortage of lactation consultants; and
- With workplace support, women can combine breastfeeding and work.

TERMS OF REFERENCE

To turn specifically to the terms of reference of this inquiry:

a. the extent of the health benefits of breastfeeding;

Over the course of my time as a parent I have learnt so much about breastfeeding, largely through self-education, but prompted by my membership of the Australian Breastfeeding Association. In this submission I do not plan to go into the known and likely health benefits of breastmilk and breastfeeding, as others with authority to do so will provide you with this information. Suffice to say, there is overwhelming scientific evidence available to the inquiry that proves beyond a doubt that breastfeeding is a health promoting behaviour. Research continues to mount and inform us of just what we give to our infants when we breastfeed them. Conversely, the evidence is also mounting to show us the risks associated with not breastfeeding and with feeding artificially. To support this health promoting behaviour, women and communities need:

- To see breastfeeding promoted as the norm for infant feeding, not as something they may or may not choose to do or be able to do;
- Far greater information about the fact that breastfeeding is not a lifestyle choice, but a health promoting behaviour; and
- Far greater factual information about the health risks associated with artificial feeding.

While public funding is available to draw attention to the health risks of other behaviours detrimental to good health such as smoking and over consumption of alcohol, no such funding or health campaigns exist for breastfeeding. Promotion of breastfeeding is always done in the positive, "breast is best" framework. But breast is not best, breast is normal and if you don't breastfeed, there are identifiable risks to your baby and to yourself. Furthermore, as science continues to identify more about the link between breastfeeding and health, it is likely that there will be more risks from not breastfeeding identified in the future.

Despite what we now know about the health risks of not breastfeeding, we do not convey the breastfeeding message to the community in these terms. I would urge the inquiry to recommend a change in the way messages about breastfeeding are conveyed. I understand that talking about breastfeeding can be highly emotive and that heated debate, anger, feelings of guilt and the like often come into play. However, if we can confront smokers and drinkers with the risks associated with their behaviour, then we should be able to do so on the subject of breastfeeding.

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

Artificial feeding – a great social experiment on humankind, controlled by multibillion-dollar profit-making multinational manufacturers of infant formula.

In all honesty, I am frightened and overwhelmed by the power of infant formula manufacturers to influence behaviour of mothers across the globe. I am demoralised by the ineffectiveness of the self-regulatory body that oversights the marketing of infant formula in Australia and feel that the battle to influence and support mothers to breastfeed is lost if we do not introduce rigorous legislative protection against the unethical marketing of infant formulas, bottles and teats. This legislation must not only apply to the manufacturers, but to the retailers who aggressively promote the products on their shelves.

In my spare room-cum-study I have a pile of promotional material for infant formulas. These have easily been collected and photographed around my community – in my local shops, at my son's childcare centre, from my daughter's school, at the local chemist. The material includes the specials that the local shop offers so that I can afford to buy more formula; there are the adverts in the parenting magazines that imply to me that my child won't be as intelligent as they could be unless I provide them with a particular brand of follow-on formula (carefully labelled to look exactly like the infant formula of the same brand so that cross-promotion and brand association occur and I think it is all the same and all health giving). There are the adverts for the various solutions-in-a-tin that I can turn to when my baby has colic, reflux, "poor sleep" and other nasty baby problems. There are the adverts that imply that my toddler will have been weaned and that to get them to have a nutritionally balanced diet I should give them this amazing health giving stuff in a tin. There are the adverts for other products, such as the nappy wrapper that talks about baby poos changing when I wean my baby at around four months, implying that this is when I should be weaning my baby. There's the magazine from the retailer called "Everything for baby" that tells me all about the formula and feeding-related equipment I need, alongside all the beautiful things I can put in the nursery. Included, as they always do (because they are so caring?), a token reference to breastfeeding, but then the implication from the pictures that breastfeeding is difficult – goodness, look at all that expressing equipment I'll need to be able to do it. But then, thank heavens, all the easy alternatives/equivalents.

From this, I hope you get an idea of how insidious the advertising of artificial feeding options has become. I would be happy to forward you some examples to demonstrate what I mean. What astounds me is not only the audacity of the material, but the quantity. This material has literally multiplied through my community in the time I have been watching. Not only is it in paper form, but it abounds on television and on the internet where companies are able to make direct contact with mothers in breach of the World Health Organization's International Code of Marketing of Breast-milk Substitutes (WHO Code). Women will never be able to make informed choices with advertising of this sort perverting the messages they receive.

