Submission no. 223
AUTHORISED: 4/4/07

February 2007

Submission from the Dietitians Association of Australia
Inquiry into Breastfeeding

The Dietitians Association of Australia (DAA) is the National Association of the dietetic profession, with branches in each State and Territory. DAA represents over 3000 members. DAA is a leader in nutrition and advocates for better food, better health, better living for all. DAA welcomes the opportunity to comment on the House of Representatives parliamentary inquiry into the health benefits of breastfeeding. Members working in a range of practice areas including clinical dietetics, public health nutrition, Indigenous and culturally and linguistically diverse (CALD) communities contributed to the development of this submission. DAA believes the Commonwealth government can take a lead role in improving the health of the Australian population through support for breastfeeding.

Contact person: Ms Kate Poyner
Position: Professional Services Dietitian
Organisation: Dietitians Association of Australia
Address: 1/8 Phipps Close, Deakin, ACT 2600
Phone: 02 6282 9555
Fax: 02 6282 9888
E-mail: kpoyner@daa.asn.au

Summary of Recommendations

1. **DAA recommends that a national system of monitoring breastfeeding in Australia be adopted including monitoring of breastfeeding practices of populations at risk, for example, Aboriginal and Torres Strait Islander women and CALD women in Australia.**
2. **DAA recommends that the Marketing of Infant Formula in Australia (MAIF) agreement become mandatory for formula and should be extended to include marketing of all infant and toddler formula.**
3. **DAA recommends that the Baby Friendly Hospitals Initiative be adopted by all hospitals across Australia including strategies such as rooming-in practice, health promotion, development of education resources and hospital support to breastfeed from health professionals.**
4. **DAA recommends that 'at risk' populations, e.g. CALD, low socioeconomic status and teenage mothers, receive appropriate interventions to support breastfeeding e.g. resources in key community languages, use of interpreters and targeted initiatives.**

5. **DAA recommends that future initiatives to encourage breastfeeding build on the types of effective interventions summarised in a recent DHS report, in addition to those mentioned in section D of this submission.**
6. **The DAA recommends improved access to dietitians, who are experts in nutrition science and education, to ensure consistent, accurate and up to date information and training about the importance of breastfeeding and the appropriate introduction of solids to health professionals and workers who deliver individual/group counselling or support classes (maternal and child health nurses, high school health and wellbeing programs, antenatal and postnatal classes etc.).**
7. **It is recommended that the Australian Government establish an expert committee with broad representation and adequate funding to oversee the implementation of all the recommendations included in the DAA submission. DAA recommends that there is dietetic representation on this group.**
8. **DAA recommends the promotion of exclusive breastfeeding to 6 months of age and that breastfeeding be continued until at least the age of 12 months with the appropriate introduction of solids, to assist with reducing of costs to the Australian health care system associated with artificial feeding.**

a) The extent of the health benefits of breastfeeding

The health benefits of breastfeeding are extensive. They reach beyond solely benefiting the infant. Breastfeeding promotes maternal health, and the benefits last beyond the duration of lactation and effect a wide range of health outcomes covering infant and maternal physical, psychological and emotional health. The Dietitian's Association of Australia (DAA) supports 3 documents which list promotion of breastfeeding as a key priority, and where the benefits of breastfeeding are reported - the National Health and Medical Research Council's *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers* (2003), *Eat Well Australia – An Agenda for Action for Public Health Nutrition 2000 - 2010* (SIGNAL, 2001) and the *National Aboriginal and Torres Strait Islanders Nutrition Strategy and Action Plan 2000 – 2010,* (SIGNAL, 2001).

Breastfeeding has proven to protect against infectious diseases and childhood malnutrition. Throughout at least the first 6 months of an infant's life, breast milk meets all their nutritional requirements, preventing conditions caused by nutritional deficiencies. Many nutrients contained in breast milk are more bioavailable, making them easily absorbed by the infant at a time when their bodily systems are immature and aren't functioning to their full capacity (NHMRC, 2003). A submission by the Australian Breastfeeding Association to the NHMRC (ABA, 2003) summarises evidence demonstrating the significance of breastfeeding in reducing the incidence of overweight and obesity in our society. In rural and remote areas, a substantial proportion of Indigenous children have an unacceptable level of malnutrition, which pre-disposes them to infectious diseases and overweight/obesity, while

Indigenous women have lower rates of initiation and duration of breastfeeding (SIGNAL, 2001). The benefits of breastfeeding are of greater magnitude in populations with higher infant mortality rates (NHMRC, 2003), so there is potential for considerable health benefits to this population with an increase in breastfeeding rates.

