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The Parliament of the Commonwealth of Australia

# The Best Start

**Report on the inquiry into the health benefits of breastfeeding**

House of Representatives  
Standing Committee on Health and Ageing

August 2007  
Canberra

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ISBN 978-0-642-78982-2 (printed version)  
978-0-642-78983-9 (HTML version)

Printed by CanPrint Communications Pty Ltd, Canberra.

Cover design by Lisa McDonald, Department of the House of Representatives, Printing and Publishing Office, Canberra.

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## Foreword

Australia is currently experiencing a 'baby boom' with the number of births in 2006 being at its highest level since 1971, and the second-highest since 1911.<sup>1</sup> During the last 'baby-boom' breastfeeding rates were at their lowest. However, since that time, due to the work of groups such as the Australian Breastfeeding Association, breastfeeding rates have increased and more evidence has been found about the health benefits of breastfeeding for the baby and mother.

Breastfeeding is the normal way to feed a baby. The majority of Australian women intend to breastfeed their baby and most initiate breastfeeding after the birth. However, after several weeks or months many women have stopped breastfeeding and are feeding their baby infant formula.

There is a level of concern from government, the community and individuals that when babies are not being breastfed to the recommended six months, they are missing out on the scientifically proven short and long-term health benefits. It is the responsibility of the entire community to ensure the best possible nutrition and health is available to all of its members, beginning with its youngest.

The issues around the low rates of breastfeeding are complex. When a woman makes the decision to breastfeed, what her partner thinks and what the community around her thinks are three of the factors that can influence this decision. Additionally the effect of the interactions with health professionals and provision of breastfeeding support have an effect on the duration of breastfeeding. The effect of having to return to work is also important on breastfeeding duration.

The committee was initially surprised by the level of interest in the inquiry, particularly from members of the community. Much of the evidence obtained was

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<sup>1</sup> Australian Bureau of Statistics media release 'New ABS population estimates show births second highest and deaths highest on record' June 5, 2007; 63/2007

from individuals who wanted to share their own experience and the depth of feeling in these submissions was unmistakable.

However, this is not a simple 'breast versus bottle' argument. The passionate advocates of breastfeeding through those who had an incredibly difficult breastfeeding experience or chose not to breastfeed all have a voice in this inquiry. The committee observed that most mothers are at some point along this spectrum and it is vital that all mothers are supported. The amount of guilt and emotion that surrounds a mother's decision of how to feed her baby was a recurrent theme in the inquiry and one that the committee recognises. The marketing and availability of infant formula was considered by some in the community to be a critical factor in breastfeeding rates. Although there are certainly views in the community that infant formula is 'as good as' breastmilk, the committee contends that most mothers revert to infant formula because they experience significant difficulties with breastfeeding.

The committee considers many of the issues affecting breastfeeding initiation and duration could be addressed by ensuring that all expectant and new mothers have availability to consistent, accurate and timely support for breastfeeding from the health system and the community at large.

Further research into breastfeeding in Australia is also required to develop successful strategies to increase the rate of exclusive breastfeeding to six months. For example, Margaret Barnes of the University of the Sunshine Coast was recently awarded a research grant to investigate the link between breastfeeding problems and assisted conception treatments. She also hopes to develop a midwifery intervention program to educate mothers who have difficulty breastfeeding. This and other research programs will undoubtedly assist efforts to increase breastfeeding duration in Australia.

The committee received 479 submissions, held 10 public hearings and made 3 site inspections. I would like to thank those who put in so much time and effort into their submissions and travelled to appear at public hearings and assist the committee.

It was pleasing to receive submissions and hear evidence from the governments of Queensland, South Australia, New South Wales, Western Australia, Tasmania and the Northern Territory. The committee thanks the remote communities of Pormpuraaw and Kowanyama, on the Gulf of Carpentaria in far north Queensland for hosting a site inspection as part of this inquiry. The committee appreciated the communities' candour.

Finally, I would like to especially thank the Deputy Chair, Steve Georganas MP, the previous Deputy Chair, Jill Hall MP and all the members of the committee.



The committee's focus on fully comprehending the issues that arose from this inquiry is to be commended.

**Hon Alex Somlyay MP**

**Chair**



## Membership of the Committee

Chair            Hon Alex Somlyay MP

Deputy Chair   Mr Steve Georganas MP (from 06/12/06)

Ms Jill Hall MP (until 06/12/06)

Members        Hon Alan Cadman MP

Mrs Justine Elliot MP

Mrs Kay Elson MP

Hon Warren Entsch MP

Mr Michael Johnson MP

Ms Catherine King MP

Mr Ross Vasta MP

## Committee Secretariat

Secretary	Mr James Catchpole
Inquiry Secretary	Ms Pauline Brown
Research Officer	Ms Meg Byrne (22/05/07 to 17/08/07)
Administrative Officer	Ms Lauren Walker



## Terms of reference

The House of Representatives Standing Committee on Health and Ageing has reviewed the 2005-2006 annual report of the Department of Health and Ageing and resolved to conduct an inquiry.

“The Committee shall inquire into and report on how the Commonwealth government can take a lead role to improve the health of the Australian population through support for breastfeeding.

The Committee shall give particular consideration to:

- (a) the extent of the health benefits of breastfeeding;
- (b) evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;
- (c) the potential short and long term impact on the health of Australians of increasing the rate of breastfeeding;
- (d) initiatives to encourage breastfeeding;
- (e) examine the effectiveness of current measures to promote breastfeeding;  
and
- (f) the impact of breastfeeding on the long term sustainability of Australia’s health system.”

(29 November 2006)



## List of abbreviations

ABA	Australian Breastfeeding Association
ABS	Australian Bureau of Statistics
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
ALCA	Australian Lactation Consultants Organisation
AMIHS	Aboriginal Maternal and Infant Health Strategy
APMAIF	Advisory Panel on the Marketing in Australia of Infant Formula
ART	Assisted Reproductive Technology
BFHI	Baby Friendly Hospital Initiative
BFWA	Breastfeeding Friendly Workplace Accreditation
CATI	Computer Assisted Telephone Interview
CDC	Centers for Disease Control (US)
DHA	Department of Health and Ageing
FAO	Food and Agriculture Organisation (UN)
FSANZ	Food Standards Australia New Zealand
GAA	Growth Assessment and Action
GDP	Gross Domestic Product

GP	General Practitioner
GST	Goods and Services Tax
HIV	Human Immunodeficiency Virus
IBCLC	International Board Certified Lactation Consultant
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
IFMAA	Infant Formula Manufacturers Association of Australia
IVF	In Vitro Fertilisation
JIM	Justice and International Mission (Unit of the Uniting Church in Australia)
LBW	Low Birth Weight
LCPUFA	Long Chain Polyunsaturated Fatty Acid
MAIF	Marketing in Australia of Infant Formula
MCHN	Maternal and Child Health Nurse
MGRS	Multicentre Growth Reference Study
MMB	Mothers Milk Bank
NATSINS AP	National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
NCHS	National Centre for Health Statistics (US)
NCSMC	National Council of Single Mothers and their Children
NEC	Neonatal Necrotising Enterocolitis
NHANES	National Health and Nutrition Examination Survey (US)
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
PANDA	Post and Antenatal Depression Association

PATS	Patient Assisted Travel Scheme
PND	Postnatal Depression
PROBIT	Promotion of Breastfeeding Intervention Trial
RACP	Royal Australasian College of Physicians
RFDS	Royal Flying Doctor Service
SIDS	Sudden Infant Death Syndrome
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation







# List of recommendations

## 2. Breastfeeding in Australia

### Recommendation 1

That the Department of Health and Ageing coordinate and oversee the implementation of a national strategy to promote and support breastfeeding in Australia, including providing leadership in the area of monitoring, surveillance and evaluation of breastfeeding data.

### Recommendation 2

The Department of Health and Ageing implement the recommendations in the *Towards a national system for monitoring breastfeeding in Australia* document commissioned by the Commonwealth Government in 2001.

### Recommendation 3

That the Department of Health and Ageing fund research into:

- the long-term health benefits of breastfeeding for the mother and infant; and
- the evaluation of strategies to increase the rates of exclusive breastfeeding to six months.

### Recommendation 4

That the Department of Health and Ageing fund research into best practice in programs that encourage breastfeeding, including education programs, and the coordination of these programs.

### Recommendation 5

That the Department of Health and Ageing fund the Australian Breastfeeding Association to expand its current breastfeeding helpline to become a toll-free national breastfeeding helpline.

#### Recommendation 6

That the Department of Health and Ageing fund a national education campaign to highlight:

- the health benefits of breastfeeding to mothers and babies;
- that breastfeeding is the normal way to feed a baby;
- that the use of breast milk is preferable to the use of infant formula; and
- the supportive role that the community can play with breastfeeding.

#### Recommendation 7

That the Department of Health and Ageing fund an awards program, which provides recognition for workplaces, public areas and shopping centres that have exemplary breastfeeding facilities.

### 3. The health and economic benefits of breastfeeding

#### Recommendation 8

That the Department of Health and Ageing fund a feasibility study for a network of milk banks in Australia including the development of a national regulatory and quality framework within which a network of milk banks in Australia could operate. The feasibility study should include funding pilot programs at the Mothers Milk Bank at the John Flynn Private Hospital, Gold Coast and the King Edward Memorial Hospital milk bank in Perth.

#### Recommendation 9

That the Department of Health and Ageing commission a study into the economic benefits of breastfeeding.

### 5. Breastfeeding challenges

#### Recommendation 10

That the Speaker of the House of Representatives and the President of the Senate take the appropriate measures to enable the formal accreditation by the Australian Breastfeeding Association of Parliament House as a Breastfeeding Friendly Workplace.

#### Recommendation 11

That the Department of Health and Ageing provide additional funding for the Australian Breastfeeding Association to expand the Breastfeeding-Friendly Workplace Accreditation (BFWA) Program nationally to enable the accreditation of more workplaces.

#### Recommendation 12

That the Treasurer move to exempt lactation aids such as breast-pumps, nipple shields and supply lines from the Goods and Services Tax.

#### Recommendation 13

That the Attorney General investigate whether breastfeeding is given suitable consideration in the implementation of shared custody arrangements and also provide advice to the Family Law Court and Family Relationships Centres on the importance of breastfeeding.

### 6. The health system

#### Recommendation 14

That the Department of Health and Ageing fund the Australian College of Midwives to run the Baby Friendly Hospital Initiative in Australia, to facilitate the accreditation of all maternity hospitals.

#### Recommendation 15

That the Department of Health and Ageing work with the Australian Council on Healthcare Standards (and/or equivalent accreditation organisation) towards including Baby Friendly Hospital status as part of the accreditation process.

#### Recommendation 16

That the Commonwealth Government, when negotiating future Australian Health Care Agreements, require state and territory governments to report on the number of maternity wards in public hospitals that have been accredited under the Baby Friendly Hospital Initiative.

#### Recommendation 17

That the Minister for Health and Ageing, in consultation with state and territory health ministers, decide on a standard infant growth chart to be used in all states and territories.

Recommendation 18

That the Minister for Health and Ageing provide Medicare provider/registration numbers to International Board Certified Lactation Consultants (IBCLC) as allied health professionals.

7. Regional, remote and Indigenous communities

Recommendation 19

That the Department of Health and Ageing provide leadership in the area of monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas.

Recommendation 20

That the Commonwealth Government promote breastfeeding within Indigenous Australian communities as a major preventative health measure.

8. The impact of breast milk substitutes

Recommendation 21

That Food Standards Australia New Zealand change the labelling requirements for foods for infants under Standard 2.9.2 of the Food Standards Code to align with the NHMRC Dietary Guidelines recommendation that a baby should be exclusively breastfed for the first six months.

Recommendation 22

That the Department of Health and Ageing adopt the World Health Organisation's International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.

*Breastfeeding is the normal and most appropriate method for feeding infants and is closely related to immediate and long-term health outcomes. Exclusive breastfeeding to the age of six months gives the best nutritional start to infants and is now recommended by a number of authorities.<sup>1</sup>*

## Introduction

### Overview

- 1.1 Breastfeeding ensures the best possible start to a baby's health, growth and development. It provides valuable short and long-term health benefits for babies and mothers. Breastfeeding protects against gastrointestinal and respiratory illnesses, as well as ear infections, which can affect a baby's ability to thrive in the earliest months of life.<sup>2</sup> The health advantages of breastfeeding also translate into benefits for the health system. Evidence shows that breastfeeding positively affects the incidence of chronic disease, including obesity rates, at the population level and is therefore of great significance to public health policy.<sup>3</sup>
  - 1.2 Despite knowledge of the proven health benefits of breastfeeding, Australia's breastfeeding rates fall well short of the levels recommended by both the World Health Organisation (WHO) and the National Health and Medical Research Council (NHMRC).
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1 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 1.

2 Government of South Australia, sub 274, p 5.

3 Smith J, Harvey P, Australian Centre for Economic Research on Health, sub 319, p 7.

Although rates have increased from the low points of the 1960s and 1970s, only a small proportion of mothers are exclusively breastfeeding their babies for the first six months of life, as recommended by the WHO and NHRMC.

- 1.3 The reasons why women do not breastfeed for the recommended period are complex and multifaceted. They include consistency of advice, timing and quality of breastfeeding education, perceptions about infant formula, and the level of community support. Breastfeeding can also be a very emotional issue; guilt and anger can be part of many women's experiences of breastfeeding. Many mothers are surprised to find that breastfeeding can be quite challenging, but with the right advice and appropriate support it seems that many would breastfeed for longer.
- 1.4 Governments need to provide more resources for the practical aspects of breastfeeding support. These include timely support, ensuring consistency of advice from health professionals and providing support to mothers in the early days to enable a good breastfeeding relationship to develop.
- 1.5 The committee considers that there is a leading role for the Commonwealth to take in promoting breastfeeding and improving infant nutrition as a national priority.

## **Setting the context**

- 1.6 On 29 November 2006 the House of Representatives Standing Committee on Health and Ageing resolved to conduct an inquiry into the health benefits of breastfeeding.
  - 1.7 During its previous inquiry into health funding, the committee received a submission and a private briefing from the Australian Breastfeeding Association.<sup>4</sup> This submission highlighted that poor nutrition in infancy has a significant influence on health outcomes throughout life as well as placing a potential financial burden on the health system in the long-term.
  - 1.8 The committee considered this an appropriate inquiry topic, focusing on the health benefits of breastfeeding both in the short and long-term and looking at the longer term effects on the health budget.
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<sup>4</sup> Standing Committee on Health and Ageing, *The Blame Game: Report into the inquiry on health funding* (2006), Commonwealth of Australia.

- 1.9 Additionally, the committee considered that the long-term benefits of breastfeeding are so important that the best way to ensure that more of Australia's youngest have the opportunity for the best possible start in life is to increase the rate of breastfeeding.
- 1.10 The inquiry generated a great deal of interest from the community with a large number of submissions being received and groups wishing to appear at public hearings. The committee was initially surprised by the number of submissions but appreciates the level of commitment to breastfeeding that exists in the community and the public health system.
- 1.11 The committee welcomes the funding of \$8.7 million in the 2007-08 Budget in recognition of the need for breastfeeding education and support. This will fund a community information and education campaign and research into breastfeeding choices.<sup>5</sup>

**Box 1.1 Breastfeeding – education and support - Budget Initiative 2007-08**

*Why is this important?*

- Breastfed infants have lower rates of illness such as asthma, middle ear infections and gastrointestinal illness. Breastfeeding also protects against the development of obesity and Type 2 diabetes later in life.
- In mothers, breastfeeding reduces the risk of developing breast and ovarian cancer as well as osteoporosis.
- This initiative will involve research, improved data collection, an information and community education campaign on the benefits of breastfeeding, and activities to support families such as access to 24-hour advice, and innovative programs for disadvantaged and young mothers.

*Who will benefit?*

- Better information, resources and support for young families will encourage more mothers to start and continue breastfeeding their babies. It will also encourage their families to support continued breastfeeding.
- Higher rates and longer periods of breastfeeding will benefit Australian families by promoting better health for babies and children, and for mothers. This is especially true among younger, lower-income, Aboriginal and Torres Strait Islander and rural families.

*What funding is the Government committing to the initiative?*

- The Government has committed \$8.7 million over four years for initiatives to promote breastfeeding.

*What have we done in the past?*

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5 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Preventing Chronic Disease*, 8 May 2007.

• The Government has provided \$0.9 million over 10 years (1998-2008) to the Australian Breastfeeding Association. Dietary guidelines for children including infants have been developed and a voluntary industry code limiting the marketing of infant formula has been implemented.

***When will the initiative conclude?***

• This is an ongoing initiative.

Source: Department of Health and Ageing website viewed on 30 July 2007 at <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2007-hfact37.htm>.

## **Conduct of the inquiry**

- 1.12 The inquiry was launched on 6 December 2006, with the chair of the committee issuing a media release calling for public submissions.<sup>6</sup> Advertisements calling for submissions were placed in *The Australian* in December 2006 and letters were sent to individuals and peak bodies, including state and territory governments, inviting them to make a submission to the inquiry.
- 1.13 A total of 479 submissions were received (see appendix A) and 36 exhibits were accepted as evidence to the inquiry (see appendix B). Submissions were received from all states and territories from individuals and groups residing in metropolitan, regional and remote areas.
- 1.14 The committee was particularly pleased that six state and territory governments made submissions – Queensland<sup>7</sup>, South Australia<sup>8</sup>, Western Australia<sup>9</sup>, Tasmania<sup>10</sup>, New South Wales<sup>11</sup> and the Northern Territory<sup>12</sup>. The committee also welcomed the contributions from several Commonwealth agencies.
- 1.15 To further involve the community in the inquiry, the committee held ten public hearings in four states between 26 March and 13 June 2007 (see appendix C). Some three site inspections were held by the committee; a visit to the Mothers Milk Bank, a human milk bank, at

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6 Hon Alex Somlyay MP, media release, *Parliament launches new inquiry into breastfeeding*, 6 Dec 2006.

7 Queensland Health, sub 307.

8 Government of South Australia, sub 274.

9 Government of Western Australia, sub 475.

10 Government of Tasmania, sub 364.

11 NSW Health, sub 479.

12 NT Department of Health and Community Services, sub 334.



John Flynn Private Hospital at the Gold Coast and to the Westpac head office in Sydney, as an example of a breastfeeding friendly workplace. To explore the indigenous perspective, the committee travelled to the remote communities of Pormpuraaw and Kowanyama on the western side of the Cape York Peninsula in far north Queensland.

- 1.16 At the public hearings, the committee reserved time for ‘community statements’ when members of the public could attend the hearing and make a short statement in a less structured format. These community statements proved a successful way for the committee to hear the personal stories of those who did not, or could not, participate in the inquiry’s more formal processes.
- 1.17 Copies of the transcripts of the public hearings are available from the committee’s website.<sup>13</sup>
- 1.18 During the course of the inquiry, committee members attended a number of breastfeeding and infant formula information sessions. The committee also utilised several parenting websites with online forums as a means to promote the inquiry and to observe current community perspectives on the topic.

## Scope and structure of the report

- 1.19 The terms of reference for the inquiry were developed to consider both the short-term benefits of breastfeeding as well as the long-term benefits to both the mother and baby, and the health system.
- 1.20 While a large amount of evidence to the inquiry focused solely on the terms of reference, there were a number of ‘recurring themes’ presented to the committee about breastfeeding which are examined in their own right throughout the report. These important concepts and arguments are outlined below:
- breastfeeding is the normal way to feed a baby;
  - breastfeeding is a complex relationship; it is linked to many women’s developing sense of themselves as a mother and it can be

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13 House of Representatives Standing Committee on Health and Ageing, viewed on 30 July 2007 at [www.aph.gov.au/house/committee/haa/index.htm](http://www.aph.gov.au/house/committee/haa/index.htm); PO Box 6021, Parliament House, Canberra, ACT, 2600.

a highly emotional period if there are problems or if a mother feels she cannot continue breastfeeding;

- there is a critical time when breastfeeding support and advice are required, and it is at this time when women need immediate and appropriate help from qualified experts in lactation management;
- breastfeeding has been shown to provide significant health benefits but more research is needed to support this evidence; and there needs to be consistency across Australia in the use of breastfeeding terms in research and data collection;
- the health system can have a significant effect on breastfeeding success, with the advice and support of health professionals being key to a mother's success in initiating breastfeeding;
- Australia no longer has a breastfeeding culture; although people support breastfeeding, acknowledging that it is the best way to feed a baby, they also consider infant formula is a more than adequate substitute; and
- the community also has mixed views of women breastfeeding in public; they do not see it often and may consider it is something that should be kept private especially as a baby gets older.

- 1.21 Chapter 2 presents an introduction to the current state of breastfeeding in Australia. Breastfeeding rates are not adequately monitored in Australia and there needs to be more research into successful promotion of breastfeeding. The chapter outlines existing programs that are working well but indicates these would benefit from more support and increased awareness by the community of the importance of breastfeeding.
- 1.22 Chapter 3 examines the health benefits of breastfeeding for babies and mothers, as well as focusing on the unique properties of human breast milk and the valuable role that milk banks could play in the health system. This chapter also analyses breastfeeding from an economic perspective, discussing the short and long-term impacts on Australia's health system.
- 1.23 Chapter 4 discusses the management of breastfeeding and factors which influence breastfeeding initiation and duration as well as the science of breastfeeding. Some of the major myths and misconceptions about breastfeeding are also considered.
- 1.24 Chapter 5 looks at breastfeeding challenges and the barriers to successful breastfeeding. These include conditions such as postnatal

depression and drug use by a mother. The difficulties that a mother may face when returning to work are discussed as well as the emotion and guilt that can exist around breastfeeding.

- 1.25 Chapter 6 discusses the impact that the health system can have on breastfeeding. During the process of childbirth and through interaction with health professionals there are many opportunities for breastfeeding promotion. Ensuring consistency of advice from health professionals and appropriate training of health professionals in breastfeeding are two areas addressed.
- 1.26 Chapter 7 examines rural and regional experiences of breastfeeding, with an emphasis on Indigenous communities and the challenges posed by a lack of access to services. The committee considers options for ensuring better access to maternal health and breastfeeding support services for women in rural and remote areas.
- 1.27 Chapter 8 considers infant formula and the impact that marketing of infant formula has on breastfeeding. The committee considers the Marketing in Australian of Infant Formula (MAIF) Agreement, how it is different to the World Health Organisation (WHO) code, and how this is working in Australia.

**Box 1.2 An experience with breastfeeding**

Our breastfeeding relationship has been rock solid, intimate and pain free. It is only recently that I realised that our auspicious start is quite uncommon. I have spoken to many mothers who have told me how their first moments with their baby were disturbed and later attachment found problematic. Gabriel and I were fortunate enough we had home visits from my midwife in the first weeks. She answered all my anxious queries about right positioning, duration, and night feeding. I still treasure this intimacy. My toddler is confident, social and affectionate. His digestion is good with regular movements after breastfeeds. He had one skin infection at eight months that required hospitalization. That was quite traumatic, and he stopped eating. Throughout the two weeks of ordeal though, we found comfort in each other's arms and through my breastmilk he kept up his nourishment. To this day he settles easily. Mothering is not easy, there is no recipe. I sometimes doubt myself. Breastfeeding builds my confidence in my mothering capacity. I have greater respect for my body, as i can rejoice in its capacity to nurture. I am more relaxed about feeding him solids. After all I know he gets digestive enzymes and protein from my milk. Best of all it is self regulating. We can communicate. For me it has been the most enjoyable part of mothering, a break in an often hectic day. Breathe and meditate meantime he explores my face with his little hand. I wish it was more accepted and encouraged.

*Source: Kolb F, sub 246, p 1.*



*Even though it is a natural act, breastfeeding is also a learned behaviour. Virtually all mothers can breastfeed provided they have adequate information, and support within their families and communities and from the health care system. They should also have access to skilled practical help from trained health workers, lay and peer counsellors, and formally certified lactation consultants, who can help to build mothers' confidence, improve feeding technique, and prevent or resolve breastfeeding problems.<sup>1</sup>*

## Breastfeeding in Australia

### Overview

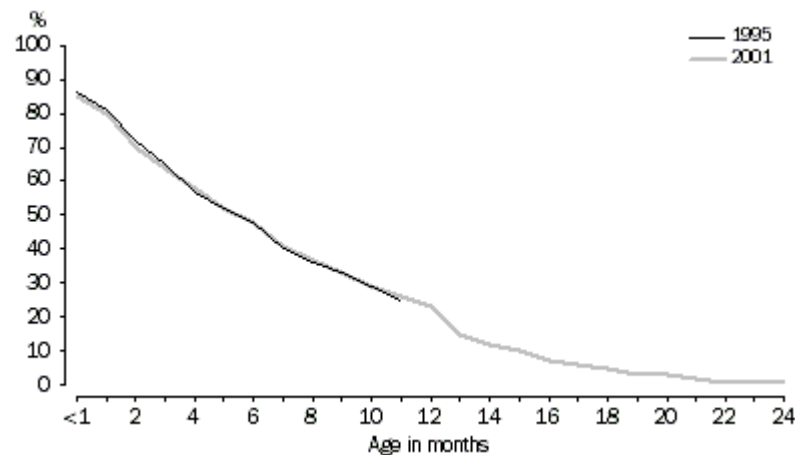
- 2.1 In Australia and internationally, breastfeeding receives attention as a focus for improving public health. Breastfeeding is one of the most important contributors to infant health, providing a range of benefits for the infant's growth, immunity and development. In addition, breastfeeding improves maternal health and contributes economic benefits to the family, health care system and workplace.
- 2.2 Breastfeeding in Australia begins well. The most recent National Health Survey, conducted in 2001, showed breastfeeding initiation rates in hospital have approximately 83 per cent of babies being breastfed upon discharge from hospital.