I note newspaper articles this week reporting that junk food advertising is being banned from television in the United Kingdom. The Australian Government has refused to follow this lead, or indeed to take the lead on this issue, despite the growing call for the removal of such advertising. To my mind, artificial infant milks are the equivalent of junk food for babies and their advertising needs to be strictly controlled. While the Government argues that parents have a choice to control the eating patterns of their children when it comes to junk food, the decision parents make about how they feed their baby is even more critical than the decisions they make for older children, in that this decision can only be made

once, has an irreversible impact and is made on behalf of infants who have absolutely no say in the matter. Furthermore, this decision is often made with limited information of the associated risks and at a time when women are at their most vulnerable.

The aggressive marketing of infant formulas, baby and toddler foods happens because our regulatory framework is totally inadequate. The Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement has as its aim "to help ensure safe and adequate nutrition for infants through the protection and promotion of breastfeeding and by ensuring the proper use of breast milk substitutes when they are necessary". However, manufacturers are not required to be a party to the MAIF, and indeed some are not. MAIF also does not apply to retailers – all those retailers where I find the products, the promotional materials and the specials.

The MAIF was developed not by the Australian Government alone, but with the member companies. It is hardly surprising then that inclusion is voluntary, that it applies only to manufacturers and importers of infant formulas and does not include other milk products, foods, beverages or feeding bottles and teats and does not implement all aspects of the WHO Code. I have watched as friends have forwarded example after example of breaches of the WHO Code, only to be told that it does not breach MAIF. As a result, I have no faith that this framework is fulfilling its stated aims.

Until such time as the WHO Code is fully adopted by the Australian Government and implemented in legislation free from the control of the corporations that profit from the sale of artificial feeding products, there will be no real protection of breastfeeding in this country. I urge the inquiry to recommend this in their report.

The issue of labelling on babies foods also needs to be addressed. In my own case, because I needed to return to Jakarta and was unsure of what was available in the way of introductory foods, I bought some baby foods in Australia to take back with me. I found the labelling on these sorts of products quite confusing because I had read about delaying the introduction of solids to six months in information referring to the World Health Organisation. However, the products themselves indicated that they could be introduced from four months. I decided to go with WHO guidelines, and our baby was happy being exclusively breastfed until then (but less so with the bland packaged food we introduced, and soon dispensed with). It was only later that I learned just how hard the infant food manufacturers are fighting to keep these misleading guidelines on their products, because the earlier mothers wean their babies, the greater the profits they make.

In my paid work I have been undertaking work relating to the Trans Tasman Mutual Recognition Agreement (TTMRA) and the issues it is causing for a particular profession. While it facilitates the flow of goods and the movement of professionals, it essentially does this through a "lowest common denominator" approach. I now realise that the TTMRA is part of the reason that manufacturers selling infant foods are able to retain labelling that states that their product can be introduced between four and six months, contrary to NHMRC dietary guidelines for infants. As long as New Zealand fails to change its official infant feeding guidelines from four months exclusive breastfeeding to six, and the TTMRA requires that there be congruity between the labelling for both countries, this situation will continue, to the detriment of breastfeeding rates in Australia.

I would urge the inquiry to recommend that the Australian Government make stronger approaches to the New Zealand Government to adopt WHO guidelines in their infant feeding guidelines and then for both governments to require labelling on infant foods to reflect these guidelines.

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

If one accepts the plethora of research showing how significant a health promoting behaviour breastfeeding is, then it goes without saying that the potential short and long term impact on the health of Australians that would result from increasing the rate of breastfeeding is enormous. Given that only one in three Australian infants receives nutrition in line with the NHMRC's guidelines on infant feeding, there is not only a great need, but wide scope for increasing the rates of breastfeeding rates and thereby seeing significantly improved health outcomes for infants.

I am confident that you will receive submissions and identify information yourselves that will detail for you the health benefits that will result from increasing the rates of breastfeeding in Australia, so I do not wish to go into this in detail. I would like to make the point, however, that an increase in breastfeeding rates would not just impact on the physical health of Australia, but the economic health and the environmental health of Australia.

Economic health: On this, there are others far better qualified to advise you than I. However, from my work with the BFWA program, I am aware of the bottom line benefits that employers can realise by supporting their paid employees to combine breastfeeding and work – reduced absenteeism from healthier babies and mothers, possible earlier return to work, reduced costs of recruitment and retraining from the retention of skilled female staff and the like. In addition there are un-costed benefits like increased staff loyalty and improved work-family life balance.

