Submission no. 290
AUTHORISED: 17/4/07

Submission for Parliamentary Inquiry into the Benefits of Breastfeeding by Michelle Player

a) The extent of the health benefits of breastfeeding

Breastfed babies and toddlers have lower rates of bowel, respiratory and gastrointestinal illness, are rarely constipated and protection from urinary tract infection can last until well after weaning. Breastfed babies and toddlers are less likely to have tooth decay, eczema and middle ear infection, and allergies will be minimised if a baby is breastfed for at least six months. Breastfeeding is linked to lower rates of obesity, SIDS, juvenile diabetes, leukemia and coeliac disease. The action of breastfeeding enhances eyesight, speech and jaw development.

Breastmilk can be safer if parents or caregivers have low literacy levels and more hygienic, as no water or containers are required.

For mothers breastfeeding has been linked to lower rates of osteoporosis, breast and ovary cancer. It helps mothers lose pregnancy fat quicker, which can be beneficial both physically and psychologically. It can be empowering, relaxing and pleasurable, making it important for stressed or tired new mothers.

As a mother of two breastfeeding children, aged ten and a half months and almost three years (33 months), I believe breastfeeding has laid the foundation for my children's good health and contributes to their health every single day.

Unlike formula, breastmilk is an adaptive living fluid that changes from one feed to the next to suit a babies developing needs. It can contain antibodies and anti-infective properties and I believe this is why my ten and a half month old has never been sick once. Even when others close to him and in daily contact (sister, father, grandparents) had gastroenteritis, he remained well. When he had surgery at three and eight weeks to repair hernias and a prolapsed bowel, I am sure breastmilk was kinder to his recovering body than formula, as well as making the whole 'hospital experience' (pre and post operative feeding, waiting around, waking at night) so much easier for both him and I.

My almost three year old has been 'sick' (as in cold/flu symptoms, fever, vomiting) only three times. Despite being exclusively breastfed for six and a half months, she does have eczema and a peanut allergy. However if she had been formula fed, her eczema would probably have been worse and her body may have shown an intolerance or allergy to ingredients found in formula as babies' developing immune and digestive systems are not meant to be exposed to cow's milk/soy/other ingredients at such a young age. .

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

Any marketing of breastmilk substitutes reinforces the common perception that formula is just as good as breastmilk and is a healthy alternative to breastmilk which produces healthy babies.

When my daughter was around fourteen months I found myself doubting whether a good diet and breastmilk were adequate for her nutrition. As a committed breastfeeder I never considered stopping breastfeeding, but I did consider buying a 'follow on' 'toddler' milk, as a result of advertising. Other mothers not as committed to breastfeeding may be tempted to wean around this time, or when they must return to work. Advertisements for toddler milk make it sound as if it is perfect (or even superior) nutritionally. For other mums who would never even consider breastfeeding a toddler, the existence of such ads could reinforce their beliefs that toddler breastfeeding is not normal/wrong or even disgusting.

While I am unaware of the extent of marketing of breastmilk substitutes in disadvantaged, indigenous or remote communities, I assume these groups have low breatsfeeding rates and any marketing (whether it be advertising or advice given) would only help keep rates low by ensuring bottle feeding is the norm. Any marketing would perpetuate a cycle where there is little or no experience or knowledge of breastfeeding and so no experience or knowledge to pass on.

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

The immediate impact of increased rates of breastfeeding would obviously be healthier babies and toddlers, and happier mothers.

Babies and toddlers would have stronger immune systems and therefore less colds, flu's, middle ear infections, eczema and allergies. Children would have lower rates of obesity, juvenile diabetes, leukemia and coeliac disease, and better eyesight, speech and jaw development.

In the long term this would lead to healthier adults and long term benefits would also be evident for breastfeeding mothers, who will have lower rates of osteoporosis, breast and ovarian cancer.

d) Initiatives to encourage breastfeeding

Initiatives could include:

-An education program for medical staff. Some medical staff currently give wrong and outdated information about breastfeeding and have an ambivalent approach to it. A goal must be set by the Government to have the majority of babies breastfed for at least six months and all health professionals dealing with pregnant women and new mothers should be committed to this. At present Australian Breastfeeding Association counselors (who undergo two years training) are more knowledgeable, committed and experienced in dealing with breastfeeding 'problems', than some GPs or child health nurses. Almost all breastfeeding 'problems' can be solved with patience and perseverance, but unfortunately formula is a quick fix. For the health of our babies and future generations we really must get to a point where formula becomes a last resort, not seen as a quick, healthy solution to breastfeeding problems. The education of health professionals has a major role to play in helping us reach that point.

-An education campaign for the general public. This should be a national campaign with television and newspaper advertisements (as has been done for anti smoking and skin cancer campaigns), and also specific targeting of women. It could be focused on three main areas – the benefits of breastfeeding, addressing factors which make women unlikely to breastfeed or to breastfeed for long periods and dispelling myths associated with breastfeeding.

For breastfeeding to become the norm everyone fro schoolchildren to grandparents must learn of the benefits and this can be done via television and newspapers.