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1 WHO Global strategy for infant and young child feeding report, viewed on 30 July 2007 at [http://www.who.int/gb/ebwha/pdf\\_files/EB109/eeb10912.pdf](http://www.who.int/gb/ebwha/pdf_files/EB109/eeb10912.pdf).

- 2.3 In 2001, by age six months, around half (48 per cent) of all children were being breastfed. Results from the 1995 and 2001 National Health Surveys indicate that the proportion of children receiving any breast milk declines steadily with age, with the number of fully breastfed babies at three months decreasing to approximately 57 per cent, and at six months, decreasing to approximately 18 per cent being fully breastfed (see Figure 2.1). Finally, at one year of age there are only 23 per cent of babies still receiving any breast milk at all as part of their normal diet and one per cent of children being breastfed by age two.<sup>2</sup>

Figure 2.1 Proportion of children breastfed by age in months 1995<sup>3</sup> and 2001



Source: Australian Bureau of Statistics, *Breastfeeding in Australia, 2001, 2001*, cat no 4810.0.55.001, p 2

## NHMRC's Dietary Guidelines

- 2.4 Breastfeeding is included in the National Health and Medical Research Council's (NHMRC) *Dietary Guidelines for Children and Adolescents in Australia* because of the nutritional, health, social and economic benefits it provides for the Australian community and in acknowledgement of the need for family and community support. The purpose of the Dietary Guidelines is to promote the potential benefits of healthy eating, not only to reduce the risk of diet-related disease, but also to improve the community's health and well-being.
- 2.5 It is indicated in the Dietary Guidelines that exclusive breastfeeding until around six months should be the aim for every infant, which is in line with the World Health Organisation's recommendation. The Guidelines also recommend that mothers then continue breastfeeding

2 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001 (2001)*, cat no 4810.0.55.001, p 2.

3 Note: data by age in months is only available from the 1995 NHS for children under the age of one.

until 12 months of age and beyond if both the mother and the infant wish.<sup>4</sup>

- 2.6 In 2003 when the Dietary Guidelines were published, they articulated the goal that 50 per cent of infants should be exclusively breastfed for the first six months within 'a few years'. It further proposed that within a decade 80 per cent of infants in Australia should be exclusively breastfed for six months.<sup>5</sup>
- 2.7 The most recent data on exclusive breastfeeding was obtained through the 1995 National Health Survey which indicated that only 18.6 per cent of infants were fully breastfed at six months (see Table 2.2 for definitions).<sup>6</sup> It seems unlikely in 2007 that the rate of 50 per cent, let alone 80 per cent, exclusive breastfeeding at six months is being achieved.<sup>7</sup> Additionally as there is no mechanism for national monitoring of infant feeding rates, it is not possible to measure the current rates of breastfeeding on a national basis.

## The national perspective

- 2.8 Many individuals and organisations are increasingly concerned about the incidence and duration of breastfeeding in Australia. Australia has included breastfeeding in its national health goals and targets and all states and territories have accorded high priority to maximising initiation rates and the duration of breastfeeding.<sup>8</sup> In 2001, the Australian Health Ministers endorsed *Eat Well Australia 2000-2010*, a national framework for population based action in public health nutrition for all Australians.<sup>9</sup>
- 2.9 The Commonwealth Government funded a range of activities through the \$2 million National Breastfeeding Strategy (1996 – 2001) including research and breastfeeding projects and resources. The

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4 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 14.

5 Key Centre for Women's Health in Society, University of Melbourne, sub 294, p 5; National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 307.

6 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 3.

7 Key Centre for Women's Health in Society, University of Melbourne, sub 294, p 6.

8 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 306.

9 Government of Western Australia, sub 475, p 1.

Commonwealth provided support for the work of the Australian Breastfeeding Association for the last ten years at \$90,000 per year. The Commonwealth Government has also supported the Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement (1992) (MAIF Agreement) as the Government's response to the World Health Organisation's International Code of Marketing of Breast-milk Substitutes (WHO Code).<sup>10</sup>

2.10 State governments also provide financial support for breastfeeding programs and encourage breastfeeding through policy documents. In Queensland the *Optimal Infant Nutrition: Evidence-Based Guidelines 2003 – 2008* were developed to improve the healthy growth and development of infants and children by promoting and supporting the WHO and NHMRC infant feeding recommendations.<sup>11</sup> The plan identified priority population groups in addition to outlining partnerships and key actions required to influence the provision of optimal infant nutrition. The guidelines aim to achieve by 2008:

- breastfeeding rates at discharge from hospital of at least 90 per cent;
- exclusive breastfeeding at three months of at least 60 per cent; and
- exclusive breastfeeding at six months of at least 50 per cent.<sup>12</sup>

2.11 In recent years promoting breastfeeding has been a priority for NSW Health. They have developed a comprehensive NSW Health Breastfeeding Policy which was released in April 2006 and is mandatory for all Area Health Services. NSW Health has also run area level planning workshops for Area Health Services to ensure adequate local compliance. The policy includes five strategic areas for action for the NSW Department of Health and Area Health Services:

- organisational support for an enhanced, coordinated NSW Health effort;
- workplace development and provision of breastfeeding-friendly workplaces;
- provision of evidence-based health services;
- intersectoral collaboration with organisations outside of the NSW Health system; and

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10 Department of Health and Ageing, sub 450, p 3.

11 Bligh A, Deputy Premier, Queensland Government, sub 12, p 1.

12 Queensland Health, sub 307, p 8.



- monitoring and reporting of breastfeeding rates.<sup>13</sup>
- 2.12 Groups such as the Public Health Association of Australia<sup>14</sup>, the Royal Australasian College of Physicians<sup>15</sup>, the Australian Medical Association<sup>16</sup> and the Pharmaceutical Society of Australia<sup>17</sup> have also published position statements in support of breastfeeding.

### Recommendation 1

- 2.13 **That the Department of Health and Ageing coordinate and oversee the implementation of a national strategy to promote and support breastfeeding in Australia, including providing leadership in the area of monitoring, surveillance and evaluation of breastfeeding data.**

## The Australian Breastfeeding Association

- 2.14 The Australian Breastfeeding Association, the ABA (formerly the Nursing Mothers Association of Australia), is one of the country's largest women's non-profit organisations and is Australia's leading source of breastfeeding information and support. It was established by six mothers in 1964, when the breastfeeding rates were approaching their lowest point. The ABA is represented in all Australian states and territories.
- 2.15 The ABA provides support and encouragement for women who want to breastfeed their babies, and raises community awareness of the importance of breastfeeding and human milk to infant and maternal health. They run a volunteer-based 24 hour telephone hotline for mothers who are experiencing breastfeeding difficulties, breastfeeding education classes and seminars for health professionals. The ABA has a Lactation Resource Centre with one of the most comprehensive collections of breastfeeding information in the world. The ABA plays an integral part within the health sector in planning and assisting with implementation of breastfeeding services in the community.

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13 NSW Health, sub 479, p 6.

14 Public Health Association of Australia, sub 181.

15 The Royal Australasian College of Physicians, sub 174.

16 Australian Medical Association, sub 358.

17 Pharmaceutical Society of Australia, sub 154.

## Breastfeeding rates in Australia

- 2.16 Breastfeeding rates reach their peak when women are discharged from hospital. However, the exclusivity and duration of breastfeeding decline dramatically once women are discharged from hospital, and both fall well short of the World Health Organisation recommendations and the Dietary Guidelines.<sup>18</sup> A study in the ACT in 2002 found that while breastfeeding was initiated by 92 per cent of participants, only one in ten babies in the ACT is exclusively breastfed for the recommended six months.<sup>19</sup>
- 2.17 When Australia's breastfeeding rates are compared with those of developed countries it can be seen that the initiation rate is similar, but the continuing rate lags behind Sweden and Norway and is similar to other countries such as the US and Britain.

Table 2.1 Breastfeeding rates around the world in 2002

Country	% of mothers who start	% who continue 6 months or longer
Sweden	98	53
Norway	98	50
Poland	93	10
Canada	80	24
Netherlands	68	25
Britain	63	21
United States	57	20
Australia (2001/1995)	83 <sup>20</sup>	18 <sup>21</sup>

Source <http://kellymom.com/writings/bf-numbers.html> viewed on 24 July 2007

- 2.18 Breastfeeding rates in Australia began to decrease in the 1950s, reaching a low point in the late 1960s – early 1970s (see Figure 2.2). There are complex reasons as to why these rates dropped, including the increase in availability of infant formula and its promotion by the health system.<sup>22</sup>

18 Women's Electoral Lobby, sub 310, p 9.

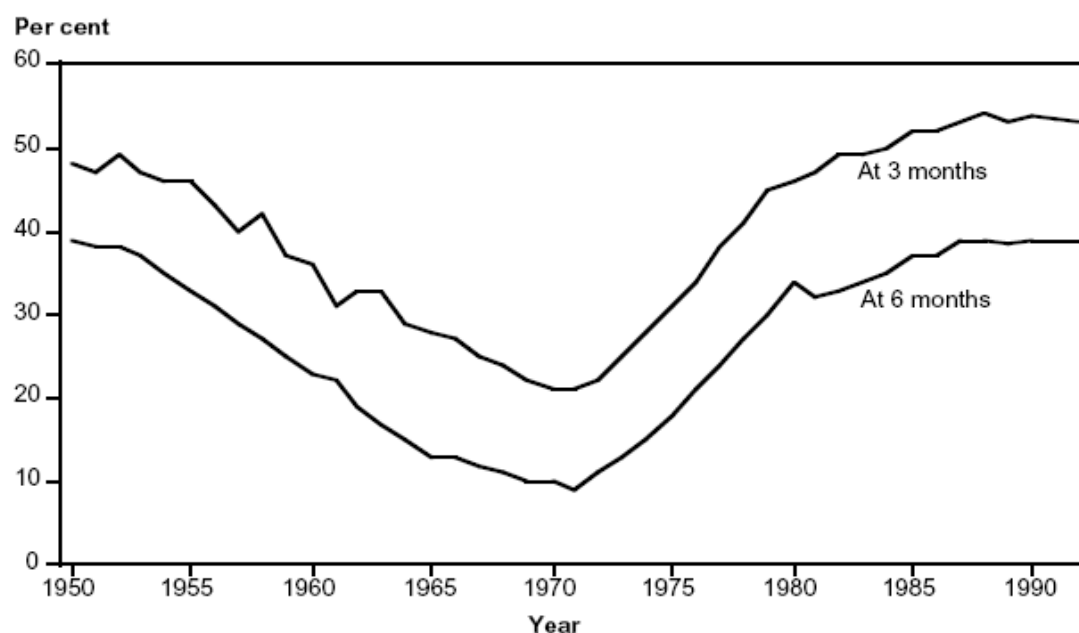
19 Lording R, sub 186, p 13.

20 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001* (2001), cat no 4810.0.55.001, p 2.

21 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 3.

22 Minchin M, *Breastfeeding Matters* (1998), 4<sup>th</sup> Ed, Alma Publications, p 223.

Figure 2.2 Mothers fully breastfeeding at three and six months, Victoria, 1950-1992



Source <http://www.aihw.gov.au/publications/index.cfm/title/3800> p 194

## Monitoring breastfeeding

- 2.19 Australia has no reliable national data collection system in place to effectively monitor infant feeding practices.<sup>23</sup> The most recent nationally reliable data was sourced by the Australian Bureau of Statistics in 2001, which included breastfeeding as a health risk factor topic but there are no recent figures to monitor trends in infant feeding practices. Additionally, the 2007 National Health Survey has not included breastfeeding as a health risk factor; however, it may be considered for the survey in 2010.
- 2.20 The committee is concerned that the rates of breastfeeding in Australia are not appropriately monitored. One reason is that terms and definitions are not consistent which can make it difficult to compare studies of breastfeeding rates. This lack of clear definitions has made the interpretation of data linking breastfeeding with infant health, nutrition, growth and development and maternal fertility difficult.<sup>24</sup>

23 Tyler C, sub 242, p 1.

24 Australian Food and Nutrition Monitoring Unit, *Towards a national system for monitoring breastfeeding in Australia: recommendations for population indicators, definitions and next steps*

- 2.21 There are varying definitions of breastfeeding terms and time periods. For example 'breastfed' may mean exclusively breastfed or it may mean that an infant took breast milk at some time in the survey period. The age at which breastfeeding occurs is also subject to interpretation: 'at three months' may mean over the three-month period or until some time in the third month.<sup>25</sup>
- 2.22 The 2001 document, *Towards a national system for monitoring breastfeeding in Australia: recommendations for population indicators, definitions and next steps*, commissioned by the Commonwealth Government, highlighted the need for, and was a first step towards, standardising the monitoring and reporting of breastfeeding practices in Australia. It included the development of standardised approaches to monitoring breastfeeding, adoption of WHO standard definitions of breastfeeding practices and a 'core' set of breastfeeding indicators (see Table 2.2). This national system, however, has never been implemented.

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(2001), p 31.

25 Australian Institute of Health and Welfare, *Australia's Food and Nutrition* (1994), cat no 8904.0, p 192.

Table 2.2 Summary of the WHO definitions of breastfeeding

<i>Category of infant feeding</i>	<i>Requires that the infant receive</i>	<i>Allows that the infant receives</i>	<i>Does not allow the infant to receive</i>
Exclusive breastfeeding (EBF)	Breast milk (BM) including colostrum, expressed breast milk (EBM) or breast milk from wet nurse	Drops, syrups (vitamins, minerals, medicines)	Anything else
Predominant breastfeeding (PBF)	BM, including EBM or from wet nurse, as the predominant source of nutrition	Liquids (water and water-based drinks, fruit juice, ORS), ritual fluids and drops or syrups (vitamins, minerals, medicines)	Anything else (in particular, non-human milk, food based fluids)
Full breastfeeding (FBF)	BM, including EBM or BM from wet nurse	Substances specified for EBF or those specified for PBF	Anything else (in particular, non-human milk, food based fluids)
(Sum of Exclusive and Predominant BF)			
Complementary breastfeeding (CBF)	BM and solid or semisolid foods or non-human milk	Any food or liquid including non-human milk, as well as BM	
Non-breastfeeding (NBF)	No BM	Any food or liquid including non-human milk	BM, including EBM or from wet nurse
Breastfeeding (BF)	BM	Any food or liquid including non-human milk, as well as BM	

*Source: Australian Food and Nutrition Monitoring Unit, Towards a national system for monitoring breastfeeding in Australia: recommendations for population indicators, definitions and next steps (2001), p15.*

2.23 The Australian Breastfeeding Association is amongst the chorus of voices that consider the national monitoring of breastfeeding practices inadequate. The Women's Electoral Lobby notes that there is currently no comprehensive national monitoring and surveillance system in place to monitor and report breastfeeding patterns and consider that the data is important to inform policy.<sup>26</sup> The Dietitians Association of Australia consider adopting the recommendations of the report *Towards a national system for monitoring breastfeeding in Australia: recommendations for population indicators, definitions and next steps* would be of great value in determining the barriers to initiation and continuation of breastfeeding and possible initiatives to increase breastfeeding rates.<sup>27</sup>

2.24 The New South Wales and Queensland health departments have used the recommendations from the *Towards a national system for monitoring*

26 McKenzie I, Women's Electoral Lobby, transcript, 7 May 2007, p 31; Tyler C, sub 173, p 1.

27 Dietitians Association of Australia, sub 223, pp 3-4.

*breastfeeding in Australia* report to develop and refine the indicators and measurements in their state wide computer assisted telephone interview (CATI) surveys. CATI surveys have been used to survey mothers on their breastfeeding rates. This information could be usefully shared with other states and territories and with federal agencies such as the ABS to improve methods for monitoring breastfeeding.<sup>28</sup>

- 2.25 As mentioned earlier, the committee has recommended that the Commonwealth provide national leadership in the area of monitoring, surveillance and evaluation of breastfeeding data. The committee considers that having systematic collection, analysis, interpretation and evaluation of breastfeeding data will enable a more accurate picture of breastfeeding rates to be obtained and enable a clearer evaluation of the effects of breastfeeding. To this end, the committee considers the adoption of the recommendations in the *Towards a national system for monitoring breastfeeding in Australia* document is a vital step in ensuring consistency of terms in data collection and research. The committee responds accordingly.

## **Recommendation 2**

- 2.26 **The Department of Health and Ageing implement the recommendations in the *Towards a national system for monitoring breastfeeding in Australia* document commissioned by the Commonwealth Government in 2001.**

## **Research**

- 2.27 There is a lack of quality Australian data on the effectiveness of measures to promote breastfeeding and improve initiation and duration of breastfeeding. This can be attributed to the fact that it has been difficult to obtain funding for applied breastfeeding research in Australia. Competition for medical research funding in general is significant and breastfeeding may not be considered 'cutting edge or sexy'.<sup>29</sup> The Public Health Association considers it is time for a competitive funding round for grants, scholarships and fellowships for further research into breastfeeding.<sup>30</sup> Dr Julie Smith noted that the

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28 New South Wales Centre for Public Health Nutrition, sub 178, pp 12-13.

29 Binns C, transcript, 26 March 2007, p 14.

30 Amir, L, Public Health Association, transcript, 4 June 2007, p 20.

quantum of research into breastfeeding in Australia is minuscule and it parallels the meagre resources applied to collection of any national data on breastfeeding which might assist with such research.<sup>31</sup>

- 2.28 There is support for the focus of research to be directed towards doing more to help women to continue breastfeeding.<sup>32</sup> Professor Colin Binns noted that there is a marked lack of good intervention trials to promote the increased duration of breastfeeding in Australia and it is important that funds be made available to fund such trials.<sup>33</sup> This will provide more information as well as building capacity in the area which should assist with increasing breastfeeding duration.
- 2.29 Dr Smith also notes that it is important to consider whether that research funding is really supporting national policy goals for breastfeeding. Consideration of the NHMRC funded projects purportedly 'related to breastfeeding' confirms that most of its funded research is not focused on the goal of increasing breastfeeding. Rather it is predominantly directed to investigating the immunological, biochemical or nutritional properties of human milk. This research field is more relevant to the research and marketing needs of the infant food industry than it is to a public health agenda of promoting or supporting breastfeeding. It is also an area where current empirical knowledge is already sizable.<sup>34</sup>
- 2.30 The nature of breastfeeding research can be complex. Queensland Health noted that it is difficult to desegregate the various behavioural characteristics and identify breastfeeding as a single issue of interest when research is being conducted. For example, behavioural issues associated with the decision of whether or not to breastfeed may also depend upon other practices conducted in the family, such as the early introduction of solids and the beliefs within the family about the appropriate introduction of solids.<sup>35</sup>
- 2.31 The Division of Nursing and Midwifery at La Trobe University noted that it may be beneficial to establish a national specialised research centre, which could build a research program, such as was established for immunisation research (National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases).<sup>36</sup>

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31 Smith J, sub 474, p 2.

32 Jones L, sub 137, p 1.

33 Binns C, sub 86, p 6.

34 Smith J, sub 474, pp 2-3.

35 Lee A, Queensland Health, transcript, 17 April 2007, p 6.

36 Division of Nursing & Midwifery, La Trobe University, sub 184, p 4.

2.32 Infant formula manufacturers may fund research and provide support for health professionals but this is a complex and controversial topic.<sup>37</sup> The Australian Lactation Consultants Association noted that when formula companies provide information to health professionals about their products, it is not always supported by research.<sup>38</sup> The Royal Australasian College of Physicians (RACP) has developed guidelines for its members for the funding of paediatric research by formula companies.

Research sponsored by a formula company may become a vehicle for the promotion of the formula and the concept of artificial feeding. It is inappropriate for professional associations in the field of human health to accept from formula companies funding for the running of conferences, airfares of speakers or delegates, sponsorship of sessions, meals or secretariat assistance with organisation. Trade displays are acceptable. Gifts or financial incentives for health workers are ways of ensuring formula market share. Regular education during in-service training to increase awareness of these ethical matters would benefit health professionals.<sup>39</sup>

2.33 The committee is pleased that there is a research and program evaluation component in the May 2007 breastfeeding budget initiative. The committee encourages the Department of Health and Ageing to promote further research ensuring that it supports breastfeeding initiation and duration and not supporting research into making infant formula more like breast milk.

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### **Recommendation 3**

2.34 **That the Department of Health and Ageing fund research into:**

- **the long-term health benefits of breastfeeding for the mother and infant; and**
- **the evaluation of strategies to increase the rates of exclusive breastfeeding to six months.**

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37 Weller J, sub 61, p 1.

38 Moody G, Australian Lactation Consultants Association, transcript, 4 June 2007, p 33.

39 'Guidelines for the Funding of Paediatric Research by Formula Companies', viewed on 30 July 2007 at <http://www.racp.edu.au/download.cfm?DownloadFile=AE98B656-2A57-5487-DF63DE35C7581397>.



## Factors affecting breastfeeding

- 2.35 The high rates of breastfeeding initiation suggest that most women want to breastfeed. As stated earlier, breastfeeding initiation rates in hospital have approximately 83 per cent of babies being breastfed upon discharge from hospital.<sup>40</sup> However, after initiating breastfeeding, many women are not continuing to breastfeed beyond a couple of weeks after the birth.
- 2.36 A woman's decision to breastfeed is influenced by many factors: demographic, psychological, cultural and social, and it is often difficult to identify which, if any, is of greater importance. Additionally different mothers will not necessarily place the same emphasis on each factor.<sup>41</sup>
- 2.37 The Centre for Public Health Nutrition developed a conceptual framework that illustrates the individual, group and social level influences on breastfeeding (see Figure 2.3). This framework demonstrates that breastfeeding can be influenced by many factors.<sup>42</sup> Group level and societal level influences may interact in either positive or negative ways with individual factors such as maternal knowledge and skills. For example, a mother may plan to breastfeed, but a non-supportive environment in the hospital may lead to her deciding to stop breastfeeding early. Similarly, even if breastfeeding is still occurring at hospital discharge, a lack of support at home or in the community may also lead to her stopping early.<sup>43</sup>

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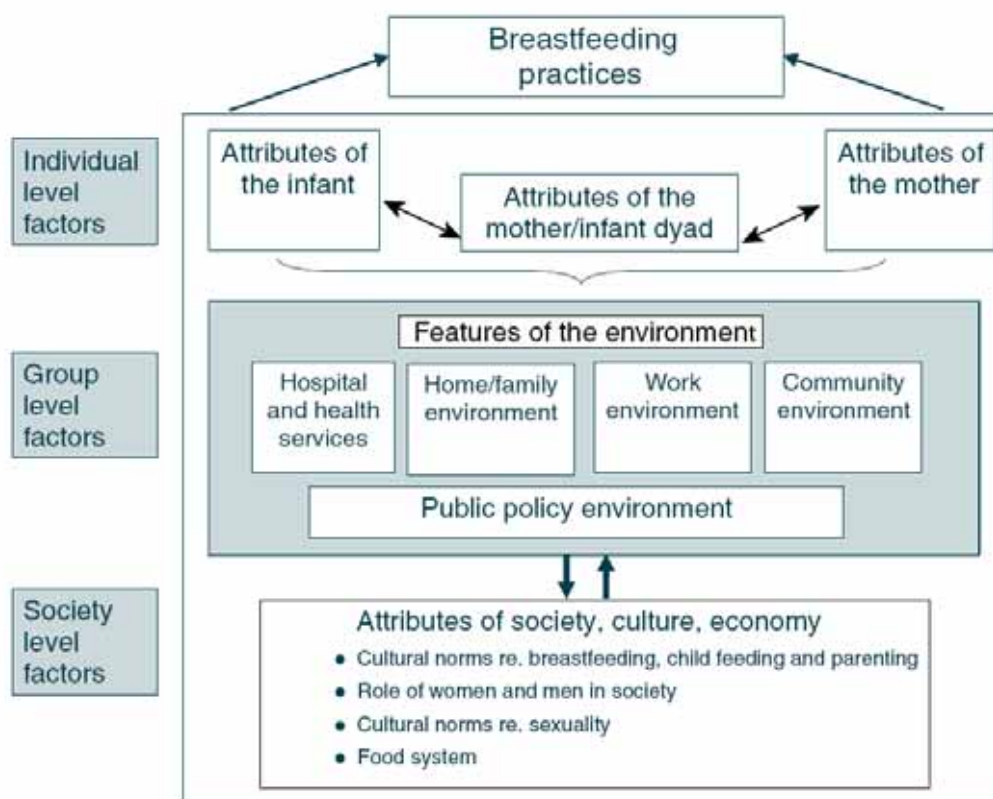
40 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001* (2001), cat no 4810.0.55.001, p 2.