Unfortunately, the contribution that breastfeeding women make to the economy is not factored into Australia's Gross Domestic Product (GDP). This results in a perverse situation whereby if breastfeeding rates decline and the use of artificial products increases, so does GDP. Little work has been done to assign a cost to this precious living fluid or to assign a monetary value to what it provides in terms of health of the community. In this regard, the work of economist Julie Smith and colleagues is ground breaking and I would urge you to consider her findings. As I understand it, human milk could be costed at about $50 a litre and the cost of hospitalisation alone from premature weaning in Australia (the tip of the iceberg in terms of health costs, both physical and monetary) is between $60 to 120 million annually.

Just as we are now coming to terms with valuing other things previously considered intangibles – water, air, forests – I would urge the Government to include the economic value of breastfeeding in GDP. Protecting breastfeeding as a resource requires good public policy because there is no profit incentive to promote breastfeeding, but very strong commercial incentives to undermine it. Valuing breastmilk and breastfeeding, values mothers and the contribution they make to the economy and the health of the nation.

Environmental health: Breastfeeding is environmentally friendly and ecologically sustainable. It is a locally-owned and locally produced quality product:

a. No manufacturing or transportation is required, whereas manufacturing formula requires energy and the product then has to be transported to and from the point of manufacturing to the point of sale, sometimes involving overseas shipping;
b. There is no packaging in plastic, metal, cardboard and so on with breastfeeding as there is with formula, bottles and teats;
c. Conversion of food to breastmilk is very efficient and babies digest breastmilk efficiently. Wastage is inevitable from the production, storage and transportation of formula and because babies cannot digest the product as efficiently. Breastmilk is the

only food commodity for which production equals consumption, that is, there are no "post harvest losses" or plate waste;

d. No detergents and chemicals are needed to breastfeed as they are to wash and sterilise bottles and teats;

e. Breastfed babies digest milk more easily so they have less pooey nappies, less smell and less bacterial contamination - saving on water, cleansers and chemicals;

f. Cows produce lots of methane gas, a potent greenhouse gas affecting the ozone layer. Mothers produce a very small amount in comparison;

g. By promoting health, breastfeeding lessens use of hospitals, which are heavy users of fuel and energy resources, and of drugs;

h. Because breastfeeding delays the return of menstruation, there is an associated lower use of sanitary products, saving energy and forests, and reducing disposal problems which currently affect waterways and oceans.

These arguments may all sound a bit off-beat, but I have a genuine concern for the environment and believe that every individual has a responsibility to monitor their own environmental impact on the planet and to do what they can to reduce their contribution to environmental degradation and climate change. Who knows, one day in a carbon credit economy, breastfeeding mothers might be viewed as some of our more efficient off-setters!

d. initiatives to encourage breastfeeding

I believe there are many initiatives that could be implemented that would encourage breastfeeding in Australia:

1. Provide the Australian Breastfeeding Association, Australia's leading authority on breastfeeding, with greater financial support from all levels of government to allow it to continue its role.

Back in 1971 when my mother was being told by everyone that breastfeeding an adopted baby was impossible, it was the Australian Breastfeeding Association (Nursing Mothers Association at the time) where she got the only positive reaction to her plan. She also received useful information on how she might proceed, and counselling by mail to support her as she did so. This is no surprise to me, because it is from the Australian Breastfeeding Association that I have learnt so much about breastmilk and breastfeeding. It is also where I have received more informed mother-to-mother support and information than anywhere else along my path as a parent.

My own experience, and the experience of so many mothers I have seen, confirms for me that mothers who are linked into the support and breastfeeding-friendly culture of the Australian Breastfeeding Association are well informed and more likely to keep breastfeeding for longer. Many women gain confidence from being members of the association and go on, as I have, to become advocates for breastfeeding. To continue to provide this support, the association needs adequate funding over and above the minimal levels of funding it currently receives, so that counsellors and community educators can get on with doing the work they have been trained for, rather than being diverted to run sausage sizzles and other fund raisers.

2. Funding for research

Funding is required to undertake research to better inform policy makers on the real rates of breastfeeding and exclusive breastfeeding and to understand breastmilk in greater detail than we currently do. I understand there is a question mark over the next National Health Survey and its examination of breastfeeding rates. This data is important and should be collected on a regular basis, with appropriate definitions.

3. Far greater support from employers and community for mothers returning to work to combine their paid employment with breastfeeding.

Through my own experience and my role in the Australian Breastfeeding Association's BFWA program, I have seen first-hand how disempowered women can feel in trying to negotiate to return to work and continue breastfeeding. Many of the women I have spoken with have said that they will not even attempt to combine the two activities as they know that their workplace facilities and culture are inadequate to meet their needs. With such large numbers of women returning to work sooner after the birth of their baby, programs such as the BFWA need to be implemented across the country to ensure that employer support is a normal feature of Australian workplaces.