We should be looking at why women aren't breastfeeding or aren't breastfeeding older babies or toddlers. Do they think it will 'wreck' breast shape, do they think it limits freedom? Do they think it means decreased libido? do they think because they had problems with a first baby they will have problems again? Do they not consider breastfeeding because they never see it in everyday life? I think we really need to look at who is breastfeeding and who isn't and address the issues that are stopping women breastfeeding.

We need to dispel myths about breastfeeding. Grandparents, friends, family members or women with past bad experience of breastfeeding sometimes pass on misinformation to mums. They may be unaware that most 'problems' can be solved or older people may refer back to the way they raised children – solid food at three months, timing of feeds, etc. Only education can help dispel myths.

Some type of payment to breastfeeding mothers. An elderly German neighbour once told me this used to occur in Germany. While it is important not to strip mothers of choice in regards to how they feed their babies, a monetary incentive may encourage mothers less likely to breastfeed (disadvantaged, young, with low education levels) to attempt it and stick with it. Mothers could be paid once per month, upto six months. The payment should be small ($30 a week?) and combined with an education program saying 'breastfeed for six months and you will receive $120 per month plus save $X per month on formula costs'. Breastfeeding could be checked by a child health nurse or lactation consultant once per month. There would need to be flexibility and honesty involved – for e.g breastfeeding may stop at two months one week and a mother may claim it stopped just before the three monthly check. Women who have genuine problems with breastfeeding (including, for some cases, being mentally unable to cope) should be assessed by a lactation consultant and could still receive a part or full payment.(?) This is possibly just one for the 'too hard' basket, but if the Federal Government can pay women merely for having babies (Baby Bonus), and it can pay women childcare costs to return to work, then why couldn't it pay women to breastfeed?

-Better support for pregnant women and new mothers. This can best be achieved by using one to one midwifery services (such as at Belmont Birthing Service), where a relationship can be built up with the one midwife before and after birth. This has been proven to lead to less intervention in birth, which then results in more successful breastfeeding due to lower caesarean rates and less drug use. Conflicting advice from too many different sources can also frustrate or confuse a new mother, whereas consistent advice from a known, trusted midwife can lead to more successful breastfeeding. At the Federal level Medicare payments must be available for midwifery services, so that women can seek this type of care from midwives both inside and outside of the hospital system.

-Increased workplace rights of breastfeeding women. All breastfeeding women should be entitled to time to breastfeed (which could be made up if outside of breaks), a private room to breastfeed (not a toilet), a fridge to store expressed breastmilk (if possible) and facilities to wash hands and equipment. Otherwise women will continue to view combining work and breastfeeding as a hassle. If these rights were mandatory I have no doubt breastfeeding rates would increase. Less women would wean to return to work and women in unskilled/semi-skilled work would view breastfeeding as a viable option for them. At present working breastfeeding mothers are most likely to be highly skilled professionals, able to negotiate contracts. An easily replaceable checkout operator or factory worker may not want to 'rock the boat' making demands. Without mandatory workplace rights in relation to breastfeeding the vast majority of working women will continue to be 'bottle feeders'.

e) Examine the effectiveness of current measures to promote breastfeeding

Current measures to promote breastfeeding seem to be adhoc and mostly left to luck or chance.

GPs, midwives and obstetricians can have vastly different opinions and experiences of breastfeeding. Some may encourage a reluctant breastfeeder whereas others may just say "fine, stop breastfeeding, the choice is upto you."

Beyond contact with GPs, midwives or obstetricians I am unaware of any active promotion of breastfeeding. It is all left upto chance – a pregnant woman may go to a GP or hospital which hands out information on breastfeeding, or she may not. She may attend a hospital which holds breastfeeding classes (separate from antenatal classes) or she may not. Unless a woman goes actively searching for help and advice with breastfeeding, she may not get any. The Australian Breastfeeding Association is the largest and best promoter of breastfeeding in Australia, but I sometimes feel as if it is 'preaching to the converted'. A woman with no interest in breastfeeding would be unlikely to come into contact with them or use their resources.

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

A decrease in colds, flu, middle ear infection, eczema, allergies, bowel and gastrointestinal illnesses and middle ear infection for babies and toddlers, a decrease in obesity, juvenile diabetes, leukemia and coeliac disease for children, and a decrease in osteoporosis, breast and ovarian cancer for women, will obviously place less demand on GPs, specialists and hospitals, resulting in massive financial savings to our health system.

To make this possible, funding will be required to increase breastfeeding rates. GPs, midwives and obstetricians may require retraining and education. One to one midwifery care, which provides more pre and post natal care and less intervention in birth, should become the standard model of care for pregnant women/new mothers. It should be available to all women, through all hospitals and outside of hospitals via independent midwives. From the Federal Government this would require midwifery services to be covered by Medicare.

If the majority of Australian babies were breastfed for at least six months, initially there may be an increased need for lactation consultants. However if breastfeeding became the 'norm', with women passing on their knowledge to their family, friend, peers and future generations, breastfeeding 'problems' would become rarer. GPs and child health nurses would be exposed to more cases of successful breastfeeding but may even become a last resort for advice as mothers, grandmothers, sisters, etc would know how to help new mums.

Financial savings and less demand on our health services will result in greater sustainability of our health system, and this can be achieved by increasing the rate of breastfeeding.