41 Brodribb W, sub 312.

42 Hector D, King L, Webb, K, 'Factors affecting Breastfeeding Practices – applying a conceptual framework', NSW Public Health Bulletin (2005), vol 16, no 3-4, p 53.

43 Hector D, King L, Webb, K, 'Factors affecting Breastfeeding Practices – applying a conceptual framework', NSW Public Health Bulletin (2005), vol 16, no 3-4, p 54.

Figure 2.3 A conceptual framework of factors affecting breastfeeding practices



Source Hector D, King L, Webb, K, 'Factors affecting Breastfeeding Practices – applying a conceptual framework', *NSW Public Health Bulletin*, (2005), vol 16, no 3-4, p 53.

- 2.38 The loss of collective knowledge about breastfeeding, due in part of the decrease in breastfeeding in the 1970s, has led to a community and a health system where breastfeeding is not regarded as the default source of nutrition for a baby. There are many women having babies who have never seen a baby being breastfed. Their own mothers may not have breastfed. This has meant that women in Australia have lost a wealth of knowledge and confidence which would enable them to see breastfeeding as the normal and only way to feed their babies.<sup>44</sup>
- 2.39 The main reason women give for choosing to breastfeed is the health benefits of breastfeeding for their baby. Other reasons included family influence, and because it was more convenient than formula feeding. The decision to breastfeed or formula feed is often made early in pregnancy or before conception and women who decide to breastfeed before they become pregnant tend to breastfeed for longer.
- 2.40 The lack of support and information from health professionals, as well as from the wider community are seen as two of the more

44 Heppell M, sub 291, p 4.

significant factors which make the task of continuing to breastfeed more difficult.<sup>45</sup>

## Individual factors that influence breastfeeding

2.41 Individual factors which are positively associated with a longer duration of breastfeeding are:

- an intention to breastfeed;
- earlier timing of the decision to breastfeed;
- increasing maternal age;
- higher maternal education;
- not smoking or smoking less; and
- being married or being in a relationship.<sup>46</sup>

2.42 Women, in general, are less likely to choose to breastfeed if they:

- are of low socio-economic status;
- are less educated;
- have language, literacy or cultural barriers limiting access to impartial information;
- are younger mothers (less than 25 years of age);
- smoke (which may be linked to that fact that smoking inhibits lactation capacity);
- feel that breastfeeding labels them solely as a mother and they want to re-establish their identity as an individual; or
- are depressed.<sup>47</sup>

2.43 If women in these groups do breastfeed, they tend to do so for a shorter duration. Women also tend to breastfeed for a shorter duration if they are obese or have insufficient breastfeeding

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45 Cheers A, sub 29, p 6; BellyBelly.com.au, sub 441.

46 Forster D, McLachlan H, Lumley J, Factors associated with breastfeeding at six months postpartum in a group of Australian women, *International Breastfeeding Journal* (2006), Vol 1 no 18.

47 Department of Health and Ageing, sub 450, pp 5-6.

knowledge. However, first-time mothers are more likely to breastfeed.<sup>48</sup>

- 2.44 The timing of the decision to breastfeed plays a role in both breastfeeding initiation and duration. Deciding to breastfeed while pregnant as distinct from deciding after birth is a strong predictor across almost all groups of women, including those with less formal education, younger women and those with less social support.<sup>49</sup>

## Group and social factors that influence breastfeeding

- 2.45 Group and social factors that undermine a woman's confidence or negatively influence initiation as well as duration of breastfeeding include:
- lack of support by a partner;
  - perceived or genuine lack of freedom and independence;
  - inconsistent advice from health professionals and peers;
  - lack of role models;
  - the misconception that infant formula is nutritionally equivalent to breast milk;
  - embarrassment caused by negative and ill-informed community attitudes;
  - lack of community support for breastfeeding in public places; and
  - cultural attitudes.<sup>50</sup>

## Partners

- 2.46 Partners are a critical link in both the initiation and duration of breastfeeding. The Perth Infant Feeding Study Mark II found that the mother's perception of her partner's infant feeding preferences was a common factor in both breastfeeding initiation and duration.<sup>51</sup> Four

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48 Department of Health and Ageing, sub 450, pp 5-6.

49 Forster D, McLachlan H, Lumley J, Factors associated with breastfeeding at six months postpartum in a group of Australian women, *International Breastfeeding Journal* (2006), Vol 1:18.

50 Department of Health and Ageing, sub 450, p 8.

51 Binns C, Graham K *Perth Infant Feeding Study II: Report to the Department of Health and Ageing* (2005), Curtin University, p 78.

fathers wrote in support of their partners' breastfeeding.<sup>52</sup> One commented on the lack of encouragement from the wider community for breastfeeding mothers:

It is truly unfortunate when we consider the ease with which we have come to accept many less than positive images of women in public, that so many are embarrassed by one of the most beautiful interactions between two human beings.<sup>53</sup>

- 2.47 Evidence given to the committee indicated that clientele of John Flynn Private Hospital in Queensland have little or no family around them and research indicated that partners were their main support structure.<sup>54</sup> In response to this, the hospital chose to focus on the fathers, invite them to antenatal classes and educate them about what the baby does, what is normal and what to expect:

You will find a dad up in the middle of the night making sure that the baby is on properly, helping and that sort of thing which is lovely. The fathers have been instrumental in the mothers successfully breastfeeding.<sup>55</sup>

- 2.48 Queensland Health noted that their data did not support the role of men to the same degree; in comparison, family, friends and mothers were seen to be the most important source of support in Queensland. However, this was seen to exemplify the difficulty of making state comparisons when there is no standard question or approach or coordinated response, as referred to earlier.<sup>56</sup>

- 2.49 As the support of partners is important, many hospitals include partners in antenatal classes or special classes just for partners. The Royal Women's Hospital in Melbourne runs a men-only program called 'Talking Dads'.<sup>57</sup> This program was designed to try and better support men in the whole pregnancy, labour, birth and early parenting continuum; to give them more information and show them how they can help.

- 2.50 However, if a partner was not breastfed himself, then his attitude can have a negative influence on the woman who is trying to breastfeed.

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52 Valente P&M, sub 257, p 1; Hendriks M, sub 262, p 2; Cameron B, sub 266, p 1; Dawson B, sub 309, pp 1-4.

53 Cameron B, sub 266, p 1.

54 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 22.

55 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 22.

56 Lee A, Queensland Health, transcript, 17 April 2007, p 9.

57 Moorhead A, Royal Women's Hospital, transcript, 7 June 2007, p 33.

There is a whole generation out there who did not breastfeed and were not breastfed, and their attitude tends to be, 'It did not do me any harm.'<sup>58</sup>

## Successful strategies to encourage breastfeeding

- 2.51 There are successful strategies already in existence in Australia to promote breastfeeding and support breastfeeding mothers. Community organisations such as the ABA play a significant role in breastfeeding promotion and breastfeeding success. Hospitals that have implemented the Baby Friendly Hospital Initiative (see chapter 6) report an increase in breastfeeding initiation and there are community based initiatives which show a noticeable increase in rates.<sup>59</sup>
- 2.52 There are a certain types of programs which have been seen to be more successful. These include structured education programs such as breastfeeding classes as well as education programs that also include ongoing support. Peer support or counselling programs have also been shown to work.<sup>60</sup> The Baby Friendly Hospital Initiative's 10 Steps to Successful Breastfeeding marries together the concept of peer and professional support (see chapter 6).<sup>61</sup>
- 2.53 Coordination of services can be an issue. While the value of breastfeeding support from health professionals is well documented and is well established in Australian health care services, there is little coordination between the various providers of this support. For example, prenatal and postnatal counselling and education, hospital policies and procedures, and follow-up support given by child and family health nurses, lactation consultants, general practitioners and other groups are often developed in isolation and with little cross-discipline consultation.<sup>62</sup>
- 2.54 The committee was pleased to hear about the programs that are working in the community and in the health system but considers

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58 Brittain H, Logan Hospital, transcript, 18 April 2007, p 26.

59 Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 11.

60 Centre for Community Child Health, *Breastfeeding Promotion Practice Resource* (2006) p 10; Gardiner N, sub 420, p 1.

61 New South Wales Baby Friendly Health Initiative, sub 339, p 21.

62 Webb K, Stickney B, Heywood P, 'Breastfeeding and the Public's Health', NSW Public Health Bulletin (2005), vol 16, no 3-4, p 40.

there needs to be more coordination of programs such as these to reduce duplication of resources and increase consistency. In particular it commends the work of the Queensland Government in implementing the *Universal postnatal contact service* and the NSW Government in developing and implementing the *Breastfeeding in NSW: Promotion, Protection and Support Policy*.<sup>63</sup>

**Box 2.1 Queensland's universal postnatal contact service - 2007**

The Queensland Government announced a universal postnatal contact service, a \$29.67 million program, expected to be rolled out across the state by 2012.

Under this program, all mothers of newborns will receive follow-up contact after they leave hospital to ensure they are coping with the early stresses of parenthood. Under the Universal Postnatal Contact Service:

- all mothers of newborns will receive one occasion of contact by a qualified health professional – mostly a nurse – through a phone consultation, a home visit or by visiting their nearest community health centre;
- the contact will occur within ten days of discharge and will aim to assess how the baby and family are coping and to provide appropriate support where necessary;
- further assistance from the health system will be managed by Queensland health services or other government agencies and relevant non-government organisations;
- offers to provide the contact service will occur prior to mothers being discharged from hospital to determine the level of need and how the family would like to be contacted.

*Source: Hon Peter Beattie, Premier, Queensland, media release, Beattie Government to enhance support to new parents, 20 May 2007.*

**Recommendation 4**

- 2.55 **That the Department of Health and Ageing fund research into best practice in programs that encourage breastfeeding, including education programs, and the coordination of these programs.**

63 NSW Department of Health, *Breastfeeding in NSW: Promotion, Protection and Support* (2006); Develin L, NSW Health, transcript, 4 June 2007, p 76.

## Breastfeeding education

2.56 There is a clear need for breastfeeding education to occur, at a variety of times and to an audience beyond the expectant mother. Education has an impact on the initiation of breastfeeding, with women who report attendance at antenatal classes or receiving breastfeeding information and education either antenatally or postnatally more likely to initiate breastfeeding.<sup>64</sup>

I think that a part of the success of breastfeeding must be to find the balance of forewarning expectant mothers that there can be difficulties, but reassuring them that these will improve.<sup>65</sup>

2.57 Programs which offer both education and support, deliver information from structured education programs in one-on-one sessions with a new mother, either when she is still in hospital or when she first goes home and then follow-up with support through telephone calls and home visits have been shown to have been successful.<sup>66</sup>

2.58 Most education about breastfeeding takes place as part of the antenatal classes program run by hospitals prior to the birth.<sup>67</sup> However, breastfeeding education needs to be more than a single 30 minute discussion.<sup>68</sup> It should be the subject of a specialised class which includes information on breastfeeding being the normal way to nourish a baby, provides practical information on positioning and attaching, gives realistic expectations about infant behaviour and discusses the barriers to breastfeeding.<sup>69</sup> It is also important that breastfeeding educators are qualified and have relevant and up-to-date experience.<sup>70</sup>

2.59 The ABA, through its volunteer network, regularly offers breastfeeding education classes which are highly regarded.<sup>71</sup> Although attendance is not free, the cost includes 12 months

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64 Brodribb W, sub 312, p 4.

65 Bertoli T, sub 176, p 1.

66 Centre for Community Child Health, *Breastfeeding Promotion Practice Resource* (2006) p 10; Barnwell M, sub 255, p 2.

67 Ball R, Cairns Base Hospital, transcript 4 April 2007, p 32.

68 How M, sub 146, p 2; Eldridge S, sub 214, p 2; Torepe R, sub 220, p 1; Brook B, sub 236, p 2; McCarthy C, sub 396, p 1.

69 Thorley V, sub 97, p 4; Bull M, sub 114, p 1; Roberts J, sub 372, p 2.

70 Cheers A, sub 29, p 4; Ward K, sub 56, p 5.

71 Pile C, sub 38, p 1.



- membership to the ABA, which allows mothers to receive ongoing support.
- 2.60 Not all women choose to access antenatal education.<sup>72</sup> The NT Government estimates that only five per cent of women access childbirth education classes in the territory.<sup>73</sup> Outreach programs that support these women need to be implemented in areas where attendance rates for antenatal classes are low.
- 2.61 A significant factor in initiating breastfeeding is the timing of the decision to breastfeed, as mentioned earlier.<sup>74</sup> Whether the woman's partner is supportive of breastfeeding is the other significant factor.<sup>75</sup> Both of these factors should be considered in the development and timing of any education program and partners should be included where possible.
- 2.62 Breastfeeding education should ideally start as early as possible. To effect community change and for breastfeeding to be seen as the norm, breastfeeding should be modelled at all opportunities, including as a component of sex-education programs run in schools.<sup>76</sup>

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72 Logan Hospital, sub 351, p 1.

73 Northern Territory Department of Health & Community Services, sub 334, p 3.

74 Forster D, McLachlan H, Lumley J, Factors associated with breastfeeding at six months postpartum in a group of Australian women, *International Breastfeeding Journal* (2006), Vol 1:18.

75 See for example see Robertson M, sub 84, p 1; Galilee M, sub 385, p 1, Campbell A, sub 226, p 1; Daniel A, sub 78, p 3; Pile C, sub 38, p 2; Binns C, Graham K, *Perth Infant Feeding Study II: Report to the Department of Health and Ageing* (2005), Curtin University, p 3.

76 Hastie C, sub 18, p 5; Hunter New England Health Representatives, sub 22, p 1; Clayton-Smith D, sub 43, p 1; McKeown N, sub 83, p 1; Ferluga R, sub 108, p 3; Myers F, sub 140, p 2; Sheehan D, Australian Lactation Consultants Association – Victoria, sub 166, p 1; New South Wales Aboriginal Maternal & Infant Health Strategy, sub 171, p 5; Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 10; Addison M, sub 268, p 2; Hensby J, sub 269e, p 6; Bowen M, sub 337, p 6; Felsch J, Royal Flying Doctor Service, transcript, 4 April 2007, p 7; Moorhead A, Royal Women's Hospital, transcript, 7 June 2007, p 33.

### **Box 2.2 Core of Life in Pormpuraaw, Far North Queensland**

The remote community of Pormpuraaw, visited by the community as part of the inquiry, undertook Core of Life through the Royal Flying Doctor Service.

*We tried a program called Core of Life last year in Pormpuraaw. It is a school based as well as a teenage based program, teaching the realities of pregnancy, breastfeeding and things like that. We had a good response. In the two sessions we covered approximately 60 people, including schoolchildren and young mums. Education through something like Core of Life, which teaches about the realities of pregnancy and the issues of breastfeeding and things like that – is very important for these young people and for the young, teenage mums.*

*Source: Felsch J, Royal Flying Doctor Service, transcript, 4 April 2007, p 7.*

- 2.63 The committee considers that the right type of breastfeeding education at the right time can have a significant effect on breastfeeding initiation and duration.<sup>77</sup> Breastfeeding needs to be an integral part of education programs, for schools, the community and women and their partners, both prior to and during pregnancy.<sup>78</sup>

## **Peer support or counselling programs**

- 2.64 Professional and peer support have had a significant impact on short term duration and exclusivity of breastfeeding. Peer support is particularly effective for low income, ethnic minority or disadvantaged groups.<sup>79</sup> One type of peer support or counselling involves pairing volunteers with first hand breastfeeding experience with new mothers in order to offer breastfeeding support in the first few weeks after the birth. The types of support provided are varied; for example, educational support relating to breastfeeding practices, emotional support, and feedback on ways to make breastfeeding easier and more relaxed. The program is based on the premise that practical support from a woman with direct breastfeeding experience is a particularly effective way of increasing the likelihood that women will breastfeed for longer and be more satisfied with the process.<sup>80</sup>
- 2.65 Breastfeeding support groups have been found to normalise women's experiences and are important to the success of continued breastfeeding. The ABA noted that the strength in mother-to-mother support may lie in the fact that the women providing the support are,

77 Dyson T, sub 32, p 1.

78 Sieker H, sub 348, p 3.

79 Government of Western Australia, sub 475, p 10.

80 Centre for Community Child Health, *Breastfeeding Promotion Practice Resource* (2006) p 14.

or have been, in a similar situation to the one coming to them for assistance. This provides equality in the relationship within which both empathy and friendship can develop. It has been found that a large part of the reason why women find peer-to-peer groups helpful is due to the psychosocial support they provide, resulting in increased confidence in breastfeeding for the women and greater satisfaction with their breastfeeding experience.<sup>81</sup> For some mothers the support they received from mother-to-mother support groups was the only source of support or guidance outside of professional support.<sup>82</sup>

2.66 The ABA's 24-hour telephone helpline provides non-medical peer support over the phone. It is estimated that the state based breastfeeding helplines receive about 200,000 calls a year.<sup>83</sup> Trained volunteer counsellors are rostered to provide support to women who are experiencing difficulties with breastfeeding.<sup>84</sup> Mothers wishing to use this service need to make two calls, an initial call to receive the home number of the counsellor then the actual call to the counsellor. The calls can be either local calls or STD and the mother may need to bear the cost of what could be a long counselling call.

...when we talk to mothers on the helpline a lot of calls are really reassurance calls to clarify. Mothers sometimes know what the answer is for themselves and have received some conflicting advice, or sometimes they do not know what the answer is for their circumstance and five people have told them five different things so they are just confused. They just want to do the best for their baby and they just want whatever is happening to them to improve.<sup>85</sup>

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81 Australian Breastfeeding Association, sub 306, p 25.

82 Mackay A, sub 3, p 1; Jackson B, sub 9, p 1; Gifford J, sub 42, p 3; McCormack J, sub 48, p 1; Newman P, sub 66, p 2; Christoff A, sub 72, p 2; Sands B, sub 73, p 5; Daniel A, sub 78, p 4; Rothenbury A, sub 87, p 4; Boswell D, sub 99, p 1; Foley K, sub 112, p 1; Gaskill K, sub 119, pp 1-2; Jeffrey L, sub 138, p 1; Tattam A, sub 199, p 1; Smith D, sub 234, p 3; Boomsma C, sub 252, p 1; Austin P, sub 254, p 2; Colman C, sub 260, p 1; Messner S, sub 264, p 15; Kelly M, sub 265, p 1; Radel E, sub 286, p 1; Toxward J, sub 297, p 3; Parker L, sub 305, p 1; Australian Breastfeeding Association, sub 306, p 26, Women's Electoral Lobby, sub 310, p 9; Smith J, Australian Centre for Economic Research on Health, sub 313, p 2; Hirsch H, sub 326, p 1; Nichols B, sub 368, p 1; Buckley S, sub 456, p 1; Phillips J, sub 460, p 11.

83 Berry N, Australian Breastfeeding Association, transcript, 7 June 2007, p 8.

84 Taylor K, sub 135, p 1.

85 Hamilton R, Australian Breastfeeding Association (QLD Branch), transcript, 17 April 2007, p 12.

- 2.67 The committee believes that at the least, the Commonwealth can assist the ABA in providing this valuable service by funding a toll-free number for mothers to use. The committee recommends accordingly.

### **Recommendation 5**

- 2.68 **That the Department of Health and Ageing fund the Australian Breastfeeding Association to expand its current breastfeeding helpline to become a toll-free national breastfeeding helpline.**

## **Breastfeeding - a community responsibility**

- 2.69 The committee believes it is the responsibility of the entire community to see that the best possible nutrition and health is available to all of its members, beginning with its youngest. Additionally the committee believes that a major attitude change is required across all levels of society which will enable women to breastfeed and see others breastfeed, in a society that values breastfeeding.<sup>86</sup>
- 2.70 Australia no longer has a breastfeeding culture.<sup>87</sup> The culture in Australia is that breastfeeding is the ideal and it is a 'nice thing to do', but if it gets difficult, bottle feeding is seen as a reasonable alternative.<sup>88</sup> Myths and misconceptions about breastfeeding continue to be perpetuated through generations (see chapter 5).
- 2.71 The health benefits of breastfeeding for the mother and baby seem to be poorly understood by the community. There also seems to be a lack of understanding of the long-term benefits that breastfeeding bestows. In many cases a mother can be surrounded by a community which provides minimal or no support for her decision to breastfeed and may actively discourage the continuance of breastfeeding.<sup>89</sup>

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86 Department of Human Services (Vic), *Giving breastfeeding a boost – community based approaches to improving breastfeeding rates – a literature review* (2005), p vii.

87 Wheatley N, sub 59, p 1.

88 Moody G, Australian Lactation Consultants Association, transcript, 4 June 2007, p 30; Australian Association for Infant Mental Health, sub 120, p 2; de Villiers S, sub 388, p 1.

89 Stephenson C, sub 222, p 1; Gray N, sub 10, p 2; Smith J, Australian Centre for Economic Research on Health, sub 313, p 10; Crosbie R, sub 415, p 1.

A new mother who is confident that she is doing the correct thing for her baby is much more likely to withstand negative pressure from well meaning, but ignorant, friends and relations.<sup>90</sup>

2.72 There is a perception in the community that infant formula is as good as breast milk. Many people believe that infant formula is nutritionally equal to breast milk, which was what the previous generation were told 30 years ago and what retailers and manufacturers continue to imply.<sup>91</sup>

2.73 The community's views on breastfeeding can actively discourage mothers from breastfeeding in public.<sup>92</sup> It is unacceptable to the committee that mothers feel that they have to express and feed from a bottle as they feel it is more publicly acceptable than breastfeeding.<sup>93</sup> Conversely, mothers report that the community can be judgemental when they are feeding using a bottle, even when it is to feed expressed breast milk.

The looks I receive in public giving my daughter a bottle breaks my heart, people naturally assume its formula, not something I put a lot of effort into getting.<sup>94</sup>

2.74 The perception by many in the community that the breast is a sexual or provocative object rather than maternal and primarily for the purpose of nurturing young, can lead to women feeling uncomfortable with breastfeeding and less likely to initiate it.<sup>95</sup> Young women are concerned with the idea of breastfeeding and may decide to feed using infant formula rather than undertake what they see as an embarrassing activity.<sup>96</sup>

Have a campaign to educate the rest of the population (particularly men and the older generation) that breastfeeding is natural and nothing to be ashamed of. It's not sexual and

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90 Binckes E, sub 323, p 3.

91 Wighton M, sub 41, p 2; Clapperton S, sub 88, p 2; Trinder M, sub 128, p 1; Stafford R, sub 192, p 1; Smit W, sub 209, p 1; Nichols B, sub 368, p 1.

92 Mussared D, sub 23, p 1; name withheld, sub 424, p 1.

93 Gribble K, School of Nursing, University of Western Sydney, sub 251, p 13.

94 Pedrana D, sub 389, p 1.

95 van Galen L, sub 170, p 2; Victorian Maternal & Child Health Coordinators Group, sub 293, p 6.

96 Propadalo L, sub 40, p 5.

we should feel comfortable breastfeeding in any place or situation without feeling embarrassed or ashamed.<sup>97</sup>

- 2.75 Mothers or parents rooms can be uncomfortable, dirty, smelly and isolated, leading to mothers feeling very vulnerable when breastfeeding.<sup>98</sup> The location of such rooms, often in close proximity to public toilets and isolated from the main shopping area, can imply that breastfeeding is something that needs to be hidden away. The absence of breastfeeding in public places sets up a vicious cycle, where breastfeeding is less common and becomes increasingly marginalised.

**Box 2.3 Man assaults breastfeeding mother**

A mother of a week-old boy says she was left shaken and embarrassed after a man indecently assaulted her as she breastfed her son at a shopping centre in Melbourne's north. Police and the victim, "Janelle", say they are concerned the offender will strike again and today begged other women to come forward if they had experienced a similar scare.

The 37-year-old Romsey woman said she was breastfeeding her son in a curtained area of a baby change room in the Broadmeadows Shopping Centre about 3.45pm on Monday when a man entered the room and pulled back the curtain. She said the man asked if she had seen his sister and told her his wife was pregnant. He asked questions about breastfeeding, such as whether it hurt. When Janelle's son stopped feeding, leaving her breast exposed, the man assaulted her. Janelle said she told the man several times to back off before he left.

She said she was very shaken and felt stripped of her "dignity and pride".

*Source: Hill-Douglas O, 'Man gropes breastfeeding mother', The Age, 3 May 2007, viewed on 30 July 2007 at <http://www.theage.com.au/news/national/man-gropes-breastfeeding-mother/2007/05/03/1177788264018.html>.*

- 2.76 The committee would like to see mothers/parents rooms more centrally located in shopping centres and public spaces, not isolated down corridors near toilets. Mothers should be able to feel safe and still part of the community, while having the necessary privacy and facilities to breastfeed.
- 2.77 The committee considers there is a need for a community based campaign that highlights the benefits of breastfeeding, reaffirms breastfeeding as the normal way to feed an infant, and informs the public that infant formula is not equivalent to breast milk.<sup>99</sup>

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97 Attard H, sub 449, p 3.