4. Paid maternity leave and lactation breaks

By providing paid maternity leave and paid lactation breaks, mothers are in a better position to establish breastfeeding and to continue to breastfeed when they return to work, with the consequential benefits outlined above. The current situation in Australia is that few women are entitled to paid maternity leave, and even fewer to paid lactation breaks in line with the International Labour Organization's recommendation of up to an hour a day. It is not reasonable to leave these conditions to market forces, because this means that only women in larger and more forward thinking organisations will have access to them.

5. Greater education of health professionals.

The World Health Organisation recommends that governments be responsible for providing education on infant feeding. In Australia, many health professionals have limited training about, and understanding of breastfeeding and need more education in order for them to be able to support breastfeeding effectively. This education needs to include information about the WHO Code and the importance of keeping infant formula manufacturers at arms length from mothers. Formula manufacturers should not be allowed to have any involvement in the education of health professionals (as currently happens in some instances).

6. Public health campaign to promote breastfeeding.

While there is a general consensus that "breastfeeding is best" and most people would say that they support breastfeeding, women experience this "support" in some pretty unsupportive ways. Mothers are told how frequently they should be feeding, they are told they should not breastfeed in public, they are told they should not breastfeed beyond a few months of age, and certainly not into toddlerhood and beyond, and they are pressured to wean if they show signs of feeding "too long" and once "there is no value in the milk". A concerted public health campaign is required to change the community attitudes that lead to these sorts of comments. Such a campaign should not, as outlined in **a)** above, talk about the benefits of breastfeeding but about breastfeeding as the norm, the importance of breastfeeding and the risks associated with premature weaning.

7. Funding for human milk banks

Early exposure to infant formula, even one bottle, predisposes infants to developing Type 1 diabetes, asthma, eczema and allergies. Premature babies are at greater risk of life threatening complications like necrotising enterocolitis when infant formula is used. Because of this, the WHO recommends that donor human milk be given to babies, in preference to artificial baby milk. Because of premature birth, maternal illness or birth complications some mothers have a delay in milk production and currently, due to the lack of supplies of donor human milk, there is no choice but to give these babies infant formula.

With funding for milk banks, the number of babies exposed to formula in hospitals would be greatly reduced. It would not only be good medicine to provide donor human milk through milk banks, but it would make economic sense because the cost of treatment for preventable illness in babies exposed to infant formula would be reduced. The technology is available for these milk banks to be set up, and indeed the process has started, but needs to be rolled out across the country. When my mother had her babies in the mid to late 1960s, she was asked by midwives to wet-nurse other babies on the maternity ward. Indeed across the world, wet-nursing and the giving of human milk to mothers and babies in need is a regular practice, accepted as a gift between women. With fear of AIDS and legal implications, this culture of sharing has been taken away from women and we are the poorer for it. To set up a network of milk banks across the country would reintroduce the opportunity for giving the gift of human milk.

Recently, a friend of mine delivered her first child with her terminally ill husband laying along side her. With the health of her husband as a priority and significant physical complications of her own, breastfeeding was not, in the end, able to be established. Several weeks later, my friend's husband passed away. This situation is tragic, and the fact that the health system was unable to offer human milk to this baby angers me. I look forward to the day when women with maternal illness or complications that are preventing them from breastfeeding are told by their health professional not to worry, not to become stressed, because there is some donated human milk available for their baby. This will be the day when women who have their heart set on breastfeeding, who have tried so hard but not been able to achieve their goal, will not have to grieve that their child did not receive human milk.

8. Use of WHO growth charts across Australia

The growth charts that have been used in Australia for many years were developed in the United States in the 1950s and represent the growth patterns of largely artificially fed babies. Given that we know there are health risks for babies that put on too much weight too fast, it is not acceptable that these charts are still being used in most Australian states and territories. I urge the inquiry to recommend nation-wide use of the growth charts recently put out by the WHO.

9. NHMRC adoption of the full WHO guidelines

The WHO recommends exclusive breastfeeding to six months then ongoing breastfeeding with complementary foods to two years and beyond. While the NHMRC has adopted the six months of exclusive breastfeeding part of the recommendation, they have not adopted the two years and beyond and opted for only twelve months and beyond. I am unaware of why this has happened, but would urge that the WHO recommendation be adopted as the standard in Australia.

e. examine the effectiveness of current measures to promote breastfeeding

I would contend that it is not possible to say that the current measures being used to promote breastfeeding in Australia are effective. If they are, how is it that when virtually all babies at the turn of the Twentieth Century were breastfed, we now have a situation where only one in three Australian babies receives nutrition in line with NHMRC guidelines? How is it that this can happen even when the science is there showing us the risks of the "alternatives", and that there are multi-million dollar savings to be made for health budgets, the community, employers and the environment?