The *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers* (2003) list the health advantages of breastfeeding for infants. These include reduced risk, severity or incidence of diarrhoea, respiratory infection and asthma, otitis media, neonatal necrotising enterocolitis, bacteraemia, meningitis, botulism, urinary tract infection, type 1 diabetes, inflammatory bowel disease, allergy, malocclusion, celiac disease, sudden infant death syndrome, some childhood cancers, reflux and improved visual acuity and psychomotor development. Breastfeeding has been shown to promote maternal health with some protection against pre-menopausal breast cancer, ovarian cancer and osteoporosis. Breastfeeding also promotes maternal weight loss, and improved iron status postnatally due to amenorrhoea (NHMRC, 2003) [see Box 1.1 'Health Advantages of breastfeeding for infants and mothers' in the *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*, (2003) p 6].

Breastfeeding promotes infant and maternal psychological health through regular close interaction and skin to skin contact. The maternal hormones released during breastfeeding, prolactin and oxytocin, stimulate the development of maternal behaviour and bonding. Additionally, children who are breastfed have been shown to have increased cognitive development than those infants who were bottle fed (NHMRC, 2003).

For further information on the long term benefits of breastfeeding, see section C of this submission.

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

Data available on breastfeeding rates in Australia is difficult to locate. The 1995 National Nutrition Survey has been examined to extract the percentages of mother's breastfeeding in specific age groups and there is an Australian Bureau of Statistics National Health Survey report from 2001. Both of these indicate rates of breastfeeding fall far short of targets.
A full nutrition survey of children aged less than 4 years would be timely to ascertain feeding methods, length of breastfeeding, use of formula and demographics and other characteristics of groups with both high and low breastfeeding rates. A comparison could also be made for Indigenous and remote communities. In 2001 the Australian Food and Nutrition Monitoring Unit (Webb, 2001) prepared an extensive document which details methods to standardise the monitoring of breastfeeding practices in Australia. Adoption of the recommendations in this report would be of great value in determining

barriers to initiation and continuation of breastfeeding and possible initiatives to increase breastfeeding rates.

The WHO code on marketing of infant formula is designed to protect and promote breastfeeding. The Marketing of Infant Formula in Australia (MAIF) agreement drives the implementation of the WHO code in Australia, but as it is a voluntary agreement, manufacturers and distributors are not actually required to be signatories to the agreement. Direct marketing to mothers, magazine ads, point of sale advertising and the provision of free samples are all breaches of the WHO code which happen frequently around Australia. Advertisements often imply that feeding problems can be cured by using various infant formulas. Health claims such as these imply that breast milk substitutes are superior to breastfeeding. The WHO *Global Strategy for Infant and Young Child Feeding* categorically states that breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants and that "national policy should foster an environment that protects, promotes and supports appropriate feeding practices".
As health professionals we have a responsibility to ensure this sort of advertising and promotion is not allowed to continue and recommend that stronger legislation be applied from the Australian government.
This agreement should also be extended to include all types of infant and toddler feeds as currently toddler formulas are heavily marketed including prime time television. This strong marketing, by extrapolation, infers that formula is an appropriate choice.

- **DAA recommends that a national system of monitoring breastfeeding in Australia be adopted including monitoring of breastfeeding practices of populations at risk, for example, Aboriginal and Torres Strait Islander women and CALD women in Australia.**

- **DAA recommends that the Marketing of Infant Formula in Australia (MAIF) agreement become mandatory for formula and should be extended to include marketing of all infant and toddler formula.**

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

Increasing rates of breastfeeding will potentially affect the health of Australians in the short and long term.

Breastfeeding has continually been acknowledged as the optimal choice of infant feeding (WHO 2001). Research has provided evidence that breastfeeding is particularly well suited to matching the growth and development requirements of an infant. In her excellent review article, Oddy (2002) emphasizes the risk of not breastfeeding is associated with a greater incidence of childhood disease, specifically acute diarrhoea, lower respiratory tract infections, ear infections, asthma, necrotising entercolitis, botulism, SIDS, diabetes, childhood lymphoma and coeliac disease. Breast milk also

contributes to optimal cognitive development. Lack of breast milk has potential long term effects on diseases that occur later in life such as cardiovascular disease, rheumatoid arthritis, multiple sclerosis, and some cancers, (ABA, 2007).

There is also a significant link between weight control and breastfeeding. The problem of obesity in Australian children and adolescents (particularly Indigenous children) would be reduced if more babies were breastfed and breastfed for longer duration (ABA 2003).

Positive implications for women's health have also been recognised. Breastfeeding helps the mother to lose weight after the baby is born (Lovelady 2000; Kramer 1993; Dewey 1993). Lactation will also protect against breast cancer (Collaborative Group 2002), ovarian cancer (Hartage 1994; Rosenblatt 1993), endometrial cancer (Rosenblatt 1995) and osteoporosis (Kramer 1993; Melton 1993).

d) Initiatives to encourage breastfeeding

DAA recommends that a number of initiatives that map across the Health Promotion Interventions framework be undertaken to encourage breastfeeding. An integrated approach offers the greatest potential for positively affecting health and has been used by some jurisdictions , (DHS 2003).