98 Leng S, sub 47, p 1; Campbell Y, sub 53, p 1; Nussey C, sub 148, p 2; Messner S, sub 264, p 1; Cameron B, sub 266, p 1; Cawthera J, sub 453, p 2.

99 Forster S, sub 62, p 1; Maack E, sub 273, p 1.

**Recommendation 6**

**2.78 That the Department of Health and Ageing fund a national education campaign to highlight:**

- **the health benefits of breastfeeding to mothers and babies;**
- **that breastfeeding is the normal way to feed a baby;**
- **that the use of breast milk is preferable to the use of infant formula; and**
- **the supportive role that the community can play with breastfeeding.**

**Recommendation 7**

**2.79 That the Department of Health and Ageing fund an awards program, which provides recognition for workplaces, public areas and shopping centres that have exemplary breastfeeding facilities.**





## The health and economic benefits of breastfeeding

### Overview

- 3.1 Over the last few decades, a growing number of scientific studies have shed light on the extensive health benefits of breastfeeding for both babies and mothers. These benefits are diverse, relating to the physiological, nutritional and cognitive aspects of infant development as well as maternal well-being.
- 3.2 The first part of this chapter examines the health benefits of breastfeeding for babies and mothers. These health benefits are immediate and also persist until later in life. The chapter will also focus on the unique properties of human breast milk and the valuable role of milk banks. Breastfeeding is also examined from an economic perspective, with an analysis of the short and long-term impacts on Australia's health system.
- 3.3 Breast milk is also an environmentally friendly product. Many consumables are needed for the packaging of infant formula and the production of bottles and teats. This requires significant resources and poses the problem of waste disposal for some of these items. Although breastfeeding is environment friendly it is often overlooked in environmental programs.

## Health benefits for the baby

- 3.4 There is solid evidence for the protective effects of breastfeeding against three classes of infectious disease in babies: gastrointestinal illnesses, respiratory tract infections, and otitis media (middle ear infections).
- 3.5 Studies suggest that the longer a baby is breastfed, the greater the protective effect against infections (known as a 'dose-response' effect). Exclusive breastfeeding appears to confer a greater protective effect against gastrointestinal and respiratory illnesses, while partial or minimal breastfeeding is not as protective.<sup>1</sup> Even an extra two months of breastfeeding can make a difference. A recent study showed that babies exclusively breastfed for four to six months only were four times more likely to suffer from pneumonia and twice as likely to suffer recurrent ear infections than those breastfed for six months or longer.<sup>2</sup>
- 3.6 A landmark study in breastfeeding research was the Promotion of Breastfeeding Intervention Trial (PROBIT) in the Republic of Belarus, which examined more than 17,000 mother and baby pairs. The findings showed that exclusive breastfeeding in the first year of life decreased the risk of gastrointestinal tract infections by 40 per cent.<sup>3</sup>
- 3.7 Babies who are not breastfed have a significantly increased risk of developing middle ear infections.<sup>4</sup> Breastfeeding also protects against recurrent otitis media, which can eventually result in hearing loss in children. Again, the shorter the duration of breastfeeding, the greater the risks of contracting these infections. It is worth noting that the rates of recurrent otitis media are also ten times worse in Indigenous children than in the general population (see chapter 7).

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- 1 Raisler J et al, 'Breastfeeding and infant illness: a dose-response relationship?', *American Journal of Public Health* (1999), vol 89, no 1, pp 25-30.
- 2 Chantry C et al, 'Full breastfeeding duration and associated decrease in respiratory tract infection in US children', *Pediatrics* (2006), vol 117, no 2, pp 425-432; NSW Centre for Public Health Nutrition, sub 178, p 6; Australian Breastfeeding Association, sub 306, p 14.
- 3 Kramer M et al, 'Promotion of breastfeeding intervention trial (PROBIT) – a randomised trial in the Republic of Belarus', *Journal of the American Medical Association* (2001), vol 285, no 4, pp 413-420.
- 4 Heinig M and Dewey K, 'Health advantages of breastfeeding for infants: a critical review', *Nutrition Research Reviews* (1996), vol 9, p 97; Duffy L et al, 'Exclusive breastfeeding protects against bacterial colonisation and day care exposure to otitis media', *Pediatrics* (1997), vol 100, no 4, p e7; Australian Breastfeeding Association, sub 306, p 10.

- 3.8 The incidence of asthma and allergies may also be reduced by breastfeeding for longer. Dr Wendy Oddy and colleagues from the Telethon Institute for Child Health Research conducted the Western Australian Pregnancy Cohort Study, which followed 2187 children to six years of age. They found that a significant reduction in the risk of childhood asthma at the age of six years occurs if exclusive breastfeeding is continued for at least four months after birth. While the exact reasons are still unknown, protection against allergies may be because breastfed babies are less exposed to foreign dietary antigens (e.g. from cow's milk). The special properties of breast milk may also promote a more effective immune system.<sup>5</sup> The extent to which breastfeeding can protect against asthma and allergies is still to be determined, with a recent Australian study at the Children's Hospital at Westmead, finding that longer duration of breastfeeding did not prevent the onset of these conditions by the age of five years.<sup>6</sup>
- 3.9 Some studies suggest that breastfeeding could also have a positive effect on a child's neurodevelopment. However, the links between breastfeeding and increased cognitive ability and intelligence are subject to debate. It is difficult to attribute greater intelligence to breastfeeding alone, when environmental factors could also have an influence.<sup>7</sup> For example, a recent study examined the effect of breastfeeding on the IQ of preschool children. Results showed that neither the mode of feeding (breastfed or formula fed) nor the duration of breastfeeding were related to the IQ of children at four years of age when the quality of the home environment and socio-economic status of families were taken into account.<sup>8</sup>
- 3.10 Breastfeeding may help to prevent a number of other conditions including some childhood leukaemias, urinary tract infections, inflammatory bowel disease, coeliac disease and sudden infant death
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5 Oddy W, Telethon Institute for Child Health Research, sub 216, pp 19-25; Oddy W et al, 'Association between breastfeeding and asthma in 6 year old children: findings of a prospective birth cohort study', *British Medical Journal* (1999), vol 319, pp 815-819.

6 Mhrshahi S et al, 'The association between infant feeding practices and subsequent atopy among children with a family history of asthma', *Clinical and Experimental Allergy* (2007), vol 37, no 5, pp 671-679.

7 Allen J and Hector D, 'Benefits of Breastfeeding', *NSW Public Health Bulletin* (2005), vol 16, p 43; Der G et al, 'Effect of breastfeeding on intelligence in children: prospective study, sibling pairs analysis, and meta-analysis', *British Medical Journal* (2006), vol 333, pp 945-948; Jain A et al, 'How good is the evidence linking breastfeeding and intelligence?', *Pediatrics* (2002), vol 109, pp 1044-1053; Mortensen E et al, 'The association between duration of breastfeeding and adult intelligence', *Journal of the American Medical Association* (2002), vol 287, no 18, pp 2365-2371; Allen J, sub 316.

8 Zhou S, Makrides M and Gibson R, sub 270, p 1.

syndrome (SIDS). There is also evidence of possible associations between breastfeeding and lower rates of dental occlusion<sup>9</sup>, bacteraemia, meningitis and type 1 diabetes.<sup>10</sup> Further research is required to determine the significance of these associations.

- 3.11 The fact that breastfeeding provides important health benefits for both mothers and babies is demonstrated in the consistency of results from a growing body of breastfeeding research. However, most breastfeeding studies are observational as it is considered unethical to conduct controlled infant feeding experiments. Therefore, it is important to note that there are limitations to breastfeeding research methods.<sup>11</sup>

## **Obesity, early nutrition and chronic disease risk**

- 3.12 There is growing interest amongst public health researchers in exploring the links between early nutrition and chronic disease risk in childhood and into adulthood.<sup>12</sup> Given that obesity has become a serious health problem in Australia, the association between breastfeeding and weight gain is of particular interest to the committee.
- 3.13 Strong evidence is accumulating to show that children are less likely to be overweight or obese if they have been breastfed as babies.<sup>13</sup> Babies who are breastfed for at least three months have a lower rate of obesity during childhood, with the protective effect increasing if

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9 Brown L, sub 121, pp 1-2.

10 Allen J and Hector D, 'Benefits of Breastfeeding', *NSW Public Health Bulletin* (2005), vol 16, p 44; Heinig M and Dewey K, 'Health advantages of breastfeeding for infants', pp 89-110; National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 6.

11 Smith J, Harvey P, Australian Centre for Economic Research on Health, sub 319, p 11; Allen J and Hector D, 'Benefits of Breastfeeding', *NSW Public Health Bulletin* (2005), vol 16, p 42.

12 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 5.

13 Oddy W, Telethon Institute for Child Health Research, sub 216, pp 5-15; Harder T et al, 'Duration of breastfeeding and risk of overweight', *American Journal of Epidemiology* (2005), vol 162, no 5, pp 397-403; Grummer-Strawn L and Mei Z, 'Does breastfeeding protect against pediatric overweight? Analysis of longitudinal data from the Centers for Disease Control and Prevention Pediatric Nutrition Surveillance System', *Pediatrics* (2004), vol 113, no 2, pp e81-86.

breastfeeding continues until six months. This protective effect may also extend into adulthood.<sup>14</sup>

- 3.14 Professor Colin Binns of the School of Public Health at Curtin University has emphasised the importance of the association between breastfeeding and obesity. He argues that evidence of this single health impact is more than sufficient justification to implement a major public health promotion campaign for breastfeeding.<sup>15</sup>
- 3.15 There are several ways in which breastfeeding may lower the risk obesity. One hypothesis is that breastfed babies grow at a slower rate. Putting on weight too quickly may reduce the likelihood of growing into a leaner body shape.<sup>16</sup> The Perth Infant Feeding Study Mark II found a positive association between weight gain at one year of age and early and regular consumption of formula.<sup>17</sup>
- 3.16 Satiety, or the feeling of fullness, could be another key to explaining the breastfeeding and obesity relationship. Breastfeeding babies know when they have consumed enough. The practice of encouraging formula-fed babies to finish all of the milk in a bottle could make them less responsive to natural hunger cues and feelings of fullness as they move onto solids later in life.<sup>18</sup> Conversely, breastfeeding may help to program and regulate appetite at an early age.<sup>19</sup>
- 3.17 Evidence also suggests that breastfeeding protects against a range of chronic illnesses which can develop in adulthood, including type 2 diabetes, heart disease, atherosclerosis, and high blood pressure.<sup>20</sup>
- 3.18 Breastfeeding can provide optimal nutrition from birth, and confers health advantages that persist until later in life. As seen later in the chapter, these long-term health benefits can also have more pronounced effects at the population level, with broader implications for economically sustainable health care.

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14 Binns C, transcript, 26 March 2007, pp 14-15.

15 Binns C, sub 86, pp 2-3.

16 Binns C, sub 86, p 3.

17 Oddy W, Telethon Institute for Child Health Research, sub 216, p 12.

18 Hector D, NSW Centre for Public Health Nutrition, transcript, 4 June 2007, p 43.

19 Binns C, sub 86, p 3.

20 Allen J and Hector D, 'Benefits of Breastfeeding', *NSW Public Health Bulletin* (2005), vol 16, pp 43-44; Oddy W, Telethon Institute for Child Health Research, sub 216, pp 5-6.

## Health benefits for the mother

- 3.19 Convincing evidence exists for breastfeeding's positive impact on maternal health. It is beneficial in promoting the mother's recovery from childbirth; ensuring the delayed return of menstruation and fertility; and significantly reducing the risk of pre-menopausal breast cancer. Breastfeeding promotes a more rapid return of the uterus to its pre-pregnant state. It stimulates the release of the hormone oxytocin, stimulating uterine contractions and minimising the risk of haemorrhage.<sup>21</sup>
- 3.20 Breastfeeding also contributes to a longer period of infertility after birth, leading to increased spacing between pregnancies. However, the extent of both the maternal recovery process and suppressed fertility also depends on the duration, intensity and frequency of breastfeeding.<sup>22</sup>
- 3.21 The protective effect of breastfeeding against pre-menopausal breast cancer has been shown in a number of studies. Protection against post-menopausal breast cancer is also probable.<sup>23</sup> A recent review of 47 studies throughout 30 countries indicated that for every 12 months of breastfeeding, the risk of breast cancer decreases by 4.3 per cent.<sup>24</sup>
- 3.22 A number of other possible health benefits for mothers include:
- accelerated weight loss and return to a pre-pregnancy body weight;<sup>25</sup>
  - reduced risk of ovarian and endometrial cancers;<sup>26</sup>

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21 Heinig M and Dewey K, 'Health effects of breastfeeding for mothers: a critical review', *Nutrition Research Reviews* (1997), vol 10, pp 35-56; NHMRC, *Dietary Guidelines*, p 5; Hensby J, sub 269, pp 15-16.

22 Allen J and Hector D, 'Benefits of Breastfeeding', *NSW Public Health Bulletin* (2005), vol 16, p 43; Heinig M and Dewey K, 'Health effects of breastfeeding for mothers', *NSW Public Health Bulletin* (2005), vol 16, pp 41-42.

23 Bernier M et al, 'Breastfeeding and risk of breast cancer: a meta-analysis of published studies', *Human Reproduction Update* (2000), vol 6, no 4, pp 374-386; Lipworth L et al, 'History of breastfeeding in relation to breast cancer risk: a review of the epidemiologic literature', *Journal of the National Cancer Institute* (2000), vol 19, no 4, pp 302-312; Heinig M and Dewey K, 'Health effects of breastfeeding for mothers', p 43.

24 Beral V, 'Breastfeeding: collaborative reanalysis of individual data for 47 epidemiological studies in 30 countries, including 50,302 women with breast cancer and 96,973 women without the disease', *The Lancet* (2002), vol 360, pp 187-195; Dyson T, sub 32, pp1-2.

25 Heinig M and Dewey K, 'Health effects of breastfeeding for mothers', pp 38-41.

26 Tung K et al, 'Reproductive factors and epithelial ovarian cancer risk by histologic type: a multiethnic case-control study', *American Journal of Epidemiology* (2003), vol 158, no 7, pp

- improved bone mineralisation, leading to decreased risk of osteoporosis;<sup>27</sup>
  - protection against rheumatoid arthritis;<sup>28</sup> and
  - protection against type 2 diabetes.<sup>29</sup>
- 3.23 Given that Australian women are having babies later in life, when they are at a higher risk for obstetric complications, the promotion of the health benefits of breastfeeding for mothers is all the more crucial as public health strategy.<sup>30</sup>

## Emotional benefits to the mother and baby

- 3.24 The emotional closeness generated by breastfeeding benefits both the mother and the baby. It is a pleasurable and positive skin-to-skin interaction. The hormones oxytocin and prolactin are stimulated, reducing maternal stress and fostering emotional bonding.<sup>31</sup>
- 3.25 Some studies have shown that breastfeeding can prevent or limit the duration of post-natal depression in mothers.<sup>32</sup> Others have suggested a link between breastfeeding and child and adolescent mental health. For example, Dr Oddy has found an association between breastfeeding for six months or longer and a reduction in mental health problems throughout childhood and adolescence. However, evidence in this field is still limited, given the environmental factors that need to be taken into account.<sup>33</sup>

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629-638; Newcomb P and Trentham-Dietz A, 'Breastfeeding practices in relation to endometrial cancer risk, USA', *Cancer Causes and Control* (2000), vol 11, no 7, pp 663-667.

27 Polatti F et al, 'Bone mineral changes during and after lactation', *Obstetrics and Gynaecology* (1999), vol 94, no 1, pp 52-56.

28 Karlson E et al, 'Do breastfeeding and other reproductive factors influence future risk of rheumatoid arthritis?', *Arthritis and Rheumatism* (2004), vol 50, pp 3458-3467.

29 Steube A et al, 'Duration of lactation and incidence of type 2 diabetes', *Journal of the American Medical Association* (2005), vol 294, pp 2601-2610.

30 College of Lactation Consultants Victoria Inc, sub 158, p 2.

31 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 7; Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 3.

32 Mezzacappa E, 'Breastfeeding and maternal stress response and health', *Nutrition Reviews* (2004), vol 62, pp 261-268; Hoyle Z, Post and Antenatal Depression Association, transcript, 7 June 2007, pp 58-64.

33 Oddy W, Telethon Institute for Child Health Research, sub 216, pp 16-18.

## The unique properties of breast milk

3.26 Breast milk is a complex living substance and a food that is nutritionally complete for babies until six months of age.<sup>34</sup> No formula product can exactly replicate breast milk.<sup>35</sup> It is a 'bioactive fluid' with changing physical properties and concentrations of nutrients. It is also extremely important in providing protection against infection:

Human milk represents a most valuable weapon for enhancing the immature immunologic system of the neonate and for strengthening its host defence mechanisms against infective or other foreign agents.<sup>36</sup>

3.27 Colostrum, the secretion produced in the first few days after birth, is nutrient-rich, and contains essential proteins, vitamins, enzymes, growth factors, antibodies and non-pathogenic bacteria to protect against illness.<sup>37</sup> This first secretion gradually changes into mature milk during the first one to two weeks after birth. For example, there are lower concentrations of fat in colostrum than in mature milk but higher concentrations of protein and minerals.<sup>38</sup>

3.28 Breast milk is dynamic and interactive. Its composition varies between individuals, depending on diet and stages of lactation. Breast milk's complex biochemistry means that it changes from morning to night and even over the course of a feed. The milk first ingested by a baby during a feed has a lower fat content, which steadily increases until the feeling of 'satiety' is reached.<sup>39</sup>

3.29 The concept of breast milk as a food should be better emphasised. Dr Debra Hector from the New South Wales Centre for Public Health Nutrition noted that there had been 'somewhat of a separation between breastfeeding and the introduction of solid foods into the diet.'<sup>40</sup> People may not perceive breast milk as a food, considering

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34 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), pp 4-5.

35 Stockwell D, Food Standards Australia New Zealand, transcript, 13 June 2007, p 11.

36 Oddy W, 'Breastfeeding protects against illness and infection in infants and children: a review of the evidence', *Breastfeeding Review* (2001), vol 9, no 2, p 15.

37 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 4.

38 Wagner C, 'Human milk and lactation', eMedicine, 2006, viewed on 30 July 2007 at <http://www.emedicine.com/ped/topic2594.htm>.

39 Wagner C, 'Human milk and lactation', eMedicine, 2006, viewed on 30 July 2007 at <http://www.emedicine.com/ped/topic2594.htm>.

40 Hector D, NSW Centre for Public Health and Nutrition, transcript, 4 June 2007, p 43.



that nutrition begins with solids. This can lead to a diminished understanding of the crucial importance of breast milk in establishing good nutrition from birth.

## Promoting the health benefits of breastfeeding

- 3.30 Given the extensive health benefits for both babies and mothers that can be attributed to breastfeeding, the committee believes there should be greater public promotion of the benefits of breastfeeding. This was recommended in a number of submissions to the inquiry.<sup>41</sup>
- 3.31 There were strong views expressed about the way in which public health messages around breastfeeding ought to be framed. Some argued that the slogan ‘breast is best’ is misleading, and can be interpreted as meaning that breastfeeding is a lofty ideal, but unattainable for many mothers in reality. Instead, it would be better to promote breastfeeding as the normal and natural way to feed babies.<sup>42</sup> Others suggested that a public health campaign on breastfeeding would be more effective if the risks of formula-feeding were more heavily emphasised.<sup>43</sup> However, focusing on the risks of infant formula may have the effect of alienating those mothers whose sincere efforts to breastfeed have not been supported strongly enough by the community and health profession.
- 3.32 The committee believes that a positive campaign promoting breastfeeding as normal would be the most effective way to present the breastfeeding message. Any public health campaign must also be supported by wider practical action and structural changes in the community and health profession to help breastfeeding mothers.
- 3.33 The committee supports breastfeeding for as long as the mother and child are comfortable to continue, but agrees with experts such as Professor Binns, who noted that more benefit would be gained from

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41 Werner C, sub 6, pp 2-3; Jeffery L, sub 34, p 3; Wighton M, sub 41, p 2; Pollock R, sub 60, p 1; Trinder M, sub 128, p 1; Tattam A, sub 199, pp 2-3; Australian Nursing Federation, sub 271, p 3; Pharmacy Guild of Australia, sub 331, p 2; Bowen M, sub 337, p 8.

42 Dixon G, sub 30, p 2; Binns C, sub 86, p 2; O’Dowd Y, sub 33, p 2; David Q, sub 37, p 1; Rothenbury A, sub 87, p 2; Hay L, sub 153, p 5; Day S, sub 157, p 2; Marazakis M, sub 202, p 1; Australian Breastfeeding Association (Queensland Branch), sub 207, p 3; Stephenson C, sub 278, p 1.

43 Walsh A, sub 20, p 1; Ward K, sub 56, p 2; Christoff A, sub 72, p 2; Dawson P, sub 98, p 2; Mathewson S, sub 111, p 2; Hinkley T, sub 115, p 1; Buckley M, sub 160, p 1; Eldridge S, sub 214, p 3; Fuller R, sub 228, p 2.

promoting exclusive breastfeeding for the first six months of a baby's life, than to promote prolonged breastfeeding beyond 12 months of age.<sup>44</sup> It should be noted that the health benefits of breastfeeding are at a maximum in the earliest months of life.<sup>45</sup>

## **'The gift of human milk'**

- 3.34 A human milk bank is a service that collects, screens, processes and distributes donated human milk, primarily for babies who cannot be breastfed.<sup>46</sup> Given that breast milk provides the best protection against infection and promotes proper growth and nutrition for healthy full-term babies, it is particularly important that sick and premature babies also have access to breast milk, especially when their own mother cannot provide it (for example, due to low milk supply, HIV infection, breast cancer treatment, or when the baby is on life support).
- 3.35 The WHO's Global Strategy for Infant and Young Child Feeding lists a number of feeding options for those few health situations where infants cannot, or should not, be breastfed. The alternatives are: expressed milk from the baby's mother, breast milk from a wet nurse or a human milk bank, or a breast milk substitute.<sup>47</sup> The WHO has long affirmed the value of milk banks in its policies on infant feeding.<sup>48</sup> In 1980, the World Health Assembly endorsed a joint WHO/UNICEF resolution which stated: 'Where it is not possible for the biological mother to breastfeed, the first alternative, if available, should be the use of human milk from other sources. Human milk banks should be made available in appropriate situations.'<sup>49</sup>
- 3.36 Milk banking originated in Europe in the early twentieth century as technological and hygienic advances allowed human milk to be refrigerated and stored. Prior to this, it was common practice for

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44 Binns C, sub 86, p 3.

45 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 14.

46 Lording R, sub 186, p 7.

47 WHO Global strategy for infant and young child feeding, 2002, viewed on 30 July 2007 at [http://www.who.int/nutrition/publications/gf\\_infant\\_feeding\\_text\\_eng.pdf](http://www.who.int/nutrition/publications/gf_infant_feeding_text_eng.pdf), p 10.

48 Arnold L, 'Global health policies that support the use of banked donor human milk: a human rights issue', *International Breastfeeding Journal* (2006), vol 1, no 26, pp 5-6.

49 WHO/UNICEF Joint Resolution, 1980, quoted in Wight N, 'Donor Human Milk for Preterm Infants', *Journal of Perinatology* (2001), vol 21, p 251.

babies whose mothers could not breastfeed to receive milk from another lactating mother or a 'wet nurse'. The number of milk banks grew across the developed world throughout the century, although many milk banks closed their doors during the 1980s due to fears surrounding HIV/AIDS transmission. However, as research demonstrated the safety of pasteurisation techniques in eliminating HIV and other viruses, milk banks experienced a resurgence as a safe source of donor milk.<sup>50</sup>

- 3.37 Milk banks provide an important alternative source of human milk. Because of human breast milk's unique immunologic properties, access to this milk is often critical to the survival of sick and premature babies with under-developed immune systems. Donated breast milk has also been used successfully to treat babies with intolerance to formula, severe allergies, immune deficiencies and congenital abnormalities. It also helps babies recover from surgery.<sup>51</sup>
- 3.38 One of the most serious health risks faced by premature babies is neonatal necrotising enterocolitis (NEC), a gastrointestinal infection which effectively causes a death of the bowel area.<sup>52</sup> Mortality rates from NEC in neonatal intensive care units can be as high as 40 per cent. Premature babies fed exclusively with breast milk, which promotes the maturation of the gut, have a reduced chance of succumbing to NEC. In a study of 900 premature babies, NEC was six to ten times more common in those who received only formula, than in those fed breast milk alone.<sup>53</sup>
- 3.39 Today human milk banks operate across North and South America, Europe and Asia.<sup>54</sup> Brazil is renowned for its large network of milk banks. In 1999-2000, more than 150 milk banks processed over 218,000 litres of milk that was given to 300,000 premature and low birth weight babies, saving the Brazilian Government an estimated \$620 million that year.<sup>55</sup>

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50 Human Milk Banking Association of North America, 'The History of Milk Banking', 2003, viewed on 30 July 2007 at <http://www.hmbana.org/index.php?mode=history>.