If these measures were effective, we wouldn't know that a woman's educational and socio-economic status are still indicators of her likely success at breastfeeding. We wouldn't see women questioning their body's ability to nourish their child. We wouldn't live in a largely bottle-feeding culture that promotes artificial feeding methods to women as 'almost as good' and suggest that the decision whether to breastfeed is merely a lifestyle choice rather than modifiable health behaviour. We wouldn't have a situation where successive governments have failed women by failing to accept that food marketing influences food consumption, leaving us with a weak industry regulatory framework that has permitted and facilitated commercial promotion of unhealthy infant feeding practices and left mothers milk to compete in the infant food 'market' on highly unfavourable terms, even though they are well aware of the risks of artificial feeding. We wouldn't live in a country where schools, child-care centres and other child-related institutions are filled with evidence of our bottle-feeding culture - dolls and their bottles, books that show bottle feeding far more frequently than they every show breastfeeding and the like.

If measures had been effective, then information about WHO infant feeding guidelines would be widely known and quoted in Australia, and women would be aiming to achieve those recommendations. If these measures were effective, I would not have had a spouse who suggested initially that if breastfeeding didn't work out, formula would be ok. I wouldn't later have been questioned about why I continued to breastfeed my children beyond the first few months and received comments about them being too old for breastmilk. Nor would the many mothers I know of, have been told by ill-informed family, friends and even strangers in the street (offended by their breastfeeding in public), that they should stop breastfeeding.

If measures had been effective, then I wouldn't have received advice from a Sydney doctor to wean my two year old son when I went to see him about a recurring **throat infection** that had come back while I was visiting family. As I fed my 2 year old son at the surgery, this health "professional" took it upon himself to advise me that my son didn't need to be breastfed any more and that this was probably why I kept getting sick. I was so flabbergasted that I said nothing, when I probably should have educated him about WHO guidelines. Instead, I booked myself in with my own GP back in Canberra, a mother of four breastfed babies. I asked her point-blank if there was any physical reason for toddlers to stop feeding and she said not. She ordered a series of blood tests and the reason for my tiredness was identified – low iron stores. As I understand it, breastfeeding actually assists to keep iron levels from dropping, so weaning would have exacerbated my problem, which, as it turned out, was more likely to be because of my vegetarian diet, and easily rectified.

If measures had been effective, I would have received more support from the Maternal and Child Health nurse, who when my son was 17 months old asked me how many times he was feeding and whether he was feeding at night time. When I advised her that he had been having three feeds a night, she rolled her eyes and said if I was silly enough to let this happen then she wasn't even going to discuss breastfeeding with me. Had she been

informed enough about breastfeeding to ask a few more questions, she would have found out that my son had increased his feeds because he had caught a cold from playgroup and had been unable to deal with solids for about a week. The fact that by recognising his need for comfort and a more readily digested food source, and by allowing him to almost exclusively breastfeed for that week I had prevented my son from becoming dehydrated, needing to see a doctor or even being hospitalised (as many children of this age are), was not something this health professional never found out or congratulated me on.

Breastfeeding is a learned skill; it doesn't always happen easily. However, this message doesn't seem to have gone very far, and where it has reached, it still doesn't seem to have translated into adequate support and education for mothers, and mothers to be. Without role models, new mothers in our bottle-feeding culture turn to expert advice, yet most health professionals were raised in that same bottle feeding culture. Though many are supportive and advocate breastfeeding now, far fewer have had much training about breastfeeding and all are part of a health system that has only in more recent years taken steps to make amends for its complicity in the promotion of artificial feeding and the consequent decline of breastfeeding rates in previous decades.

As outlined in **c)** above, there are many more measures that could be implemented to promote and support breastfeeding in Australia.

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

With severe constraints on funding for our health system occurring at the same time that the costs of modern medicine are spiralling upwards and we look for ways to address the increased costs of an ageing population, Australia needs to look for measures to ensure the long-term sustainability of the health system.

I would suggest that breastfeeding is an area where savings could be made. It is clear that the chronic illnesses that are caused by artificial feeding of infants are a cost on the Australian health system that could be reduced by increasing the rates of breastfeeding. Surely, for example, it would be better to spend the $20 to 30 million dollars that the Government is being pressured to spend on an oral vaccine against rotavirus, on breastfeeding promotion and support? This vaccine would be largely unnecessary if most babies were exclusively breastfed for six months. I urge the government to look at breastfeeding as a preventative health behaviour and to fund its support and promotion accordingly.