Screening/ Individual risk assessment

Initiatives to encourage and support breastfeeding must meet the needs of the populations identified as 'at risk'. 'At risk' population groups have been shown to have low rates of breastfeeding initiation and duration. They include:

- women of low education
- teenage mothers
- women of low socioeconomic backgrounds
- women of Aboriginal and Torres Strait Islander background
- women from CALD backgrounds
- women with limited partner support and inflexible working hours

These populations are identified as at risk due to the lack of education and promotion of breastfeeding, lack of support during their pregnancy and in hospital, the belief that infant formula is superior to breast milk, and possibly the lack of public breastfeeding facilities. Many mothers identified at risk may work shifts where the workplaces may not be 'baby friendly', or other family members may be looking after the baby and the use of formula may be perceived as the easier option for many of the mothers.

Health education and skill development

The literature indicates that early interventions assisting women with decision making about infant feeding options may help them make a more informed choice. Studies consistently show that the decision to breastfeed before or early in pregnancy is predictive of longer duration

Education about the importance and benefits of breastfeeding, as well as appropriate introduction of solids, incorporated into high school programs, targeting both young males and females, may influence young mothers' decision to breastfeed.

Currently there is inconsistency and inaccuracy of messages from health care providers and the lack of easily understood, evidence-based core messages and integrated programs seems to result in duplication with many well intentioned initiatives occurring in isolation. The need for coordinated strategies has been consistently demonstrated.

Breastfeeding information needs to be available in a variety of formats and easily accessible, including more practical demonstration and examples rather than sole reliance on didactic models, to allow people with low literacy and from CALD backgrounds to understand this information.

The benefits of including the partner, family and/or birth mother to encourage and support the breastfeeding mother has also shown to increase breastfeeding duration.

Vic Health (2005) indicates that mothers who breastfeed need specific information on maintenance techniques, support in overcoming any difficulties and ongoing reinforcement of their choice.

Support for breastfeeding and advice regarding the appropriate introduction of solids needs to be easily accessible. Upon discharge, daily midwife visits and access to a 24 hour breastfeeding advice line could assist mothers; however this should not replace local supports such as support groups and postnatal groups.

- **The DAA recommends the Australian government supports improved access to dietitians, who are experts in nutrition science and education, to ensure consistent, accurate and up to date information and training about the importance of breastfeeding and the appropriate introduction of solids to health professionals and workers who deliver individual/group counselling or support classes (maternal and child health nurses, high school health and wellbeing programs, antenatal and postnatal classes etc.).**

Social marketing/ health information

Breastfeeding needs to be promoted in the community as the social norm. This may be achieved by informing and educating the public about the importance and benefits of breastfeeding through public health campaigns.

It needs to be clear across all sectors that exclusive breastfeeding to 6 months of age is recommended and that breastfeeding be continued until at least the age of 12 months with the appropriate introduction of solids. Health campaigns need to be particularly targeted to 'at risk' groups including women from Aboriginal and Torres Strait Islander communities, migrant and refugee

backgrounds. These campaigns should follow a community participatory approach.

Community Action

Support for the breastfeeding mother needs to continue into the community upon discharge with prompt follow up by multidisciplinary community health services to provide continual support and education as required. To ensure the effectiveness of this strategy peer support programs need to be accessible (especially in rural and remote communities) and provide timely credible advice, lactation support services and mentoring programs.

Aboriginal and Torres Strait Islander health workers and lactation consultants and maternal and child health nurses would be best placed to provide information and support to Aboriginal and Torres Strait Islander mothers in their communities.

To increase breastfeeding rates amongst women of CALD backgrounds education programs need to be targeted appropriately to these communities (Mann et al 2003; Kong and Lee 2004; Rossiter and Yam 2000; Scott et al 2001). The use of dietitians as community educators and facilitators of peer led programs would assist to strengthen community action. In Western Australia a project titled 'Good Food for New Arrivals' focuses on breastfeeding and the introduction of solids among African communities. Another WA project has a peer led breastfeeding support group for South Sudanese women and this model could be used as a framework for programs to other CALD communities.

Settings and Supportive Environments

Service providers, support groups, governments and the broader community need to work together to create supportive environments to encourage breastfeeding, rather than independent programs and competing agendas.

Changes to the provision of the baby bonus funding so that mothers are only eligible once they have been involved in antenatal and postnatal education which support and encourage breastfeeding may be a possible strategy to increase breastfeeding rates.