51 Lording R, 'A review of human milk banking and public health policy in Australia', *Breastfeeding Review* (2006), vol 14, no 3, p 22; Wight, p 251.

52 Moorhead A, Royal Women's Hospital, Melbourne, transcript, 7 June 2007, p 31.

53 Lucas A and Cole TJ, 'Breast milk and neonatal necrotising enterocolitis', *The Lancet*, (1990), vol 336, pp 1519-1523.

54 Lording R, 'A review of human milk banking', p 23.

55 Arnold L, p 7 (note, adjusted to AUD).

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.<sup>56</sup>

## Milk banks in Australia

- 3.40 Australia currently has only two donor milk banking facilities, although the Royal Women's Hospital in Melbourne noted its capacity (and that of other hospitals) to freeze a mother's expressed milk for her own baby's consumption.<sup>57</sup> In 2006, Australia opened its first milk bank in more than two decades at the King Edward Memorial Hospital in Perth, which caters for premature babies.<sup>58</sup> The 'PREM Bank' in Perth is sponsored by the Rotary Clubs of Thornlie and Belmont, the Perron Charitable Trust and Telethon and is the result of a collaboration between North Metropolitan Health Service, The University of Western Australia and the Women and Infants Research Foundation.
- 3.41 The Mothers Milk Bank, operating at the John Flynn Medical Centre on the Gold Coast, is Australia's only other milk bank. The committee visited this site in the course of the inquiry. The Mothers Milk Bank presently operates as a pilot program with limited funding and support from volunteers. There are about 500 registered donors, with around 280 currently donating milk. After instruction in sterile techniques, these women express once a day and freeze the milk which is collected by a volunteer every week. The milk is then screened, pasteurised, re-tested, and delivered to babies and mothers in need. On a weekly basis the Mothers Milk Bank pasteurises nine litres of milk.<sup>59</sup>
- 3.42 The committee heard from parents whose babies had thrived on donations from the Mothers Milk Bank. Twins born prematurely were

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56 Eldridge S, sub 214, p 9.

57 Moorhead A, Royal Women's Hospital, Melbourne, transcript, 7 June 2007, p 31.

58 Lording R, 'A review of human milk banking', p 23.

59 Jones J and Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 8.

fed with their mother's expressed breast milk and supplemented with donor milk for two months.<sup>60</sup> Another mother, whose son had severe allergic reactions to formula, struggled with her own low milk supply. With donor milk, her son's nutritional and health needs are being met.<sup>61</sup>

### **Box 3.1 Mothers Milk Bank Pty Ltd**

Mothers Milk Bank Pty Ltd is a private not-for-profit company formed by Midwife and Nurse Manager, Marea Ryan, of the John Flynn Private Hospital on the Gold Coast.

This vital health service, the first of its kind on the East Coast, provides pasteurised donor mother's milk to infants where human milk is not available, ensuring optimal physical and neurological development for these infants. In conjunction with a similar initiative established in Perth, the Mothers Milk Bank (MMB) is committed to seeing a network of donor milk banks operational around Australia within ten years. MMB shares a common vision with our Perth colleagues – 'Human Milk for Human Babies' – every baby needs to have the best food source available. Initially MMB will offer pasteurised milk on demand to premature and sick infants. In the long-term, MMB aims to provide an avenue whereby human milk is available for all babies up to the age of at least six months. This will lay the foundation of the future health of Australian children.

*Source: Mothers Milk Bank, sub 217.*

## **Barriers to milk banking**

3.43 Roslyn Lording, a health promotion practitioner and hospital social worker, is the author of a 2006 review of human milk banking in Australia. She has analysed some of the barriers to milk banking in the Australian context. There is anecdotal evidence that there would be 'initial reluctance'<sup>62</sup> towards milk banking amongst health professionals, including neonatologists, who may be unconvinced about the value of donor milk over formula.<sup>63</sup> The costs and logistics of establishing milk banks may also be a disincentive, especially when formula is more readily accessible.<sup>64</sup>

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60 Community statements, transcript, 18 April 2007, pp 46-47.

61 Community statements, transcript, 18 April 2007, pp 49-50; McMaster D, transcript, 18 April 2007, p 41.

62 McMaster D, transcript, 18 April 2007, p 42.

63 Lording R, 'A review of human milk banking', pp 25-26.

64 Lording R, 'A review of human milk banking', pp 25-26; Schmidt P, Gold Coast Hospital, transcript, 18 April 2007, p 36.

- 3.44 Concerns about the safety of milk banking and infection control have also been raised.<sup>65</sup> However, evidence from Australia and around the world shows that modern pasteurisation techniques are effective in preventing the transmission of infection and maintaining the quality of the milk.<sup>66</sup>
- 3.45 Another minor issue relates to the classification of breast milk as a body tissue in some jurisdictions and as a food in others. There are calls for milk to be classified consistently as a food across Australia. The matter is currently under review in Queensland.<sup>67</sup>
- 3.46 NSW Health notes that given the increasing community interest in human milk banks, a review should be undertaken prior to any wider establishment in Australia. Comprehensive evidence assessing the benefits of donor human milk for premature babies and the possible risks of disease transfer has not yet been compiled in Australia. Therefore, a review should address these issues and also look at a national regulatory and quality framework within which a network of milk banks in Australia could operate. The framework would need to address a number of minimum standards, including donor recruitment and selection, storage and handling of milk, testing and pasteurisation of milk, and incident reporting.<sup>68</sup>
- 3.47 Keeping these issues in mind, the committee believes that government support for milk banks would constitute an important public health investment.<sup>69</sup> With sufficient funding, strict safety measures and greater awareness of the benefits of breast milk amongst health professionals and the public, the barriers to milk banking can be overcome.

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65 Lording R, 'A review of human milk banking', p 26; Schmidt P, Gold Coast Hospital, transcript, 18 April 2007, pp 35-36.

66 Lording R, 'A review of human milk banking', p 26; Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 5.

67 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 3.

<sup>68</sup> NSW Health, sub 479, p 35.

69 Eldridge M, sub 25, p 2; Cheers A, sub 29, p 6; Dixon G, sub 30, p 2; Long H, sub 80, p1; Moore E, sub 102, p 2; Beyer L, sub 105, p 1; MacDonald H, sub 106, p 1; Clements F, sub 122, p 5; Dickson E, sub 162, p 2; Public Health Association of Australia, sub 181, p 10; Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 13; Lording R, sub 186, pp 7-8; Eldridge S, sub 214, p 8; Australian Breastfeeding Association, New South Wales Branch, sub 276, p 13; Australian Breastfeeding Association, sub 306, p 28; Women's Electoral Lobby, sub 310, p 5; New South Wales Baby Friendly Health Initiative, sub 339, p 15; de Vries L, sub 359, p 2; Campbell A, sub 361, p 2; Martin P, sub 373, p 1; Cuff S, sub 382, p 1; Brittain H, Logan Hospital, transcript, 18 April 2007, p 31.

## The future of milk banks in Australia

- 3.48 It is clear to the committee that a national network of publicly funded milk banks would give Australian babies a healthier start to life, reduce health care costs and provide real support for mothers who are unable to provide their baby with breast milk. Gwen Moody from the Australian Lactation Consultants Association described to the committee an example of a woman who is unable to breastfeed.

I have got a woman with breast cancer at the moment who is seven or eight months pregnant. She was starting chemotherapy on Friday, so in the week before, because the baby is potentially going to be born early, we got her expressing colostrum crazily so we would at least set the baby's gut up because she had breastfed her two previous children. She has got inflammatory breast cancer, which is fairly advanced.<sup>70</sup>

- 3.49 Professor Peter Hartmann of the King Edward Memorial Hospital milk bank estimated that if a premature baby in their unit is given breast milk instead of formula, the recovery period is shortened by two weeks with cost savings of \$18,200.<sup>71</sup> In Queensland, there were 4,300 premature babies in one year who did not receive any breast milk and were therefore at greater risk for complications, infections and longer hospital stays.<sup>72</sup>

- 3.50 Interest in being a milk donor is steadily growing.<sup>73</sup> Milk banks could also offer solutions to those mothers, such as the woman below, who despair at having to dispose of their own excess milk, knowing that it would be invaluable to other mothers and babies.

It was a real tragedy, I had at least 12 bottles of milk (240ml each) in my refrigerator, and I was forced to dispose of it all down the sink when I got home, all this liquid gold. It broke my heart to do so, especially when I think of any preemie baby that could have really benefited from having breast milk, as opposed to formula.<sup>74</sup>

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70 Moody G, Australian Lactation Consultants Association, transcript, 4 June 2007, p 34.

71 Australian Breastfeeding Association, New South Wales Branch, sub 276, p 13.

72 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, pp 2-3.

73 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 9; Jeffery L, sub 34, p 5; Greenlees N, sub 324, pp 1-2; Robins J, sub 50, p 1; Virgo H, sub 155, p 1; Fellows M, sub 304, p 2; Nielsen L, sub 355, p 2; community statements, transcript, 18 April 2007, p 47; community statements, transcript, 18 April 2007, p 49.

74 Smith A, sub 110, p 2;

- 3.51 Mothers and babies in remote communities would also benefit from a system which provided the infrastructure to transport breast milk as required. With a proper courier service, the Mothers Milk Bank could have delivered milk daily to a mother in a remote area of Queensland whose milk supply was low and who had no access to formula.<sup>75</sup>
- 3.52 A commitment to a national system of milk banks in Australia should not only be a stand-alone policy, but complement a range of other measures to support breastfeeding and value of breast milk<sup>76</sup> (see chapter 4). In Brazil, donor milk banking goes hand in hand with efforts to promote breastfeeding as the cultural norm.<sup>77</sup> This mutually reinforcing approach would help to secure the health of Australia's next generation for years to come.

### **Recommendation 8**

- 3.53 **That the Department of Health and Ageing fund a feasibility study for a network of milk banks in Australia including the development of a national regulatory and quality framework within which a network of milk banks in Australia could operate. The feasibility study should include funding pilot programs at the Mothers Milk Bank at the John Flynn Private Hospital, Gold Coast and the King Edward Memorial Hospital milk bank in Perth.**

## **The economic benefits of breastfeeding**

- 3.54 One of the committee's main interests in undertaking this inquiry was to investigate the short and long-term impacts on the health of Australians if breastfeeding rates were increased. The effect of breastfeeding on the sustainability of the health system was also examined.
- 3.55 There are strong economic arguments in favour of increasing breastfeeding rates in Australia. As already shown in this chapter, breastfeeding and breast milk provide well-established health benefits, including greater protection against some chronic diseases, for both mothers and babies. These advantages should also be viewed

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75 Ryan M, Mothers Milk Bank, transcript, 18 April 2007, p 7.

76 Lording R, sub 186, p 8.

77 Arnold L, 'Global health policies', p 7.



from an economic perspective, given that fewer cases of illness and hospitalisations at the population level translate into significant cost savings for the health care system.

Economists have rarely considered economic aspects of breastfeeding, focusing their attention on the market economy. In recent years the importance of the unpaid economy including the care work of mothers has become more visible. It has also become evident that the policy needs to take account of the unpaid household economy to avoid unintended impacts on the work that families do in raising children – Australia’s ‘human capital.’

Breastfeeding is a good example of women’s reproductive work that is neither visible nor properly valued by existing economic statistics. Because it is neither visible nor valued, and because it competes in the market on unequal terms, breastfeeding remained unprotected from pressure of social and economic change and from ‘unfair’ market competition.<sup>78</sup>

- 3.56 Dr Julie Smith, a research fellow at the Australian Centre for Economic Research on Health, has conducted a number of studies into the economic impacts of breastfeeding in Australia. The committee has drawn extensively on her work and the evidence she presented in the following discussion of the economic aspects of breastfeeding.<sup>79</sup>

## The economic value of breast milk and breastfeeding

- 3.57 A number of inquiry participants argued that the economic value of breast milk should be recognised as a proportion of Australia’s gross domestic product (GDP). Dr Smith estimates that around 33 million litres of human milk per year is produced in Australia at present breastfeeding rates.<sup>80</sup> Using the milk bank prices in Europe, she estimates that the value of breast milk produced by Australian women is around \$2 billion per year. The annual retail value of formula is considerably less at around \$135 million.<sup>81</sup> Breast milk’s estimated value is equivalent to around 0.5 per cent of GDP, or six per cent of national food consumption. The impact of breastfeeding on the

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78 Smith J, Australian Centre for Economic Research on Health, sub 313, p 2.

79 Smith J, Australian Centre for Economic Research on Health, sub 313; Smith J, Harvey P, Australian Centre for Economic Research on Health, sub 319.

80 Smith J, transcript, 26 March 2007, p 18.

81 Smith J, Australian Centre for Economic Research on Health, sub 313, p 4.

economy would be even greater if exclusive breastfeeding to six months was widely practised:

If all Australian mothers were to breastfeed as the World Health Organization recommended, there would be an increase in economic output in the form of milk of around \$3 billion.<sup>82</sup>

- 3.58 Another concern raised by some inquiry participants was that the time invested in breastfeeding by mothers is not given economic value in Australia. Dr Smith examined this 'economic time cost' in the nationwide Time Use Survey of New Mothers, which showed that mothers who breastfeed to recommended levels spend around 16 to 17 hours per week on this activity for the first three to six months. The emotional component to breastfeeding should also be seen as a significant human capital investment. These mothers spend an additional six to eleven hours per week in 'emotional care', which contributes positively to the child's mental and emotional health. While the baby undoubtedly benefits from these breastfeeding interactions, such time-intensive unpaid care on the part of the mother is not recognised in economic terms.<sup>83</sup>

## Cost savings to the health system

- 3.59 Breastfeeding protects against a range of diseases and therefore has the potential to alleviate costs to the health care system in both the short and long-term. The Australian Medical Association notes that the potential benefits of increasing the breastfeeding rate would be extremely cost-effective, ensuring improved health outcomes and the sustainability of health care in Australia.<sup>84</sup> The NHMRC states in the Dietary Guidelines that:

The total value of breastfeeding to the community makes it one of the most cost-effective primary prevention measures available and well worth the support of the entire community.<sup>85</sup>

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82 Smith J, transcript, 26 March 2007, p 26

83 Smith J, Australian Centre for Economic Research on Health, sub 313, p 9; Smith J, transcript, 26 March 2007, pp 22-23.

84 Australian Medical Association, sub 358, p 2.

85 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 14.

### Short-term impacts – economic costs of premature weaning

- 3.60 According to a 2002 study conducted by Dr Smith and colleagues at the Canberra Hospital, there are significant hospital costs associated with early weaning. It was found that less than 10 per cent of babies in the ACT were exclusively breastfed until the recommended six months of age. Early weaning was estimated to add around \$1 to \$2 million to annual hospitalisation costs for gastrointestinal illness, respiratory and ear infections, eczema and neonatal necrotising enterocolitis (NEC). Using these figures, savings across the Australian hospital system could be \$60 to \$120 million for these illnesses alone.<sup>86</sup>
- 3.61 A preliminary economic analysis of breastfeeding in Australia in 1997 found that a minimum of \$11.75 million could be saved if the prevalence of exclusive breastfeeding at just three months was increased from 60 per cent to 80 per cent. This analysis only took into account four illnesses – gastroenteritis, NEC, eczema and type 1 diabetes. The author noted that further cost savings could be achieved if other illnesses and reduced maternal absenteeism were also taken into account.<sup>87</sup>
- 3.62 International studies have also shed light on the extent of savings to health systems. For example, an Italian study showed that for babies exclusively breastfed at three months, there were lower health care costs during the first year of life because of fewer hospital admission and ambulatory care episodes.<sup>88</sup> A US study found that for every 1,000 babies never breastfed (compared to 1,000 babies exclusively breastfed), there were more than 2,000 extra visits to the doctor, 212 extra days of hospitalisation and 609 extra prescriptions in the first year of life.<sup>89</sup>
- 3.63 A number of submissions also highlighted the Commonwealth Government's recent funding commitment of \$25 million for a rotavirus vaccine. There are around 20,000 hospital admissions every year for this common gastrointestinal infection in children under five years old. It is suggested that an investment of the same extent

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86 Smith J et al, 'Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory', *Australian and New Zealand Journal of Public Health* (2002), vol 26, no 6, pp 543-551.

87 Drane D, 'Breastfeeding and formula feeding: a preliminary economic analysis', *Breastfeeding Review* (1997), vol 5, no 1, pp 7-15.

88 Cattaneo A et al, 'Infant feeding and the cost of health care', *Acta Paediatrica* (2006), vol 95, no 5, pp 540-546.

89 Ball T and Wright A, 'Health care costs of formula-feeding in the first year of life', *Pediatrics* (1999), vol 103, no 4, pp 870-876.

towards breastfeeding promotion could further reduce the burden on the health system caused not only by rotavirus, but a range of common early childhood infections.<sup>90</sup>

- 3.64 These findings strengthen the case for lifting Australia's breastfeeding rates, given the immediate health benefits and the reduced day-to-day strain on the health care system.

### Long-term impacts – reducing the burden of chronic disease

- 3.65 As demonstrated earlier in this chapter, breastfeeding can protect against the development of a number of chronic conditions later in life, including obesity, diabetes and cardiovascular disease. Although this is a relatively new field of inquiry, international research suggests there are significant health system savings to be gained from improving breastfeeding rates. For example:

- a 2002 study of more than 500,000 babies born in England and Wales estimated that 33,100 asthma cases and 13,639 cases of obesity were directly attributable to a lack of breastfeeding<sup>91</sup>; and
- another UK study suggested that breastfeeding's protective effect against high blood pressure could prevent 3,000 coronary heart disease events and 2,000 strokes annually in those under 75 years of age.<sup>92</sup>

- 3.66 Dr Smith and Dr Peta Harvey are currently investigating the links between breastfeeding and the costs of chronic disease treatment in Australia. Their preliminary findings suggest that between 11 and 28 per cent of the chronic disease burden in Australia could be attributed to a lack of breastfeeding during infancy.<sup>93</sup>

- 3.67 Another factor to consider is the ongoing special education costs arising from poor health. For example, as discussed earlier, breastfeeding offers significant protection against middle ear infections. Recurrent infections can lead to language and learning difficulties in early childhood, with a need for speech therapy and

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90 Clements F, sub 122, p 4; Davis A, sub 237, pp 1-2; Gribble K, School of Nursing, University of Western Sydney, sub 251, p 2; Davis A, sub 367, p 1.

91 Akobeng A and Heller R, 'Assessing the population impact of low rates of breastfeeding on asthma, coeliac disease and obesity: the use of a new statistical method', *Archives of Disease in Childhood* (2007), vol 92, pp 483-485.

92 Martin R et al, 'Breastfeeding in infancy and blood pressure in later life: systematic review and meta-analysis', *American Journal of Epidemiology* (2005), vol 161, no 1, pp 15-26.

93 Smith J, Harvey P, Australian Centre for Economic Research on Health, sub 319, p 2.

remedial education programs.<sup>94</sup> The broader impact of chronic disease on economic productivity should also be investigated.

- 3.68 It is clear that the relatively small effects from improving breastfeeding rates among individuals can have a potentially large impact on population health:

Breastfeeding is a one off 'intervention' that continues to reduce chronic disease risk throughout the life cycle. Unlike other interventions, such as exercise programs, or dietary changes, it does not have to be continued throughout the life cycle in order to maintain this protection, and so has no ongoing costs. This point means that it is likely to be very cost effective as a disease prevention measure. There are few other preventative health interventions which have proven permanent effects in reducing risk factors for chronic disease in such a variety of settings.<sup>95</sup>

- 3.69 Thus, the committee sees merit in gathering further evidence on the economic impacts of breastfeeding. This would strengthen the case for government action and investment to improve breastfeeding rates in Australia.

### **Recommendation 9**

- 3.70 **That the Department of Health and Ageing commission a study into the economic benefits of breastfeeding.**

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94 Australian Breastfeeding Association, sub 306, p 10.

95 Smith J, Harvey P, Australian Centre for Economic Research on Health, sub 319, p 7.



# Breastfeeding Management

## Overview

- 4.1 Breastfeeding involves a physical process. The process of lactation starts during the pregnancy and culminates when the baby is either first put to the breast or the first milk, colostrum, is expressed. A mother needs to learn the technique of positioning and attaching a tiny, helpless infant, which may cause injury if not done correctly. There is also a strong emotional component. The effect of the skin-to-skin contact and the hormones released while breastfeeding are an important factor in the bonding process between the mother and baby.<sup>1</sup>
- 4.2 The process of breastfeeding is a very different experience for different women. For some it is an empowering experience that fills them with a sense of fulfilment.<sup>2</sup>

Breastfeeding my baby also means that I have to stop and take time out, which relaxes me and allows me to connect with my baby - I believe that this helps to develop strong attachment between us. This helps to stop me being overwhelmed by my new role as a mum...<sup>3</sup>

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1 Levin M, sub 327, p 3.

2 Sirio N, sub 247, p 1.

3 Hodge R, sub 250, p 1.

- 4.3 For others there is no such experience; it is simply providing nutrition to their child.<sup>4</sup>
- Some women simply feel like they are tied to their baby with a ball and chain, particularly if their baby won't even take a bottle of expressed milk.<sup>5</sup>
- 4.4 Women have identified the following concerns about breastfeeding during their initial hospital stay:
- over-worked staff;
  - lack of skills in assisting with attachment difficulties;
  - inconsistent advice; and
  - noise and embarrassment.
- 4.5 Most mothers do not anticipate problems with breastfeeding and health professionals may inadvertently contribute to this perception by focusing on the benefits of breastfeeding rather than the practicalities and problems that can be encountered in the early weeks.<sup>6</sup> The management of breastfeeding and breastfeeding issues needs to take into account the individual involved.<sup>7</sup> There are things that will help one woman greatly and have little or no effect on another woman. Breastfeeding should be learned and continued in a supportive environment and there needs to be an understanding that 'one size does not fit all'.

## The science of supply

- 4.6 During pregnancy a woman's breasts undergo changes and development to be ready to provide milk for the baby; this stage is called lactogenesis stage one. That milk is available even when a baby is born prematurely. The first milk in the breasts following delivery and often before delivery is called colostrum. It is thicker, yellowish milk which is more concentrated than mature milk. It is also rich in protein and in antibodies that help to protect the baby

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4 Daniel A, sub 78 , p 2; name withheld, sub 439, p 1.

5 Daniel A, sub 78, p 2.

6 Government of Western Australia, sub 475, p 18.

7 Halpin S, sub 369, p 1.



from disease. During the first three to four days post-birth, copious milk secretion occurs, called lactogenesis stage two.<sup>8</sup>

- 4.7 By sucking at the breast, the baby stimulates tiny nerves in the nipple. These nerves cause hormones to be released into the mother's bloodstream. The hormone prolactin activates the milk-making tissues. The other hormone, oxytocin, causes the breast to push out or let down the milk. The amount of colostrum in the breasts is particularly suited to the baby's small needs in the first few days after birth. Mature breast milk, which is thin and bluish-white in appearance, gradually replaces colostrum over about ten days, although this changeover can take several weeks.<sup>9</sup>
- 4.8 Breastfeeding works on a supply, demand basis. The rate of milk production is regulated to match the amount of milk removed from each breast at each breastfeed. If milk withdrawal has not started within three days post-partum, the changes in milk composition with both stages of lactogenesis are reversed and the likelihood of the establishment of successful breastfeeding declines.<sup>10</sup> In the critical first six weeks of establishing lactation it is very important that babies are fed according to their needs not according to any kind of routine or schedule.<sup>11</sup> Most mothers find that they need to feed at least six times in 24 hours just to maintain their supply. Many new babies need eight to twelve or more feeds in 24 hours. However the frequency of feeds generally declines as the baby gets older.<sup>12</sup>

## Initiation – the early days

- 4.9 As shown in chapter 2, initiation rates in Australia are close to the recommended levels. However, in the early days of breastfeeding, many women can find it to be very difficult, painful and confusing.<sup>13</sup>

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8 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 331.

9 Australian Breastfeeding Association website, 'Increasing your supply', viewed on 30 July 2007 at <http://www.breastfeeding.asn.au/bfinfo/supply.html>.

10 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 332.

11 Parker E, sub 54, p 1.

12 Australian Breastfeeding Association website, 'Increasing your supply', viewed on 30 July 2007 at <http://www.breastfeeding.asn.au/bfinfo/supply.html>.

13 BellyBelly.com.au, sub 441, p 24; name withheld, sub 381, p 2.

For many women the level of pain experienced is unexpected and they may find breastfeeding quite complex.<sup>14</sup> Even with the declared intent to breastfeed, damaged nipples, an upset, screaming baby and continuous, conflicting advice can jeopardise the breastfeeding relationship.

For the first 3 months I felt like quitting every single day. It was painful. It was hard. It was time consuming. I was extremely drained and in poor physical condition. Extremely sleep deprived, in the first few weeks, having to breastfeed 24/7 every single 3 hours...<sup>15</sup>

- 4.10 Correct positioning at the breast and correct latching-on and milking action are vital for the efficient removal of milk from the breast without nipple pain and trauma.

