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AUSTRALIAN
Rural Nurses & Midwives

16th March, 2007

Mr. James Catchpole,
Committee Secretary,
Standing Committee on Health & Ageing,
PO Box 6021
Parliament House,
Canberra ACT 2600.

Dear Mr. Catchpole

Re Invitation to make a submission to Inquiry into the health benefits of breastfeeding

Thank you for inviting ARNM to provide a submission to the inquiry and I apologise for our delay in response and for the opportunity to extend the deadline.

We undertook canvassing of our membership and other rural midwifery contacts we have and we attracted a good response.
Our submission is brief and really is relevant to only some of the terms of reference and applies to rural and remote situation.

The format of our submission is to make comments under the headings of the terms of reference points.

We would be happy to follow up with any additional information.

Yours sincerely,

Geri Malone
Executive Director,
Australian Rural Nurses & Midwives,

Introduction

Most of our comments regarding this topic under the question of effective measures are reflective of the workforce issues that impact on the ability to provide comprehensive services to women during their pregnancy and post birth period.
The other point to make is that there does appear to be a paucity of meaningful data on breast feeding rates. Whilst there is data on the rates as women leave hospital the anecdotal evidence is that this falls off dramatically but there is no clear evidence available through meaningful data which identifies the contributing factors.

The rates of breast feeding for Indigenous women again is not well documented and difficult to collect, however the anecdotal evidence is that it is low and suffers greatly from lack of support and follow up services.
There still is a lack of services appropriate for Indigenous women and particularly the follow up after discharge from hospital.
Issue of culturally safe services remains relevant and whilst there are some very good initiatives in this area there is more to be done.

Terms of Reference

a. the extent of the health benefits of breastfeeding;

The health benefits of breastfeeding have been well documented for women and children. It is known that these benefits extend even into the adult life of children who were breastfed and into the reproductive health of the next generation. With this in mind it is argued that the promotion of breastfeeding must be seen as a public health issue (O'Luanaigh & Carlson 2005).

Formula, although superior to unformulated cow's milk, is not the same as breast milk and does not confer the same advantages. Longer duration of breastfeeding increases the benefits. Over ten years ago, Inch (1996) argued that for too long those who have wished to promote breastfeeding have talked about the *benefits* it confers - yet we do not talk about the benefits of not smoking, we are emphatic about the *dangers* associated with the practice. We should be equally truthful about the dangers associated with the practice of giving non-human milk to infants.

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

In recent years marketing practices of breast milk substitutes have been partially curtailed e.g. formulae companies are meant to no longer be permitted to directly advertise their products. However, in Australia manufacturers do advertise follow-on milks, suitable for babies over 6 months.

On occasions these ads feature babies who look much younger, implying the suitability of breast milk substitutes to younger babies.

Manufacturers have developed alternate strategies that focus on the worries that the majority of new parents tend to have about their infant's health. Breast milk substitutes are now promoted as solutions to treat so-called medical problems of infants including lactose intolerance, incomplete digestion, baby being 'too hungry' even though many of these problems can be traced back to infant formulae in the initial instance. Information regarding the amount of money spent on the marketing of breast milk substitutes in Australia could not be sourced. However, in the UK it is reported that formula companies spend at least 12 million pound per year on promoting their products, often in the guise of educational materials. This is approximately 20 pound for every baby born in the UK. In return, the UK government spends about 14 pence per baby each year to promote breastfeeding (Thomas 2006).

The advertising of all breast milk substitutes should be outlawed in Australia, as should formula companies being given rein to promote breastfeeding through educational type materials. Thomas (2006) argues that these materials are used to present subtle visual messages that breastfeeding is the jurisdiction of well-resourced, middle class women and any woman falling outside of that group will have to rely on breast milk substitutes if their babies are to be well-nourished.

Lack of government monitoring of the code that prohibits the marketing of breast milk substitutes has led to a dilution of the way the code is interpreted and has allowed loopholes which formula companies are taking advantage of. It is therefore imperative that a government funded monitoring system be put in place that has the power to take action when the code is violated

Many rural and remote midwives working in Indigenous communities express concern re the low incidence of breastfeeding with the obvious health implications in an already at risk group.

"I do have concerns in particularly within the indigenous population and the very low socioeconomic group who don't often see the benefits of breastfeeding. After working with both groups and seeing what these babies get fed on, there is a need to promote healthy substitutes as most of these babies are reared on sunshine powdered milk." Quote from Rural Midwife

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

The health benefits of breastfeeding have been well documented for women and children. It is known that these benefits extend even into the adult life of children who were breastfed and into the reproductive health of the next generation. With this in mind it is argued that the promotion of breastfeeding must be seen as a public health issue (O'Luanaigh & Carlson 2005).

d. initiatives to encourage breastfeeding;

There is evidence to demonstrate that health promoting initiatives aimed at strengthening communities in the UK have had the spin off effect of increasing breastfeeding rates at 6-8 weeks (Hampshire 2002).