Early discharge from hospital has resulted in mothers going home not feeling comfortable or confident in breastfeeding in their home environment. Making day stay programs available to mothers to give them the opportunity to learn and feel confident with breastfeeding may be a strategy to increase exclusive breastfeeding to 6 months.

Workplace policies and support and provision of adequate facilities in social situations to encourage breastfeeding women to feel more comfortable and welcome to breastfeed in public is required. DAA recommends initiatives requiring workplaces and education institutions to provide breastfeeding friendly locations including required infrastructure to encourage working and studying women to either continue to breastfeed their infants or to express milk for breastfeeding continuation.

The health department website could outline strategies/ recommendations directed at members of the public, including but not limited to restaurant owners, teachers, employers, detailing information on what they can do to encourage and support breastfeeding.
Immigration expects that refugees/ people of CALD backgrounds attend and receive 500 hours of English language classes. It is recommended that an environment supportive of breastfeeding be encouraged for these women to enable them to continue to breastfeed whilst attending TAFE to learn English.

- **It is recommended that the Australian Government establishes an expert committee with broad representation and adequate funding to oversee the implementation of all the recommendations included in the DAA submission. DAA recommends that there is dietetic representation on this group.**

e) Examine the effectiveness of current measures to promote breastfeeding

The report by the Victorian government, Department of Human Services (DHS) 'Give breastfeeding a boost' (2005) refers to a systematic review of evidence which indicates that interventions targeting the prenatal period or both prenatal and postnatal were more effective than those provided only in the postnatal period.

The report outlines the types of interventions found to be effective in promoting breastfeeding. The interventions are listed below and are also supported by the NHMRC (2003).

- Small informal health education groups delivered during the antenatal period
- One to one education
- Antenatal and postnatal peer support programs
- 'Packages of interventions' which include peer support and media campaigns combined with 'structural changes to the health sector', such as rooming-in facilities.

The DHS report also highlighted interventions that did not result in a positive effect on breastfeeding duration. These types of interventions should be avoided in the future due to their limited success.

- Small scale short interventions
- Brief breastfeeding messages given amongst other topics
- Isolated use of print materials
- Brief or no face-to-face interaction
- Delivery of contradictory messages such as encouraging breastfeeding while providing infant formula

Implementation of the Baby Friendly Hospitals Initiative is not mandatory in Australia and therefore advice and support for breastfeeding are not consistent. A Promotion of Breastfeeding Intervention Trial (PROBIT) in

Belarus found that the Baby Friendly Hospital Initiative could produce a 12-fold increase in exclusive breastfeeding at 6 months.

Furthermore, mothers should be encouraged to remain in hospital following childbirth for as long as necessary to be supported with the initiation of breastfeeding. In the WHO report on *Evidence for the 10 steps to successful breastfeeding* it recommends that babies and mothers should practice rooming-in as evidence indicates improved breastfeeding outcomes.

- **DAA recommends that the Baby Friendly Hospitals Initiative be adopted by all hospitals across Australia including strategies such as rooming-in practice, health promotion, development of education resources and hospital support to breastfeed from health professionals.**
- **DAA recommends that 'at risk' populations, e.g. CALD, low socioeconomic status and teenage mothers, receive appropriate interventions to support breastfeeding e.g. resources in key community languages, use of interpreters and targeted initiatives.**
- **DAA recommends that future initiatives to encourage breastfeeding build on the types of effective interventions summarised in a Victorian government report, in addition to those mentioned in section D of this submission.**

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

A study conducted in the Australia Capital Territory found that early weaning of breastfeeding is likely to cost $1-$2 million annually. Therefore, higher exclusive breastfeeding rates could potentially enable significant hospital cost savings nationally and national savings are estimated at $60-$120 million annually. These cost estimates include the treatment of infants and children aged 0 to 4 years, for gastrointestinal illness, respiratory illness, otitis media, eczema and necrotising enterocolitis .

There is increasing evidence of the adverse effects of artificial feeding on several other chronic diseases such as insulin dependent diabetes mellitus, obesity and heart disease. Breastfeeding also has been found to offer some protection against the development of allergies. Therefore, the costs to the health system projected above are likely to be underestimated.

The above figures are also limited to direct costs associated with hospital admissions and do not include non-hospital medical and pharmaceutical costs. To provide some context of potential cost savings, figures from the United States indicate that every $100 spent on hospitalised infants with gastrointestinal illness an additional $80 was spent on indirect and out-of-hospital treatment.

Indirect and intangible costs such as household and workforce productivity associated with time and effort spent nursing sick infants and children at home, and effects on the quality of life should also be noted.

- **DAA recommends the promotion of exclusive breastfeeding to 6 months of age and that breastfeeding be continued until at least the age of 12 months with the appropriate introduction of solids, to assist with reducing of costs to the Australian health care system associated with artificial feeding.**

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