**Box 4.1 Attaching and positioning at the breast: the key to successful breastfeeding**

- The mother should be seated comfortably in an upright position, so that her breasts fall naturally. She should have good support for her back, arms and feet. The infant should be unwrapped to allow easy handling and avoid overheating.
- If the nipple is erect, support the outer area of the breast with a 'C' hold, being careful not to alter the breast position. If the nipple is flat or inverted, move the 'C' hold under the breast and shape the breast between the thumb and index finger, well back from the areola.
- The infant should be supported behind the shoulders and facing the mother, with his or her body flexed around the mother's body. The position must be a comfortable drinking position for the infant.
- The infant's top lip should be level with the mother's nipple, and a wide gape should be encouraged by teasing the infant's mouth with the nipple.
- When the infant gapes widely, bring him or her quickly onto the breast. So that the infant will take a good mouthful of breast, it is always advisable to bring the infant to the breast, not the breast to the infant.
- The chin should be tucked well into the breast, and the infant's mouth should be wide open, with the bottom lip curled back. More areola will be evident above the infant's top lip than below the bottom lip. When positioning is correct it is not necessary to hold the breast away from the infant's nose.

14 Artlett C, sub 145, p 1; Name withheld, sub 374, p 1; Healy L, sub 423, p 1; Emery D, sub 429, p 1; Thomme F, sub 430, p 1; Brown M, sub 432, p 1.

15 BellyBelly.com.au, sub 441a, p 23.

- After an initial short burst of sucking, the rhythm will be slow and even, with deep jaw movements that should not cause the mother any discomfort. Pauses are a normal part of the feed and they become more frequent as the feed continues.
- If the cheeks are being sucked in or there is audible 'clicking', the infant is not latched on correctly.
- The infant should stop feeding of his or her own accord by coming off the breast spontaneously. The nipple will appear slightly elongated but there should be no evidence of trauma.

*Source: National Health & Medical Research Council, Dietary Guidelines for Children and Adolescents in Australia (2003), p 336.*

- 4.11 Mothers clearly need a high level of support at this time and they need consistent advice.<sup>16</sup> The health system plays an important role in these early days, through provision of antenatal education and ongoing support and advice on how to initiate and continue breastfeeding (see chapter 6). One impact of the 'baby boom' on maternity wards means that midwives and lactation consultants have more patients and less time to sit, watch and help a new mother feed. Many inquiry participants reported that it was difficult to get help from busy staff.<sup>17</sup> Some mothers felt very upset by the technique of midwives physically bringing the baby to the breast; mothers did not appreciate strangers grabbing at their breast without asking for permission.<sup>18</sup> This technique also does little to promote proper attachment.<sup>19</sup>
- 4.12 Specific hospital practices such as skin-to-skin contact<sup>20</sup> can be very important for the mother and baby bonding process and is one of the 10 Steps of the Baby Friendly Hospital Initiative (see chapter 6). For example, early skin-to-skin contact has been shown to increase the length of time that mothers breastfeed by 42 days.<sup>21</sup> Mothers

16 Mahony J, sub 164, p 2; Parker L, sub 305, p 1.

17 See for example Gray N, sub 10, p 1; Dixon G, sub 30, p 1; Jeffery L, sub 34, p 4; name withheld, sub 232, p 1; De Lacey J, sub 285, p 1; Louis K, sub 325, p 1; West Australian Country Health Service South West Dietitians, sub 308, p 1; Ozanne S, sub 384, p 1; Richards H, sub 393, p 1; name withheld, sub 401, p 1; name withheld, sub 409, p 1; name withheld, sub 416, p 1; Attard H, sub 449, p 1.

18 See for example Simpson C, sub 16, p 1; Cheers A, sub 29, p2; Pile C, sub 38, p 1; Daniel A, sub 78, p 4; Carter N, sub 126, p 1; Hensby J, sub 269a, p 9; name withheld, sub 409, p 1; Corbett D, sub 466, p 1; Godfrey-Lea S, sub 468, p 1.

19 Bayside Breastfeeding Clinic, sub 318, p 2.

20 Walsh A, sub 20, p 1; Rothenbury A, sub 87, p 8, Edwards N, sub 107, p 2, Hensby J, sub 269e, pp 21-23.

21 NSW Health, sub 479, p 30;

with special needs such as those with type 1 diabetes are often routinely separated from their babies just after birth without this skin-to-skin contact and may need additional support to express after the birth.<sup>22</sup>

- 4.13 The variability of behaviour in the newborn infant needs to be carefully explained to the new mother. Infants may be sleepy or unsettled which can both impact on the initiation of breastfeeding.<sup>23</sup> They may want to feed frequently before the milk has come in and mothers need to know that these frequent feeds will help to stimulate the milk supply. It is important that health professionals and parents are aware that the use of bottles and dummies are usually inappropriate at this early stage of breastfeeding.<sup>24</sup> Infants will also cry and once the causes of hunger, heat, cold, noise or a clearly defined medical problem are ruled out, a crying infant can be a cause of deep distress and frustration for parents.<sup>25</sup>
- 4.14 The process of babies rooming in with their mothers, in contrast to the previous 'baby nursery', has assisted the initiation of breastfeeding. This is one of the ten steps of the Baby Friendly Hospital Initiative.<sup>26</sup> Some hospitals have a policy where a mother needs to sign a consent form<sup>27</sup> before infant formula can be given to their baby and the committee considers this should be mandatory in all hospitals. These forms will often clearly outline the reasons not to give infant formula and the acceptable medical reasons for supplementation.
- 4.15 With the increase in the rates of early discharge from hospital, many women are discharged before their milk has come in or before they have been able to successfully attach their baby to the breast.<sup>28</sup> Women are increasingly being sent home expressing using a pump and feeding the baby using a bottle and then are expected to reintroduce the breast at home, without any support.<sup>29</sup> Women are

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22 Patton MA, sub 231, p 1.

23 Irvin N, sub 440, p 1.

24 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 343; Cassar S, sub 113, p 4.

25 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 367.

26 Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 8.

27 Ball R, Cairns Base Hospital, transcript, 4 April 2007, p 33.

28 Oliver T, sub 130, p 4; Kendall C, sub 240, p 1; Stephens C, sub 377, p 1; Sarah, sub 419, p 1.

29 Hendry H, sub 422, p 1.

expected to try to position and attach their baby in isolation. Although there is the advantage that the infant still receives breast milk through expressing, the infant feeding process then becomes more complex and time consuming as it includes expressing, feeding, bottle washing, sterilising and so on. It can also be difficult for many mothers to maintain supply when only expressing and not feeding at the breast.<sup>30</sup>

- 4.16 As well as the complexity of expressing another issue relating to early discharge is that women have barely learnt about attaching their baby to the breast and they may be sent home with less than optimal attachment, which gets worse with breast engorgement. Their nipples then get sore and insufficient milk is transferred to the baby as poor attachment means the baby cannot drain the breast well. The baby then is not getting as much milk as it would with optimal attachment. The weight gain of the infant then may be less than desirable and mothers are told 'your milk's dried up!' It is normal phenomenon for most babies to lose weight in the first week, surviving on low volume colostrum and interstitial body fluid, often voiding only once or twice in 24 hours over the first three days.<sup>31</sup> There is a lack of understanding of how this whole situation may have come about and also how to fix it. Relatives often put pressure on them to 'just switch to the bottle, it is easier that way'.<sup>32</sup>

**Box 4.2 One mother's recollection of the early days**

The lactation consultants at the hospital did their best with their limited time to try to assist me, but seeing them for 1 out of 16 feeds (in other words once every second day), the damage was being done and I didn't know how to fix it. I had this hand there, this chair, a pillow here and towel wrapped up under here, a finger pushing this part of my breast, trying to get a nipple shield to stay on and all the while doing this in the middle of the night with a screaming baby and no-one by my side.

It wasn't until I saw the Early Childhood Health Nurse when my son was 7 days old that I was finally told that it wasn't normal to have such intense pain when you are breastfeeding. I had developed mastitis, had cracked and bleeding nipples, and thrush on them too. Combined with the sleep deprivation, I was not coping with the pain and stress of it all. I was advised to cease breastfeeding for a few days to allow my nipples to heal. So in the meantime I had to express every 3 hours, feed my son

30 Volders E, Royal Children's Hospital, sub 85, p 2; Lenne S, sub 362, pp 1-2; name withheld, sub 444, p 1.

31 Thompson R, sub 19, p 8.

32 Walsh A, sub 20, p 1.

the bottle every 3 hours and then try to sleep for an hour in between. This was an all day cycle.

When it came time to try breastfeeding again I had associated feeding with pain and I was experiencing panic attacks half an hour before every feed, just anticipating how painful it would be. For this I went and saw a Clinical Psychologist because I'd had a couple of severe meltdowns and was in the high risk for Post-natal depression.

I so desperately wanted to breastfeed my baby, I had an abundant supply (that took 4 months to stop dribbling out of my breasts), but I was only able to breastfeed for 10 days, I expressed until my son was 6 weeks old and then couldn't cope with the extra work of expressing any longer and made the agonising decision to bottle feed.

I had very little support from health professionals, it seems that all the emphasis is on breastfeeding and yet for someone like me that couldn't handle to intense pain (which wasn't helped by 3rd degree tearing and 80 stitches down below), there was no support. I found it difficult to get any information about how to bottle feed, what was out there in terms of bottles, teats, formula, how to navigate outside of the house. So for the first 3 months of my sons life I was a recluse, staying at home, ashamed that I had failed to breastfeed my son. I was so disappointed.

*Source: Grindley A, sub 406, pp 1-2.*

## Duration of breastfeeding

- 4.17 There are many factors that can influence the duration of breastfeeding as seen in chapter 2. Rates of initiation are high but women do not breastfeed for as long as is recommended or even as long as they would often like. Many women feel that the reality of breastfeeding is quite different to their expectations. Research has shown that these expectations can affect breastfeeding duration. The clash between highly idealised expectations and early breastfeeding problems can lead to disillusionment and ultimately to early weaning.<sup>33</sup>

Women do not make one decision to breastfeed; they make a decision almost every day to continue, particularly when they are having trouble. Most women in Australia are initiating breastfeeding. It is how long they keep going.<sup>34</sup>

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33 Lactation Resource Centre, Topics in Breastfeeding, Set XVIII, O'Brien M, *Psychology, the mother and breastfeeding duration* (2006), p 2.

34 Escott R, transcript, 7 May 2007, p 20.

- 4.18 Many women experience some difficulties with breastfeeding particularly in the early days. These can include sore nipples, lack of milk, engorgement, fast milk flow and lack of weight gain of the infant. These can usually be readily overcome with advice, assistance and support.<sup>35</sup>
- 4.19 In the study 'Psychology, the mother and breastfeeding duration', two factors were identified which had an impact upon a mother's intention to wean. The first was how breastfeeding impacts the mother's comfort and wellbeing both practically and in respect to her confidence to succeed at breastfeeding. The second factor encompasses the mother's concern for the comfort and wellbeing of her baby, including concern over having enough milk for the baby and for the baby's night sleeping behaviour. Both these factors may reflect the mother's lack of confidence in breastfeeding meeting the needs of her baby. Interestingly milk supply and the baby's sleeping behaviour are common breastfeeding problems which could almost certainly be improved by the provision of skilled postnatal support.<sup>36</sup>
- 4.20 Duration of breastfeeding could be increased by identifying the factors which contribute to early weaning and finding a way to modify those factors or remove any negative effect. Unfortunately, most of these are difficult or impossible to modify. They are things like a woman's age, years of education or early return to paid employment. There needs to be more research which focuses on identifying and exploring the modifiable factors.<sup>37</sup>

## Low supply and perceived low supply

- 4.21 The 2001 National Health Survey found that the most common reason Australian women gave for weaning early was insufficient milk supply.<sup>38</sup> Low supply is often given as a reason for stopping breastfeeding in the first six to eight weeks or around four months. This perception of low supply may be due to the baby waking at night, having shorter feeds or having a weight gain that is perceived

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35 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 354.

36 Lactation Resource Centre, Topics in Breastfeeding, Set XVIII, O'Brien M, *Psychology, the mother and breastfeeding duration* (2006), p 2.

37 O'Brien M, transcript, 17 April 2007, pp 32-33.

38 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001* (2001), cat no 4810.0.55.001, p 4.

to be lower than it should be.<sup>39</sup> Additionally the mother may consider that her breasts no longer have the full, engorged feeling and may attribute this to a lack of milk.<sup>40</sup> Dummy sucking, timed feeding, topping up with formula and non-breastfeeding friendly medications are all commonly advised by medical professionals and can contribute to this problem.<sup>41</sup>

4.22 Research has found that a perception of insufficient milk supply may not be a real insufficiency but a result of misinterpreting infant behaviour such as the effect of restricting the frequency of breastfeeding or a mother's lack of confidence in the ability to breastfeed. Mothers may also report that they weaned due to low milk supply because this is considered a socially acceptable reason for weaning.<sup>42</sup>

4.23 As these issues may have nothing to do with actual milk supply, mothers require support and well informed advice from health professionals such as Maternal and Child Health Nurses, lactation consultants and GPs to help them through this period. Without appropriate assistance women may commence using infant formula. Many women are subsequently reassured by the volume they can mix, see, and deliver to their infant when using infant formula.

In a world where having tangible outcomes and evidence is promoted in earnest, it is little wonder that new mothers also want to see exactly how much milk their infant is receiving.<sup>43</sup>

## Demand feeding and routines

4.24 Demand feeding or baby-led breastfeeding can leave some women feeling tied to the couch for hours on end and this can be enough to prompt some mothers to give up breastfeeding.<sup>44</sup> It is normal for young babies to feed eight to twelve times in 24 hours and for these feeds to be unevenly spaced; for example, evening 'cluster feeding' is very common.<sup>45</sup>

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39 NHMRC, sub 35, p 4; Poste C, sub 229, p 2.

40 BellyBelly.com.au, sub 441b, p 15.

41 Tutt S, sub 71, p 1; Nielsen L, sub 355, p 2.

42 Gribble K, School of Nursing, University of Western Sydney, sub 251, p 11.

43 Giglia R, sub 68, p 2.

44 Name withheld, p 413, p 2.

45 Hall T, sub 70, p 2.



- 4.25 Demand feeding can be very difficult for a new mother to manage and she may seek advice or suggestions from health professionals and relatives. Evidence suggests that this is often to get the baby into a routine. This can lead to mothers trying to limit their baby to three to four hourly feeds rather than stimulating supply by putting baby to the breast as the baby demands.<sup>46</sup> For some women the change to three to four hourly breast feeds can interfere with the supply-demand relationship and cause their breast milk supply to drop, encouraging the belief that breast milk supply is inadequate. The resulting practice of then introducing formula to supplement their breast milk has the effect of further reducing supply.<sup>47</sup>

Many mums I speak to don't understand the very basics of how breastfeeding works and think if they wait longer between feeds then their breasts will be fuller and there will be more for baby when the opposite is true.<sup>48</sup>

- 4.26 Mothers may find that their supply is affected by something as simple as trying to establish a routine with their baby's feeding. 'Sleep, Feed, Play' routines are a common suggestion for parents with unsettled babies<sup>49</sup> but due to fewer feeding opportunities, the reduced demand can have an effect upon a mothers milk supply.

## Myths and misconceptions

- 4.27 There are many myths and misconceptions surrounding breastfeeding<sup>50</sup> and these can contribute to breastfeeding prematurely ceasing. These myths may come from health professionals, family members or even through advertising (see chapter 6).
- 4.28 Myths seem to be continually perpetuated in both the health system and the community. Myths and misconceptions, held by people years ago, appear to remain as prevalent today. The effects of these myths can be compounded by poor advice from health professionals and lack of knowledge about breastfeeding which may cause mothers to doubt their ability to breastfeed. The committee received

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46 See for example Boas T, sub 65, p 1; Hall T, sub 70, p 2; Larner, S, sub 117, p 3; Lording R, sub 186, p 9; Poste C, sub 229, p 2; Lewis D, sub 258, p 3; Nielsen L, sub 355, p 2.

47 Robinson L, sub 90, p 1; Poste C, sub 229, p 2; Alexander M, sub 289, p 5.

48 Hall T, sub 70, p 2.

49 Ng A, sub 127, p 2.

50 Greentree J, sub 93, p 1.

evidence of mothers of newborns who had given up breastfeeding within a week of leaving hospital for the following reasons:

- one mother with inverted nipples was told by a nurse that she would not be able to breastfeed;
- one mother was concerned that she couldn't get her one week old baby to settle;
- one mother was told by her paediatrician that she probably didn't have enough milk, so she should just switch to formula; and
- one mother was told by a baby health clinic nurse that she was overfeeding by breastfeeding on demand and needed to 'get the baby into a routine'.<sup>51</sup>

4.29 Some of the more common myths relate to the composition of breast milk and its quality as well as how long breast milk has a nutritional benefit.<sup>52</sup> Many mothers presume that genetic factors are responsible for their poor milk supply. When they have difficulties they may conclude that this 'runs in the family'.<sup>53</sup> Other myths relate to normal infant behaviour such as sleeping, crying and bowel movements. One of the most prevalent myths is that if you give a baby infant formula it will sleep through the night. This myth was extremely prevalent.<sup>54</sup>

4.30 When a breastfeeding mother becomes pregnant, she may be advised by health professionals to wean, without being told that she could continue breastfeeding. Often the mother may become pregnant and continue feeding during her pregnancy and then keep feeding her older child and the new baby, which is called tandem breastfeeding. This can be done safely if the mother eats well, gets enough rest and makes sure the new baby's needs are met first and mothers can find it enhances their breastfeeding relationship.<sup>55</sup>

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51 Chapman C, sub 94, p 1; Royds D, sub 370, p 1.

52 Werner C, sub 6, p 2; Bayldon J, sub 57, p 1; Colman C, sub 260, p 2; Moss M, sub 363, pp2-3.

53 Minchin M, *Breastfeeding Matters (1998)*, 4<sup>th</sup> ed, Alma Publications, p 116.

54 See for example, Hartley M, sub 8, p 1; Dixon G, sub 30, p 1; Jeffery L, sub 34, p 3; Ward K, sub 56, p 3; Boas T, sub 65, p 1; Green S, sub 69, p 1; Daniel A, sub 78, p 4; Rothenbury A, sub 87, p 4; Carter N, sub 126, p 1; Smith S, sub 133, p 2; Groom S, sub 284, p 1; McKellar J, sub 303, p 2; Schafer D, sub 321, p 2.

55 Warner B, sub 14, p 1; Austin R, sub 49, p 2; Brycesson S, sub 96, p 1; Poggioli C, sub 100, p 1; Eldridge S, sub 214, p 2; Oates P, sub 245, p 1; Hendriks M, sub 262, p1; Heppell M, sub 291, pp 5-6; Roberts J, sub 469, p 1.

- 4.31 These myths, in conjunction with the lack of breastfeeding support and inconsistent advice, may lead women to feel they are left with no choice other than to use infant formula.

One thing for sure is that as parents we are told what it is expected of us in relation to feeding our older children a healthy diet (ie healthy natural food not just processed foods) but it is not made clear that breastfeeding is the natural milk option and that choosing formula feeding is equivalent to offering a completely processed food diet. By educating women in this fact many may very well may look for different ways to solve the above issues without threatening their own ability to keep feeding.<sup>56</sup>

## Sleep

- 4.32 The physical demand that breastfeeding may place on a mother is often underestimated. Mothers may feel that if their baby is not sleeping through the night by three to four months of age, they have failed as a parent. If a mother is unable to express then they are the only one who can breastfeed and always have to be the one who gets up at night.<sup>57</sup>

It is very, very difficult to stay focused on the benefits of exclusively breastfeeding your child for the first six months when you are absolutely at your physical and emotional limits, its four o'clock in the morning and you've just been up for the seventh time that night.<sup>58</sup>

- 4.33 Co-sleeping, where the baby and mother sleep together and night feeding can take place in bed without much disruption, can be a strategy<sup>59</sup> and can assist with maintaining supply. However, it needs to be done safely and is not an option that suits all mothers or parents.

### **Box 4.3 How do you breastfeed your baby - Night feeding**

Particularly during the first half-year it is usual that the baby requires feeding 24 hours, day and night. Night breastfeeding stimulates milk production, and with a baby night feeds are a simple matter. With the lowest possible light, take the baby up

56 Mulheron S, sub 472, p 1

57 Name withheld, sub 411, p 1.

58 Daniel A, sub 78, p 5.

59 Love M, sub 322, p 9; Miller-Mustard S, sub 206, p 1.

to you in the bed when you breastfeed, and you should there sleep together if there are not any contraindications against it. The baby should have its own doona/quilt.

If the parents smoke, the baby should sleep in its own bed because of an increased risk for SIDS. Care and nappy changes should take place only if it is absolutely necessary. Some babies sleep through the night very early, others wake every night, whether they have mothers milk or not. Only if the baby has a satisfactory weight gain, is it alright to allow it to sleep through the night.

If you for a time have too little milk or the baby is not settling, you should breastfeed often and willingly add in a night feed or two. If you become tired and stressed with all the night waking and much night feeding, try to sleep a little yourself when the baby sleeps during the day.

*Source: Translated from the Norwegian Directorate for Health and Social Affairs publication 'Hvordan du ammer ditt barn?' (How do you breastfeed your baby? 'Night feeding' p 16), viewed on 30 July 2007 at [http://www.shdir.no/vp/multimedia/archive/00004/IS-2092\\_4513a.pdf](http://www.shdir.no/vp/multimedia/archive/00004/IS-2092_4513a.pdf)*

## Infant weight

- 4.34 Mothers may be concerned that their baby is not gaining the appropriate amount of weight or be advised by health professionals that they need to complementary feed with infant formula. Information on weight and growth charts is covered in more depth in chapter 6. However, the committee noted the significant evidence of the impact that an infant's weight has on a mother and her feeding decisions particularly in the early days.<sup>60</sup>

## Extended breastfeeding

- 4.35 The WHO recommends breastfeeding exclusively for six months and then to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.<sup>61</sup> The Dietary Guidelines note that after six months,

<sup>60</sup> Gray N, sub 10, p 2; Warner B, sub 14, p 2; Eldridge M, sub 25, p 1; Dixon G, sub 30, p 2; Pile C, sub 38, p 3; Cleghorn J, sub 46, p 4; Hall T, sub 70, p 1; Davis N, sub 124, p 1; Rose M, sub 139, p 1; Anderson B, sub 183, p 2; Ellis P, sub 197, p 2; McDonald R, sub 203, p 1; Austin P, sub 254, p 2; Ballantyne M, sub 261, p 1; De Lacey J, sub 285, p 1; name withheld, sub 380, p 1; Cuff S, sub 382, p 1; name withheld, sub 391, p 1; Pearce M, sub 394, p 1; Martin P, sub 395, p 1; Jeffree E, sub 403, p 1; name withheld, sub 405, p 1; name withheld, sub 416, p 1; Gibbens M, sub 418, p 1; Webb G, sub 425, p 1; Taylor K, sub 443, p 2; Blake R, sub 447, p 1; name withheld, sub 448, p 1; Phillips J, sub 460, p 7.

<sup>61</sup> WHO Global strategy for infant and young child feeding Report, viewed on 30 July 2007 at [http://www.who.int/gb/ebwha/pdf\\_files/EB109/eeb10912.pdf](http://www.who.int/gb/ebwha/pdf_files/EB109/eeb10912.pdf).

continued breastfeeding along with complementary foods for at least 12 months will bring continuing benefits.<sup>62</sup>

- 4.36 Breastfeeding a child over the age of one is considered to be 'extended' breastfeeding in the community. Mothers report that breastfeeding beyond 12 months elicits 'significant stigma and taboo' from the public.<sup>63</sup> Some mothers deliberately avoid feeding an older infant in public, and can feel quite sad at having to do this.

The community views breastfeeding an older baby, let alone a toddler, as sick and 'child abuse'. I know of many women who are scared to breastfeed in public. I know of women who have been abused for doing so.<sup>64</sup>

- 4.37 There seems to be a curious dichotomy in the community where an infant of 18 months is still considered to be totally dependent on their parents for everything including food but is perceived to be too old to breastfeed. The committee would like to reaffirm its support for women being able to breastfeed for as long as they and the child wish to continue.

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62 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 306.

63 Boswell D, sub 99, p 2; Jackson S, sub 11, p 2; Jones R, sub 13, p 1; Johnson L, sub 167, p 1; Tustian M, sub 189, p 1; Coombes A, sub 296, p 1.

64 Warner B, sub 14, p 2.



*I am one of those mothers who found breastfeeding to be an absolute and utter nightmare. I did not successfully feed any of my children and consider it to be one of my biggest 'failures' in life.<sup>1</sup>*

## Breastfeeding challenges

### Overview

- 5.1 The barriers to initiation and continued successful breastfeeding are diverse and varied across different populations.<sup>2</sup> They include community attitudes and perceptions about breastfeeding, structural barriers such as lack of facilities to support combining breastfeeding and work, workplace policies and legislative gaps, such as the lack of entitlement to maternity leave. Other barriers identified included lack of partner or family support and inconsistent health care provider information and advice.<sup>3</sup>
- 5.2 Other barriers can include
- cultural perceptions, beliefs and practices;
  - low levels of education and or literacy;
  - low socioeconomic status;

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1 Stavrakis C, sub 433, p 1.