There are implications for disadvantaged rural, Indigenous and remote communities within Australia.

The World Health Organisation guidelines and promotion of breast feeding are universally accepted as the standard and should be more widely promoted.

e. examine the effectiveness of current measures to promote breastfeeding;

Our response to this point is focusing on the challenges that exist in rural and remote areas to continue to promote and support breastfeeding and is in the most part related to workforce and the decline of rural birthing services.

In its 2002 investigation into the supply and requirements of the midwifery workforce, the Australian Health Workforce Advisory Committee found evidence of a shortage of nearly1850 midwifes across Australia (AHWAC 2002, p2).
The report also notes as with most health professionals, there are difficulties in the recruitment and retention of midwives to rural and remote areas. The Working Party noted that maldistribution of the midwifery workforce was of major concern in most jurisdictions. A significant issue is that of ensuring staff have access to continuing education and professional development. This is primarily due to the lack of available staff to backfill core staff. (NRHA, 2006)

Birthing in small, rural Australian maternity units is not associated with adverse outcomes for low risk women or their newborn babies (Tracy et al. 2006).
However, the continuing closure of small maternity units in Australia leaves rural women with no option but to travel. It has been estimated that up to 130 rural maternity services have closed in the last decade(NRHA,2006)
This often involves traveling long distances away from their home communities in late pregnancy or early labour, to birth in larger centres.

International and Australian studies conducted in the Northern Territory and Queensland, alert us to the possibility that the impact of this translocation is likely to be negative (Kildea 2003; Hirst 2005; Kornelsen & Grzybowski 2005). It affects not only the birthing experience for the woman but also her and her newborn's future health, breastfeeding incidence and duration and the relationship she has with that child and other children in the family (Kornelsen & Grzybowski 2005; Lundgren 2005; Kornelsen & Grzybowski 2006).

This fragmentation of the services that women are able to access during their pregnancy extends to antenatal and postnatal services.
In some instances although birthing may not be available in their local community they may or may not, be able to access antenatal services locally. There may be shared care arrangements which involves some antenatal care provided by the local GP and/or midwife along with occasions of having to visit their referral Obstetrician or GP/Obstetrician at a regional or metropolitan centre which involves travel. This may actually influence the woman accessing adequate antenatal care as it presents difficulty from economic as well as social perspective.
Likewise when women have to birth away from home the arrangements for postnatal care varies. Postnatal care may be available locally where women may elect to be transferred back to the local facility post birth before being discharged home or alternatively they are discharged direct to home from hospital with no contact with local services unless there are community services available.The contact may only be to present to GP clinic for postnatal follow up. This all adds up to fragmentation of the services during the pregnancy and difficulties in establishing effective professional relationships which impacts on the women's perception of the experience and lack of support. This is particularly significant in that early postnatal period when the establishment of successful breast feeding is so critical.

"There is a large percentage of women leave hospital breast feeding but dramatically drop off without the support of midwives, although there is a lack of data available for the incidence of continuing breast feeding rates after discharge from hospital and follow up services. Shared care with a midwife and GP/ Obstetrician from conception to postnatal would show an increase in breast feeding and for longer duration. The Australian Breastfeeding association have conducted studies in this topic." Quote from rural midwife

Improvement to this situation is dependent upon having sufficient midwives in rural and remote areas that are current in practice and have the opportunities to practice their midwifery skills across the scope of practice.
The challenge for maintaining the skills of rural and remote midwives is a major factor and requires the professional development needs to be adequately addressed.

"In areas where there is no birthing service midwives not only have difficulty maintaining skills and keeping up with changes but there also seems to be little support for them to continue to give parenting information sessions antenatally (especially significant re breastfeeding) or postnatal and support in the community when the mother and babe return. There is a huge need for community midwifery services to be increased in rural/remote areas for this reason and particularly to support Mothers having difficulties with breast feeding which may cause them to give up BF early
Another significant fact is where birthing numbers are low there is more difficulty in getting mothers together for breastfeeding education and encouragement so inidviduals need to be followed up continuously by midwives.

The significance of continuity of care can't be stressed enough as I believe it to be the foundation of continued post natal contact for Mother to midwife regarding difficulties in BF, when without support they give up! " quote from rural midwife

"I agree there is a huge need to increase home visiting but in rural areas this is obviously not an easy task. It is not going to get any easier with fewer midwives and Child Health Nurses going through the system and then getting them into rural remote areas. I see a need for substitute midwives in particular in the indigenous populated areas and training responsible women to help"' quote from rural midwife.

If breastfeeding is to be encouraged then initiatives urgently need to be put in place that:

- prevent the closure of any more maternity units in rural areas
- develop models of midwifery care that are less medicalised
- promote and enable continuity of care by a known midwife throughout the woman's pregnancy, labour / birth and early days of mothering

Models of midwifery that focus on continuity of care (caseload as an example) would better enable rural midwives to maintain their skills and increase their retention in the rural midwifery workforce.

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