2 Childbirth Education Association, Brisbane, sub 212, p 2.

3 Department of Human Services (Vic), *Giving breastfeeding a boost – community based approaches to improving breastfeeding rates – a literature review (2005)*, p vii.

- lack of ongoing breastfeeding support, or access to such support; and
  - lack of appropriate education and ongoing advice on techniques for successful breastfeeding establishment in the first six weeks after the birth.<sup>4</sup>
- 5.3 Hospital practices can be a barrier to breastfeeding<sup>5</sup> but with the implementation of programs such as the Baby Friendly Hospital Initiative (BFHI) (see chapter 6) hospital practices can encourage and support breastfeeding.<sup>6</sup>
- 5.4 The online parenting forum [www.bellybelly.com.au](http://www.bellybelly.com.au), in response to this inquiry, surveyed its users on the biggest barrier to breastfeeding. 361 participants took part; most participants were mothers who had recently had children. The results indicated that they felt lack of education was the biggest barrier, followed by conflicting advice after the birth.<sup>7</sup>

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4 Brisbane Northside Population Health Unit, sub 279, p 3.

5 Hall T, sub 70, p 1; Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 8; Australian Nursing Federation, sub 271, p 6; Key Centre for Women's Health in Society, sub 294, p 11; Smith J, Australian Centre for Economic Research on Health, sub 313, p 8.

6 Northern Sydney Central Coast Health Breastfeeding Promotion Committee, sub 163, p 6; Oddy W, Telethon Institute for Child Health Research, sub 216, p 27.

7 BellyBelly.com.au, sub 441a, pp 16-27.



Table 5.1 What do you think is the biggest barrier to breastfeeding in Australia?

Barrier	%
Conflicting advice after birth	17.73%
Interventions at birth	2.49%
Lack of continuity of care	11.91%
Accessibility of artificial milk	5.54%
Marketing of artificial milk	1.39%
Lack of education	27.98%
Health professional influence e.g. MCHN, Paediatrician	4.71%
Family &/ friends ideals/advice/expectation	12.47%
Going back to work with lack of bf support	6.93%
Lack of availability/affordability of support	8.86%

Source: BellyBelly forums, viewed on 30 July 2007 at <http://www.bellybelly.com.au/forums/showthread.php?t=38097>.

5.5 The interaction between these barriers and strategies to promote breastfeeding needs to be considered. Ngala, a family resource centre in Western Australia, noted that initiatives to encourage breastfeeding are often too targeted and do not take into account the multitude of issues that are barriers to breastfeeding, such as the father's opinion, cultural roles and expectations, responsibilities, as well as the belief or assumption that using developed world products are better than old world strategies such as breastfeeding.<sup>8</sup>

## Returning to work

5.6 A high proportion of the workforce is made up of women of childbearing age who play a substantial role in the national economy. The committee considers that it is a woman's right to choose whether or not to enter the paid workforce after the birth of a baby and that she should be supported in her choice.

5.7 There has been an increase in the number of Australian mothers with a child less than 12 months old returning to work, increasing from 25 per cent in 1996 to 44 per cent in 2004. In 2004 the Longitudinal Study of Australian Children found that 25 per cent of these women

8 Ngala Family Resource Centre, sub 77, p 5.

returned to work before their child is six months old. Some mothers return to employment only a few weeks after childbirth.<sup>9</sup> The Australian Bureau of Statistics Pregnancy and Employment transition survey found 'financial reasons' was the most common response given by women for either starting or returning to work in a job within two years of the birth of their child, followed by 'adult interaction and mental stimulation'.<sup>10</sup> The National Health Survey (NHS) showed that the trend to workforce participation by new mothers might be impacting adversely on breastfeeding. One in ten mothers reported return to work as a reason for premature weaning, and an increased proportion of children were receiving solids or breast milk substitutes during the first six months of life compared to the previous survey in 1995.<sup>11</sup>

- 5.8 Evidence shows that families are increasingly struggling to combine work commitments with family needs and mothers need real and supported choices in order to return to work.<sup>12</sup> Female employees have needs related to pregnancy, birth and lactation which need to be recognised.<sup>13</sup> There is a real risk that if women are not supported, returning to employment can be an obstacle to breastfeeding to the point of affecting the duration and exclusivity of breastfeeding, or even to the degree of weaning their infants.<sup>14</sup>

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.<sup>15</sup>

- 5.9 Mothers returning to work face extra stresses.<sup>16</sup> They may be forced into returning to work for economic reasons, not through personal choice.<sup>17</sup> Many women are not entitled to paid maternity leave; the

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9 Australian Breastfeeding Association, sub 306, p 29.

10 Australian Bureau of Statistics, *Pregnancy and Employment Transitions* (2005), cat no 4913.0

11 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001* (2001), cat no 4810.0.55.001, p 3.

12 Flack-Kone A, sub 134, p 1; Stanger J, sub 428, p 1.

13 Australian Breastfeeding Association, sub 306, pp 28-29; Kelleher B, sub 44, p 2; Pollock R, sub 60, p 1; Hooper N, sub 169, p 1.

14 Stewart K, sub 64, p 1; Hartley B, sub 366, pp 2-3.

15 Eldridge S, sub 214, p 8.

16 Clinton J, sub 471, p 1.

17 Matthews K, sub 287, pp1-2.

Tasmanian Branch of the Australian Breastfeeding Association and the Women's Electoral Lobby notes that only 23 per cent of Australian workplaces offer paid maternity leave to working mothers, and the average period of leave is eight weeks.<sup>18</sup>

- 5.10 When women return to work and continue breastfeeding, they may also not be able to physically express or find the process too difficult and may prematurely wean their baby. Expressing on a lactation break can take practice but many mothers find it gets better with time. One woman indicated to the committee that:

I think also there is an assumption that returning to the workforce early is viable, but even returning part time trying to express, to maintain breastfeeding and then still have interrupted sleep is unrealistic, women will soon become exhausted and that does not go well for family life.<sup>19</sup>

## Breastfeeding and work

- 5.11 Women can find that breastfeeding and working can be combined.<sup>20</sup> There are employers that support women to combine breastfeeding with work by providing flexible work conditions, suitable facilities for expressing breast milk such as a fridge and a private office, and paid lactation breaks.<sup>21</sup> Additionally, the committee was informed that the support of work colleagues can be very important:

I am interested that my youngest sister, whose first baby is 11 months old, has the encouragement of working in a Breastfeeding Friendly Workplace, the Department of Education (etc) in Canberra. She was given a maternity package before she left work, and on return she was given the information for how to access the expressing room and support for her part-time hours. She has said all the staff speak positively to her about going out to express, including the security guard who gives her the room key.<sup>22</sup>

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18 Australian Breastfeeding Association, Tasmanian Branch, sub 172, p 8; Women's Electoral Lobby, sub 310, p 7.

19 Ormston T, sub 253, p 4.

20 Ryan K, sub 17, p 2; Rasmi Sakulsuvarn F, sub 63, p 1; Dean R, sub 288, p 1.

21 Name withheld, sub 45, p 1; Willis R, sub 193, p 2.

22 Elliott-Rudder M, sub 371, p 5.

- 5.12 Workplaces such as Queensland Health have developed a policy on work and breastfeeding. Queensland Health supports staff wishing to continue breastfeeding on returning to work by:
- allowing paid lactation breaks of up to one hour per day;
  - providing facilities suitable for breastfeeding or expressing milk; and
  - providing supportive management to assist the needs of both the staff and their work commitments.<sup>23</sup>
- 5.13 The Australian Breastfeeding Association (ABA) noted that there are benefits that employers perceive from supporting their staff to combine work and breastfeeding and these benefits can have a real impact on the bottom-line for their organisation.<sup>24</sup> They include improved retention of female employees after maternity leave, thus preventing loss of skilled staff and the costs associated with recruitment and retraining or replacement. Other benefits can be reduced absenteeism and staff turnover because of improved health of mother and baby and increased staff loyalty because of the support they provide.
- 5.14 The committee supports employers who help their female staff combine work and breastfeeding. The committee encourages all employers, large and small, to support breastfeeding employees and at the very least, offer them paid lactation breaks.

### **Breastfeeding-Friendly Workplace Accreditation (BFWA) Program**

- 5.15 The ABA has a 'Breastfeeding-Friendly Workplace Accreditation (BFWA) Program' which can accredit workplaces as being breastfeeding friendly. The accreditation process provides:
- resources from the ABA and access to information from Australia's leading source of breastfeeding resources and support;
  - information for the workplace to develop their own personalised information pack to give to employees going on maternity leave, or access to the ABA's 'Come Back Pack';

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23 Queensland Health, sub 307, p 9.

24 Makarian R, sub 159, p 3.

- heightened awareness within the workplace of the importance of breastfeeding and therefore the positive spin-offs that breastfeeding provides in the longer term;
  - the increased opportunity to attract and retain female employees and reduce on-going training and recruitment costs; and
  - recognition of supportive workplace policies and practices.
- 5.16 Since July 2002, the ABA has accredited more than 40 workplaces across Australia. This has included six major Commonwealth government agencies, several hospitals, health service providers and tertiary education institutions. State and Territory Government agencies have also gained accreditation for their agencies.
- 5.17 The committee noted that the head office of Westpac in Sydney has recently been accredited through the BFWA program and during the site inspection considered that Westpac has highly suitable facilities for women wishing to combine breastfeeding and work in the office. The committee notes and commends the recent accreditation of both the ACT Department of Health and the ACT Legislative Assembly.<sup>25</sup> The committee encourages more organisations to become formally accredited.
- 5.18 The committee received a submission from the Hon Roger Price, Chief Opposition Whip, detailing the consideration that the three Chief Whips and the Procedure Committee of the House of Representatives were giving to the facilitation of breastfeeding for Members.<sup>26</sup> The committee notes that the Procedure Committee has tabled a report in Parliament<sup>27</sup> and considers that Parliament House should be showing leadership in the area of breastfeeding and work.

### Recommendation 10

- 5.19 **That the Speaker of the House of Representatives and the President of the Senate take the appropriate measures to enable the formal accreditation by the Australian Breastfeeding Association of Parliament House as a Breastfeeding Friendly Workplace.**

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25 Stanhope, J, MLA, ACT Chief Minister, media release, *ACT Health and Legislative Assembly now breastfeeding friendly*, 23 July 2007.

26 Hon R Price MP, Chief Opposition Whip, sub 461, p 1

27 Parliamentary Joint Committee on Procedure, *Options for nursing mothers* (2007), Commonwealth of Australia.

**Recommendation 11**

- 5.20 **That the Department of Health and Ageing provide additional funding for the Australian Breastfeeding Association to expand the Breastfeeding-Friendly Workplace Accreditation (BFWA) Program nationally to enable the accreditation of more workplaces.**

**Breastfeeding equipment**

- 5.21 Lactation aids such as manual and electric breast pumps, nipple shields and supply lines are input taxed under the Goods and Services Tax (GST). These products are used to assist infants who are not able to obtain milk directly from the breast. Some babies are unable to suckle, through separation, illness or disability, or even inexperience. However, breast milk substitutes such as infant formula are GST-free.<sup>28</sup> This means that infant formula is effectively subsidised, rather than levied by the tax system, while breast milk production is taxed.<sup>29</sup>
- 5.22 The complexity of the tax system makes issues such as this rarely as straightforward as they may appear but the committee is concerned that GST-free status for infant formula may create the perception that it is perceived by the tax system to be the default food for an infant.

**Recommendation 12**

- 5.23 **That the Treasurer move to exempt lactation aids such as breast-pumps, nipple shields and supply lines from the Goods and Services Tax.**

**Family Law**

- 5.24 One area where breastfeeding is now being considered as more than just a relationship between a mother and a baby is in relation to family law. Since the changes to the *Family Law Act 2006*, the National Council of Single Mothers and their Children Inc. (NCSMC) reported to the committee situations where a mother has been directed by a

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28 Australian Tax Office website viewed on 25 July 2007 at <http://www.ato.gov.au>

29 Smith J, 'Mothers' Milk and Markets', *Australian Feminist Studies* (2004), vol 19, no 45, pp 369-379

judge to wean so that shared custody arrangements can take place after a family separation.<sup>30</sup>

- 5.25 NCSMC also reports that breastfeeding has been regarded by some legal professionals as a strategy employed by mothers to limit or prevent fathers spending time with their children after separation. An increasingly common outcome in children's proceedings involving breastfed infants is the allocation of babies to a shared care arrangement between parents, which is likely to be incompatible with successful breastfeeding.<sup>31</sup>
- 5.26 There appears to be a lack of understanding on the part of the legal profession dealing with family law matters of the mechanics of breastfeeding. It is not simply a process which can be stopped and started on cue and where milk can be extracted to send with the child to the other parent for days at a time.
- 5.27 The committee encourages Family Relationships Centres and the Family Law Court to ensure that breastfeeding is given suitable consideration in the making of interim and final orders regarding the placement of children with separated parents.

### Recommendation 13

- 5.28 **That the Attorney General investigate whether breastfeeding is given suitable consideration in the implementation of shared custody arrangements and also provide advice to the Family Law Court and Family Relationships Centres on the importance of breastfeeding.**

### People with compounding issues

- 5.29 In the community there are many women with compounding issues, such as drug use, who may be pregnant, or be a new mother and who may need greater support to assist them with being able to breastfeed their infant. Through this inquiry, the committee has received evidence on two of these situations but acknowledges that mothers may have other conditions and issues which require a similar level of support.

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30 National Council of Single Mothers & their Children, sub 182, p 4.

31 National Council of Single Mothers & their Children, sub 182, p 4; Bailey C, sub 227, p 1.

## Drug use when breastfeeding

5.30 The 2004 National Drug Strategy Household Survey found that women who were pregnant and/or breastfeeding in the previous 12 months were less likely to consume alcohol (47 per cent) and any illicit drug (six per cent), compared with when they were not (85 per cent and 17 per cent respectively). Pregnant and/or breastfeeding women appeared less likely to reduce their tobacco consumption, with 22 per cent smoking when they were not pregnant and/or breastfeeding, and 20 per cent continuing to smoke during pregnancy and/or while breastfeeding.<sup>32</sup>

Table 5.2 Drug use in the last 12 months, pregnant and/or breastfeeding women and all other women, women aged 14-49 years, Australia, 2004

	Pregnant and/or breastfeeding in the last 12 months <sup>(a)</sup>			Not pregnant and/or breastfeeding in the last 12 months <sup>(d)</sup>
	Whilst pregnant and/or breastfeeding <sup>(b)</sup>	Generally <sup>(c)</sup>		
Tobacco	20	22	25	
Alcohol	47	85	85	
Marijuana/cannabis	5	11	13	
Any illicit drug	6	17	18	
Any illicit drug other than marijuana/cannabis	2	10	10	

(a) Women reporting that they were pregnant and/or breastfeeding in the last 12 months.

(b) Responses to specific questions about drug use during pregnancy/breastfeeding.

(c) Responses to general questions about drug use during the last 12 months.

(d) Women reporting that they were not pregnant and/or breastfeeding in the last 12 months.

Source: Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2004 (2005)*, cat no PHE 62, pp 62-63.

5.31 The National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn recommend:

Mothers who are drug dependent should be encouraged to breastfeed with appropriate support and precautions. In addition, it is now recognised that skin-to-skin contact is important regardless of feeding choice and needs to be

32 Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2004 (2005)*, cat no PHE 62, pp 62-63.



actively encouraged for the mother who is fully conscious and aware and able to respond to her baby's needs.<sup>33</sup>

- 5.32 The committee considers it important that pregnant women are educated on the appropriate use of drugs, including tobacco and alcohol during pregnancy. The committee commends the work of health professionals with mothers who are drug dependent in ensuring the best possible outcomes for the baby and the mother.

### Postnatal depression

- 5.33 Around 15 to 20 per cent of Australian mothers are diagnosed with postnatal depression (PND). There is a complex relationship between PND and breastfeeding and each woman's experience is different. For some women breastfeeding can help reduce the likelihood of PND developing or the duration of the condition. For others it may be the greatest source of stress and anxiety and it may be more beneficial for the mother to discontinue breastfeeding. The additional element at play relates to the new mother's partner and their views and experience of breastfeeding. If the partner is not able to provide emotional and practical support then the new mother is less likely to persevere with breastfeeding.<sup>34</sup>
- 5.34 Many mothers indicated that they considered the pressure to keep breastfeeding had contributed to them developing or coming close to developing PND.<sup>35</sup>
- 5.35 In most cases, PND starts before breastfeeding commences and women who have PND are more likely to stop breastfeeding early. Therefore, it is possible that a mother's perception of her breastfeeding ability, caused by PND, as opposed to actual physical difficulties, may influence her decision about how long she breastfeeds.
- 5.36 The Post and Antenatal Depression Association (PANDA) advocates that breastfeeding should be encouraged for women with PND, or those at risk of developing it. PANDA notes that the physical and psychological importance of breastfeeding for the mother and baby is

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33 Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), p 19.

34 Hoyle Z, Post and Antenatal Depression Association, transcript, 7 June 2007, p 58.

35 Lerner S, sub 117, p 3; Davis N, sub 124, pp1-3; Forbes R, sub 143, p 1; Foster M, sub 147, p 1; name withheld, sub 380, p 1; Liu E, sub 383, p 1; Galilee M, sub 385, p 3; Shorten M, sub 386, p 1; Phillips J, sub 460, p 1.

likely to outweigh any potential negative effects of antidepressant medication on the baby via the breast milk.<sup>36</sup>

Too depressed to get dressed and too exhausted to move. Certain I was a failure as a mother because I couldn't nourish my daughter as nature intended. Certain she hated me since she screamed so much and fought me. Certain I was judged by everyone as a failure because I wasn't perfect enough. Deliriously tired from lack of sleep and little support. I was obsessed with breastfeeding, and felt my value as a mother depended on my ability to perform this simple task. Since I couldn't do it, I must be a bad mother and unworthy of my beautiful child.<sup>37</sup>

- 5.37 The committee considers that mothers who suffer from PND need the full support of the health system and the community to ensure an early and accurate diagnosis and treatment. Where a mother prefers to continue breastfeeding, health professionals should ensure that as far as possible medication prescribed enables breastfeeding to occur.

### Breastfeeding and medical treatment

- 5.38 One example reported to the committee of how breastfeeding is not actively supported is in the situation of women who are breastfeeding and need to be admitted to hospital for other reasons than breastfeeding. These women may have great difficulty continuing to breastfeed with reports of hospitals telling them there is no way to support their breastfeeding and they need to wean or health professionals not understanding the effect that a mother's medication may have on the breastfeeding child.<sup>38</sup>

#### **Box 5.1 Artificial Reproductive Technology**

Australian women who had conceived with assisted reproductive technology (ART) - known in lay terms as fertility treatment or IVF - are a group who may have higher levels of difficulties with breastfeeding. A recent study undertaken by Dr Karin Hammarberg of the Key Centre for Women's Health in Society found that although 89 per cent of women in the study initiated breastfeeding, at three months the proportion exclusively breastfeeding was smaller than that of the women in the 1995 Australian National Health Survey - 45 per cent versus 62 per cent respectively.

36 Hoyle, Z, Post and Antenatal Depression Association, transcript, 7 June 2007, p 61.

37 Davis N, sub 124, p 2.

38 Cassar S, sub 113, p 2; Leonard M, sub 283, p 1, Gill B, sub 392, p 1.

A number of factors associated with higher rate of initiation and longer duration of breastfeeding were all prevalent in the ART study population but in spite of this, the rate of initiation of breastfeeding was not higher and the proportion breastfeeding at three months was significantly lower than in Australian women.

*They have been through an ordeal to have that baby—to get that baby—and they potentially idealize motherhood. They do not trust their bodies to do the right thing, and that is why they need extra support. At the moment Karin is going through a real push to get that research out into the community, to midwives and others, who need to understand that women who have had fertility problems are at high risk of not just breastfeeding problems but other difficulties adjusting to becoming a mother. (Ms Amanda Cooklin)*

*Source: Key Centre for Women's Health, sub 294, pp8-10; Cooklin A, Key Centre for Women's Health, transcript, 7 June 2007, p 46.*

## When breastfeeding does not work out

5.39 The WHO in the Global Strategy for infant and young child feeding states that the vast majority of mothers can and should breastfeed, just as the vast majority of infants can and should be breastfed.<sup>39</sup> Physiologically almost all women can breastfeed.<sup>40</sup> It is estimated that two to five per cent of women are not able to make enough milk to support an infant. However, the rates of breastfeeding in Australia, as discussed in chapter 2, indicate that despite this ability to breastfeed, many women are not continuing with breastfeeding. The Australian Lactation Consultants Association noted that breastfeeding is complex:

It is not simply putting a baby to the breast; it is totally encompassing of a woman and her family and learning about her child. When things get difficult, which they do with children, it is the one thing that women can give up.<sup>41</sup>

5.40 The Women's Electoral Lobby noted that it is often said that women choose to breastfeed or not, but they question what kind of choice that is, and whether women have real choice:

Our society does not do enough to support breastfeeding, leaving women with the only choice or option of giving their

39 WHO Global strategy for infant and young child feeding Report, viewed on 30 July 2007 at [http://www.who.int/gb/ebwha/pdf\\_files/EB109/eeb10912.pdf](http://www.who.int/gb/ebwha/pdf_files/EB109/eeb10912.pdf).

40 Binns C, transcript, 26 March 2007, p 13; Huntly M, sub 343, p 3.

41 Moody G, Australian Lactation Consultants Association, transcript, 4 June 2007, p 30.

babies artificial milks. It is this lack of real choice that hurts the health and wellbeing of current and future mothers as well as their babies.<sup>42</sup>

- 5.41 Mothers feel guilt because they did not or could not persevere with breastfeeding and they consider that they have failed.<sup>43</sup> In discussions about infant feeding, often mothers are considered to have chosen to breastfeed or chosen to use infant formula:

And it is about choice. If mothers choose, that is their choice. But why should the rest of the population pay in terms of the health care costs for not breastfeeding that baby later on down the track?<sup>44</sup>

- 5.42 The committee considers that it is not simply a matter of choice. Evidence provided to the committee demonstrated that most women who stopped breastfeeding earlier than desired had taken significant steps to try and continue. The committee observed that women were not supported, they could not access help when they needed it, they were given unsuitable advice and they were ultimately placed in a situation where their ability to breastfeed was so undermined that the use of infant formula was the most likely result. Although there are some women who choose to use infant formula, the committee contends that many women who did not continue with breastfeeding did so because they did not have appropriate levels of support or advice to assist them:

These mothers have no reason to feel guilty. They have not 'failed'. Our community has failed them by not giving them timely support and accurate information to prevent the problems from developing.<sup>45</sup>

- 5.43 Mothers who have stopped breastfeeding and started using infant formula report that they feel as though they are being judged; judged by their peers, judged by the community and treated as though they made a choice to take the easy way out.<sup>46</sup> People observing from the outside may oversimplify the reasons why a mother does not continue with breastfeeding.
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42 McKenzie I, Women's Electoral Lobby, transcript, 7 May 2007, p 30.

43 O'Dowd Y, sub 33, p 2.

44 Tattam A, Key Centre for Women's Health in Society, transcript, 7 June 2007, p 43.

45 Dickson E, sub 162, p 2.

46 See for example Sands B, sub 73, p 2; Psalios S, sub 76, p 2; Davis N, sub 124, p 2; Royal Australasian College of Physicians, sub 175, p 2; Forde L, sub 243, p 4; Bowen M, sub 337, p 8; Tinsley M, sub 414, p 1; Gough K, sub 436, p 1; Attard H, sub 449, p 2.

...as soon as it gets difficult they give up as they don't know how to work through these issues and say things like, "I couldn't breastfeed" which is usually not the case, they just couldn't be bothered or didn't know how to work through the problem.<sup>47</sup>

- 5.44 There are women who choose not to breastfeed. Cairns Base Hospital noted that staff will do one-on-one antenatal counselling with mothers who are undecided or have chosen to use infant formula. These mothers are provided with information that enables them to make an informed choice.<sup>48</sup> The Royal Women's Hospital noted that when counselling women about their infant feeding choices that a history of sexual abuse can sometimes influence decision making.<sup>49</sup>

## Guilt and anger

- 5.45 Reasons for stopping breastfeeding are frequently associated with a mother's confidence in her breastfeeding ability and her perception of the impact on the comfort and wellbeing of both herself and her infant.<sup>50</sup>

It does not impact on their breastfeeding per se; we find with a lot of women that their feelings about breastfeeding and their performance as a breast feeder are very mixed up with their feelings about their performance as a mother. If a woman is unable to breastfeed for one reason or another, it affects her confidence in her mothering ability.<sup>51</sup>

- 5.46 Some women find the decision to wean to be straightforward but others may find that untimely weaning leaves them with much sadness and often guilt.<sup>52</sup>

I spent many weeks of heartache and pain, using breast pumps and other devices, to assure myself and others that my baby had to have formula as there was no possibility of breastfeeding. The distress and total disruption to the rest of my family from trying to achieve what was expected of

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47 Bellinger J, sub 149, p 1.

48 Ball R, Cairns Base Hospital, transcript, 4 April 2007, p 36.

49 Moorhead A, Royal Women's Hospital, transcript, 7 June 2007, p 56

50 Lactation Resource Centre, Topics in Breastfeeding, Set XVIII, O'Brien M, *Psychology, the mother and breastfeeding duration* (2006), p 4.

51 O'Brien M, transcript, 17 April 2007, p 36.

52 Lactation Resource Centre, sub 357, p 2.

mothers then, and I believe today, was a very unnecessary experience. The guilt still remains.<sup>53</sup>

- 5.47 The committee observed a range of opinions with respect to women who had breastfeeding difficulties. Some women felt disappointed, angry and cheated with the advice they were given by health professionals when they were having difficulties.<sup>54</sup> They indicated that they could have continued with breastfeeding if they had been given the 'right' advice when they needed it. Alternatively, there were women who indicated that they wished they had been advised to stop breastfeeding sooner.

Emotionally, it was incredibly hard to bond with my son when our sole interaction was him crying, followed by the most excruciating pain that continued at all times, not just with feeding. I did not become strongly attached to him until our breastfeeding relationship finished...I believe I should have been counselled to stop breastfeeding.<sup>55</sup>

- 5.48 Mothers may feel angry that they are being constantly judged.<sup>56</sup> When the topic of breastfeeding comes up among mothers it is often a very emotive and critical discussion that has women believing that again they are being judged for their choices.<sup>57</sup> Virginia Thorley noted that 'mother blame' and lack of community support are two factors which can affect breastfeeding.

Mothers, of course, are great blamers of themselves, whatever they do, but so also are the community, particularly other women...It is not so much breastfeeding; it is the fact that mothers are full of self-doubt, and the community will often back up that self-doubt.<sup>58</sup>

- 5.49 Mothers who used infant formula reported to the committee that they felt upset as they felt they were treated differently in hospital.<sup>59</sup> They felt pressured by health professionals voicing their opinion at their choice, or not providing infant formula in a timely manner.<sup>60</sup> The

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53 Barnett S, sub 341, p 1.

54 See for example Ferluga R, sub 108, p 4; Foster M, sub 147, p 1; Hay L, sub 153, p 3; Willis R, sub 193, p 2.

55 Johnson S, sub 463, p 1.

56 McDonald R, sub 203, p 6.

57 Hall T, sub 70, p 2.

58 Thorley V, transcript, 17 April 2007, p 51.

59 Daniel A, sub 78, p 2; Brown J, sub 344, p 1; Gywn S, sub 459, p 1.

60 Name withheld, sub 437, p 1.

Infant Formula Manufacturers Association of Australia is concerned that promotion of breastfeeding could make mothers who use infant formula feel uncomfortable.

IFMAA fully supports the Committee's desire to promote breastfeeding but requests that any campaign to promote breastfeeding be sensitive to the needs of women who are unable to or make an informed choice not to breastfeed. Infant formula is the only suitable alternative to breast milk. If a campaign to promote breastfeeding can be executed without any accompanying hostility towards formula-feeding, the needs of both breast-feeding and formula-feeding mothers can be met as well as the needs of their infants.<sup>61</sup>

- 5.50 Health professionals such as the Australian College of Midwives have a code of ethics which ensures that midwives need to continue to support people who are not breastfeeding and there is recognition that with the high rates of infant formula use, these mothers and babies need support and the correct information.

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61 Infant Formula Manufacturers Association, sub 328, pp 2-3.





## The health system

### Overview

- 6.1 The health system has a significant impact on the decisions of women to initiate and continue breastfeeding. From the process of giving birth, the follow-up health services available to the new mother and the advice provided, there are several critical areas where change is required. Antenatal education tends to have a focus on the birth, with breastfeeding often being a minor topic. As discussed in chapter 2, breastfeeding education can also be variable.
- 6.2 Reports such as the National Institute of Clinical Studies *Evidence Practice Gaps Report* and the National Health & Medical Research Council's *Dietary Guidelines for Children and Adolescents in Australia* present evidence of the gap between research recommendations and professional health practice regarding breastfeeding promotion and support.<sup>1</sup> A recurrent theme in submissions and oral evidence is that the inconsistency of advice from health professionals contributes greatly to the difficulties that women may experience with breastfeeding.
- 6.3 This chapter examines the effect of the health system on the breastfeeding relationship between a mother and her baby. The impact of the birth, advice given in the early days after birth, early

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1 Government of Western Australia, sub 475, p 8.

discharge from hospital and the ongoing role of health professionals are examined. The chapter also looks at the Baby Friendly Hospital Initiative.

## The birth

- 6.4 The birth process is an integral component of the journey to successful breastfeeding. For many mothers the process of birth can be where much of the focus is directed, with antenatal classes, information on birth choices and the model of care clamouring for her attention.<sup>2</sup> The period after the birth is seen to be in the distant future.

Before falling pregnant and during my pregnancy I was amazed at the avalanche of information relating to the act of birth in a technical sense and the almost 'afterthought' superficial information given about the presence of the baby in life from that point onwards, particularly in relation to breastfeeding.<sup>3</sup>

- 6.5 Most births in Australia occur in hospitals, either in conventional labour-ward settings or in hospital birth centres. In 2004 there were 246,012 women who gave birth in hospitals (97.3 per cent) and 5,079 in birth centres (2.0 per cent). Planned homebirths and other births, such as those occurring unexpectedly before arrival in hospital or in other settings, are the two categories accounting for the smallest proportion of women who gave birth (1,749 women, 0.7 per cent).<sup>4</sup>
- 6.6 Mothers are having shorter postnatal stays in hospital. This is reflected by the higher proportion of mothers who were discharged less than five days after giving birth. In 2004, 11.2 per cent of mothers were discharged less than two days after giving birth, and 60.5 per cent of mothers were discharged between two and four days after giving birth. This compares with 4.3 per cent and 30.8 per cent respectively, in 1995.<sup>5</sup>

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2 Moore E, sub 102, p 2.

3 Van Harskamp K, sub 353, p 1.

4 Laws PJ, Grayson N & Sullivan EA 2006. *Australia's mothers and babies 2004. Perinatal statistics series no. 18*. AIHW cat. no. PER 34. Sydney: AIHW National Perinatal Statistics Unit.

5 Laws PJ, Grayson N & Sullivan EA 2006. *Australia's mothers and babies 2004. Perinatal statistics series no. 18* AIHW cat. no. PER 34. Sydney: AIHW National Perinatal Statistics Unit.

- 6.7 The rate of caesarean sections continues to increase with 29.4 per cent of mothers having caesarean section deliveries in 2004, compared with 19.3 per cent in 1995. Over the same period, instrumental deliveries have remained stable at around 11 per cent. Caesarean section rates were higher among older mothers and those who gave birth in private hospitals.
- 6.8 With most babies being born in hospital, there is a clear opportunity for hospital personnel to promote the initiation of breastfeeding. The first days and weeks of a new baby's life are extremely important in the establishment of breastfeeding. Although breastfeeding is a natural process, and both mother and baby have instincts that support breastfeeding, there are many skills and adaptations that mothers and babies need to achieve in their early days together. It is known that many maternity hospital routines, including separation of mother and baby, using complementary feeds, inconsistent advice, and medical intervention during birth can lead to poor breastfeeding outcomes.<sup>6</sup> Health professionals can have a significant impact on the success of the developing breastfeeding relationship.

### Increasing medicalisation of birth

- 6.9 Pregnancy, birth and breastfeeding are natural processes. In Australia, however, childbirth and the care of the mother and newborn are almost exclusively the responsibility of hospitals and doctors.<sup>7</sup> The events and experiences in pregnancy and birth have significant effects on the mother and baby in the postnatal period, and can impact on the ability of the mother and baby to establish breastfeeding.<sup>8</sup>
- 6.10 Interventions in childbirth such as the use of drugs may result in prolonged or more painful labour, resulting in exhausted mothers and babies and potential difficulty breastfeeding.<sup>9</sup> These forms of intervention are also being widely used during the labours and births of healthy, low risk women, at rates which indicate that current models of care do not support women's ability to give birth normally.<sup>10</sup> Studies show that some of the opioids used in epidurals,

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6 The Maternity Coalition, sub 190, p 3.

7 Austin R, sub 49, p 1; Price L, sub 356, p 1.

8 The Maternity Coalition, sub 190, p 5, Field I, sub 24, p 1.

9 Asphyxia, sub 165, p 2; Jones L, sub 267, p 1.

10 Smethurst J, sub 239, p 2.

such as fentanyl, affect the new born infant and its ability to establish breastfeeding. Greater after birth support for breastfeeding is likely to be required.<sup>11</sup> Mothers may not always be made aware of the potential effect of epidurals on their baby and ability to feed after birth.<sup>12</sup>

## Baby Friendly Hospital Initiative

### History

- 6.11 The Baby Friendly Hospital Initiative (BFHI) is a program designed to protect, promote and support breastfeeding in maternity hospitals and facilities supporting breastfeeding mothers and their infants. It was launched by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) in 1991 and was intended to increase the initiation and duration of exclusive breastfeeding world-wide by promoting breastfeeding as the biological norm. At that time, many specific hospital practices were found to be harmful to the initiation and establishment of successful breastfeeding.
- 6.12 The 10 Steps to Successful Breastfeeding were developed by the WHO and UNICEF. The 10 Steps are statements and measurable standards against which a maternity hospital or facility that provides care to breastfeeding mothers and their infants can be assessed.

**Box 6.1 The 10 steps to successful breastfeeding are:**

- Have a written breastfeeding policy that is routinely communicated to all health care staff;
- Train all health care staff in skills necessary to implement this policy;
- Inform all pregnant women about the benefits and management of breastfeeding;
- Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed;
- Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants;
- Give newborn infants no food or drink other than breast milk, unless *medically* indicated;

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11 Curtis P, sub 204, p 2.

12 Dixon G, sub 30, p 1; Middlebrook K, sub 58, p 1; Larner S, sub 117, p 3.

- Practise rooming-in: allow mothers and infants to remain together 24 hours a day;
- Encourage breastfeeding on demand;
- Give no artificial teats or dummies to breastfeeding infants; and
- Foster the establishment of breastfeeding support and refer mothers on discharge from the facility.

*Source: Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 8.*

## BFHI in Australia

- 6.13 The Baby Friendly Hospital Initiative was launched in Australia in 1991. During these early years the UNICEF Committee in Australia was overseeing the Initiative. In 1995 the Australian College of Midwives, a not-for-profit organisation, assumed this responsibility. The BFHI has run on a self-funding basis, with financial support from the Australian College of Midwives. The Commonwealth Government also provided financial assistance from 2002 to 2004. However, there is currently no independent funding for this initiative.
- 6.14 In Australia there are 59 hospitals which are accredited as being Baby Friendly out of approximately 500 hospitals providing maternity care.<sup>13</sup>

Table 6.1 Current Baby Friendly accredited hospitals in Australia

State/Territory	Number of accredited services
Australian Capital Territory	2
New South Wales	3
Northern Territory	3
Queensland	8
South Australia	11
Tasmania	7
Victoria	23
Western Australia	2

*Source: Baby Friendly Health Initiative website, viewed on 7 August 2007 at [http://www.bfhi.org.au/text/bfhi\\_hospitals.html](http://www.bfhi.org.au/text/bfhi_hospitals.html).*

- 6.15 The Baby Friendly Community Health Centre initiative is being developed and extended from the Baby Friendly Hospital Initiative to form the Baby Friendly Health Initiative. The aim is to continue to

<sup>13</sup> Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 9; Australian Breastfeeding Association, sub 306, p 24; Baby Friendly Hospital Initiative, Queensland, sub 360, p 12; Vernon B, Australian College of Midwives, transcript, 7 May 2007, p 21.

increase the initiation of breastfeeding through hospital accreditation, but also to focus on extending the duration rate of breastfeeding through accrediting all relevant non-hospital services that care for mothers of infants.

- 6.16 The Baby Friendly Health Initiative aims to take up where the Baby Friendly Hospital Initiative finishes, at discharge from hospital. Again there will be written policies communicated to all staff. This, along with education of staff, will allow for education of women and their support people so informed choices can be made about duration of breastfeeding and appropriate introduction of other foods.<sup>14</sup>

Baby Friendly accreditation is a quality improvement measure. Becoming accredited demonstrates that a hospital offers the higher standard of care to all mothers and babies. Facilities that meet the required standard, can apply to be assessed and accredited as Baby Friendly. Attaining accreditation reflects the commitment of hospital staff. To achieve the standard, midwives and other carers obtain an increased knowledge of infant feeding, greater skills and commitment to facilitate breastfeeding. This engenders an environment that encourages best practice, improving the health of new generations.<sup>15</sup>

- 6.17 There is wide ranging support for the implementation of the Baby Friendly Hospital Initiative in more hospitals in Australia.<sup>16</sup>
- 6.18 There has been criticism that being accredited to be baby friendly can involve a cost to the hospital involved, both financial and in terms of availability of staff.<sup>17</sup> However, Logan Hospital in Queensland was able to implement BFHI for a relatively low overall cost of approximately \$15,000.<sup>18</sup> Additionally the terminology does not mean

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14 Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 9.

15 NSW Baby Friendly Health Initiative, sub 339, p 3.

16 For example see Hunter New England Area Health Service, sub 22, p 1; Cheers A, sub 29, p 6; Scurry S, sub 51, p 1; McIntyre E, sub 67, p 4; Thorley V, sub 97, p 2; Gaskill K, sub 119, p 2; Day S, sub 157, p 2; Tyler C, sub 173, p 1; Bravo A, sub 179, p 1; Lording R, sub 186, p 12; The Maternity Coalition, sub 190, p 4; Oddy W, Telethon Institute for Child Health Research, sub 216, pp 26-28; Australian Nursing Foundation, sub 271, p 5; South Australian Government, sub 274, p 20; Tresillan, sub 280, p 4; Dietitians, King Edward Memorial Hospital, sub 282, p 4; Moore J, sub 295, p 1; Australian Breastfeeding Association, sub 306, p 24; Queensland Health, sub 307, p 10; Wright W, sub 320, p 1; Northern Territory Department of Community Services, sub 334, pp 4-5; Thomme F, sub 430, p 1; Government of Western Australia, sub 475, p 10; NSW Health, sub 479, p 1.

17 Schmidt P, transcript, 18 April 2007, p 35.

18 Brittain H, transcript, 18 April 2007, p 25; Logan Hospital, sub 351, p 2.

that hospitals which are not accredited are not 'baby-friendly'. Hospitals which have not been accredited are still supporting and promoting breastfeeding. However, they are not required to follow the 10 steps.

- 6.19 The committee considers that the Baby Friendly Hospital Initiative is a step in the right direction towards eliminating hospital practices that might interfere with the successful initiation and promotion of breastfeeding. The BFHI creates an environment where breastfeeding is central. For this reason, the committee recognises the need to support the process of accreditation to Baby Friendly status to take place and would like to encourage all public hospitals to become baby friendly.

#### **Recommendation 14**

- 6.20 **That the Department of Health and Ageing fund the Australian College of Midwives to run the Baby Friendly Hospital Initiative in Australia, to facilitate the accreditation of all maternity hospitals.**

#### **Recommendation 15**

- 6.21 **That the Department of Health and Ageing work with the Australian Council on Healthcare Standards (and/or equivalent accreditation organisation) towards including Baby Friendly Hospital status as part of the accreditation process.**

#### **Recommendation 16**

- 6.22 **That the Commonwealth Government, when negotiating future Australian Health Care Agreements, require state and territory governments to report on the number of maternity wards in public hospitals that have been accredited under the Baby Friendly Hospital Initiative.**

## The health professional advice merry go round

...this mother was then exposed to the merry go round of health professionals all giving their advice about feeding, the weight of the baby, etc.<sup>19</sup>

- 6.23 One of the clear themes that the committee has observed is that a mother seeking support with breastfeeding is given a wide range of seemingly different advice. All health professionals have a responsibility to promote, protect and support breastfeeding, consistent with established national and international policies and guidelines.<sup>20</sup> Many mothers stressed that after the arrival of a new baby, it was very difficult to process and deal with the range of feeding advice presented.<sup>21</sup>

I left the hospital feeling very confused and rather alone in this brand new world of babies and breastfeeding.<sup>22</sup>

- 6.24 Studies report that women are more likely to begin to breastfeed and breastfeed for longer if the health professionals they come in contact with support and encourage this endeavour. Results of trials of interventions to increase breastfeeding initiation rates, or breastfeeding rates at varying times after the birth also indicate that primary health care professionals can have a positive effect on breastfeeding initiation and duration.<sup>23</sup>
- 6.25 Provision of clear, concise and consistent breastfeeding advice, intensive support, promotion of confidence in the ability to breastfeed, and positive reinforcement that there is sufficient milk for the baby to thrive in the first few weeks after birth is likely to increase duration of breastfeeding among women.<sup>24</sup>

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19 McDonald, R, sub 203, p 4.

20 Government of Western Australia, sub 475, p 1.

21 Wallis J, sub 1, p 1; McDonald R, sub 203; BellyBelly.com.au, sub 441; Gray N, sub 10; Brown R, sub 92; Brook B, sub 236; Taylor K, sub 443; Simpson C, sub 16; Grove G, sub 103; Mathewson S, sub 111; Bell C, sub 116; Hayes J, sub 177; The Maternity Coalition Inc, sub 190; Clancy C, sub 195; Fuller R, sub 228; name withheld, sub 232; Thorp W, sub 28, p 1; Vane C, sub 36, p 1; Burns N, sub 81, p 1; Kelly K, sub 89, p 1; Perris H, sub 129, pp 2-3; Cassels S, sub 131, p 2; Nicholls A, sub 161, p 2; Peirce V, sub 198, p 2; Fleetwood R, sub 201, p 2; Green C, sub 354, p 4; Janssen C, sub 378, p 1; Tonkin B, sub 404, p 1; name withheld, sub 408, p 1; name withheld, sub 412, p 1; Mercer S, sub 455, p 1; Hopkinson K, sub 458, p 1; Roberts J, sub 469, p 1.

22 Name withheld, sub 410, p 1.

23 Brodribb W, sub 312, p 3.

24 Key Centre for Women's Health, sub 294, p 11.



There has to be recognition of the pressures experienced by the mothers who are trying to cope with a multitude of views, attitudes and suggestions is important. All health professionals involved in the process must deliver as much as possible a consistent message.<sup>25</sup>

- 6.26 Midwives have varying amounts of education on breastfeeding. The NSW BFHI group noted that many healthcare professionals are themselves completely unaware that the health and developmental impact of breastfeeding continues for years after breastfeeding rather than months or weeks.<sup>26</sup> GPs and other health professionals need information on the existence and availability of lactation assistance services, so that women in need can be referred for specialised assistance.<sup>27</sup>
- 6.27 Mothers noted that some health professionals used emotive language when they were responding to a mother's feeding difficulties.<sup>28</sup> Also there were situations where they felt that the health professional's response made them feel as though they had been mistreating their baby.
- When I did meet the lactation consultant she was useful but destroyed my confidence by saying 'If you keep feeding your baby like that she'll starve.'<sup>29</sup>
- 6.28 Health systems are recognising the need for consistent advice. The Maternal and Child Health line in Victoria has developed its own set of clinical guidelines for nurses to use so they do not give out conflicting information.<sup>30</sup> Logan Hospital on the outskirts of Brisbane noted that it was critical that all staff that provided support and advice for breastfeeding women were up to date with the latest breastfeeding evidence, which ensured that staff provided consistent evidence based breastfeeding information to women.<sup>31</sup>
- 6.29 There is often a lack of timely support for breastfeeding difficulties. The window of opportunity for providing assistance for mothers who are having difficulties with breastfeeding is brief and the problems

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25 Chelliah L, sub 82, p 4.

26 Harris E, sub 194, p 2; NSW Baby Friendly Health Initiative, sub 339, p 12.

27 Gill P, sub 123, p 2.

28 Christopher M, sub 402, p 1; Every M, sub 462, p 1

29 Ayre L, sub 91, p 1.

30 Community statements, transcript, 7 June 2007, p 70.

31 Logan Hospital, sub 351, p 2.

may be too complex to be solved over the phone.<sup>32</sup> Mothers experiencing problems at this level may need immediate one-on-one support from a professional. Provision of out of hours support, support during holiday times and having a clear support structure to deal with breastfeeding problems would make a significant difference to many women's breastfeeding experience.

Obtaining an appointment for breastfeeding assistance in a week's time does nothing to address the immediate problem of being unable to latch a hungry infant to an engorged and bleeding breast.<sup>33</sup>

- 6.30 The committee considers the Royal Women's Hospital's Breastfeeding Education and Support Service (BESS) to be a highly worthwhile program. It caters for breastfeeding mothers and babies up to three months without referrals and will see mothers no matter where they gave birth. It is staffed by IBCLCs and offers both a day admission and short visit service. It also offers telephone consultations with the duty worker and in the six months from September 2006 to February 2007 admitted 1006 mothers and babies to the day stay program.<sup>34</sup> The committee considers there is obviously a clear need for this service and encourages other hospitals to offer an equivalent service.

## General Practitioners

- 6.31 Many women consult a general practitioner (GP) either in the prenatal or postnatal period and it is clear that the GP can have a significant influence on a woman's decision to breastfeed. The GP can also advise and support women in the post-natal period with any problems she may be experiencing or can refer the woman on to a lactation consultant. The training of GPs in breastfeeding practice contributes to improving breastfeeding outcomes,<sup>35</sup> particularly in regional and remote areas where the GP may be the sole source of health advice.
- 6.32 The Royal Australian College of General Practice's Breastfeeding Policy recommends that GPs support and encourage exclusive breastfeeding for the first six months of life, assist new mothers to establish breastfeeding in the early postpartum period, have skills in

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32 Community statements, transcript, 7 June 2007, p 70; Bellinger J, sub 149, p 1; Proudfoot C, sub 376, p 1; Rollason E, sub 431, p 1.

33 Stevens R, sub 248, p 1.

34 The Royal Women's Hospital, sub 244, p 2.

35 Government of South Australia, sub 274, p 12.

the diagnosis and management of common breastfeeding problems and know when and where to refer more unusual difficulties.<sup>36</sup>

- 6.33 There is recognition that GPs may not be the best people to provide breastfeeding advice.<sup>37</sup> Doctors usually receive only one or two hours of breastfeeding education during their training. One doctor reported getting no breastfeeding education at all.<sup>38</sup> A recent study of the role of doctors in promoting breastfeeding found that medical schools in Australia with current graduates did include breastfeeding instruction within the curriculum. However, the method and length of instruction and subject areas covered varied considerably.<sup>39</sup>

## Infant weight and growth charts

- 6.34 Growth charts are widely used as a clinical and research tool to assess nutritional status and the general health and well-being of infants, children, and adolescents.<sup>40</sup> They are used as the definitive tool to decide if an infant is growing and developing in a suitable manner and to decide if they are feeding at an appropriate level.
- 6.35 There is a significant level of concern from breastfeeding mothers about the current growth charts being used in Australia and how accurate the charts are for tracking the growth of exclusively breastfed infants. The concern stems from the fact that often exclusively breastfed infants do not put on weight at the same rate or level as formula fed infants. When exclusively breastfed babies' weight are plotted on these growth charts, the result may indicate that the baby is 'underweight' when in fact the weight gain is perfectly healthy for an exclusively breastfed baby. A mother may be advised to complementary feed with infant formula so as to correct this perceived 'underweight' status, which can interfere with breastfeeding. The Department of Human Services in Victoria notes for the Centers for Disease Control (CDC) 2000 charts used in Victoria:

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36 Brodribb W, sub 312, p 6.

37 Dawson P, sub 98, p 2; Linkson M, sub 235, p 5; Eales S, sub 249, p 2.

38 Walsh A, sub 20, p 1.

39 Brodribb W, sub 312, p 13.

40 Kuczumski R et al, 'CDC growth charts: United States' Advance Data, no 314, 4 December 2000, viewed on 30 July 2007 at <http://www.cdc.gov/nchs/data/ad/ad314.pdf>.

The revised charts are derived from a mix of infants who were exclusively breast fed and formula fed. Exclusively breast fed babies may grow at a slightly lower rate than the reference, particularly in the first 4-6 months of age. However if the charts are used as a reference (and not as a standard that must be met) the difference is not important.<sup>41</sup>

- 6.36 There has been strong support for the new WHO growth charts to be implemented in Australia.<sup>42</sup>

## Development of Growth Charts

- 6.37 The World Health Organisation (WHO) has had an ongoing interest in the development of standardised growth charts since 1951 when the Joint Food and Agriculture Organisation (FAO)/WHO Expert Committee on Nutrition first recognised this was desirable.<sup>43</sup> In developing the reference values to be used in growth charts, data from the UK, the US, Sweden, France, the Netherlands and Mexico were considered. The final growth chart values were based exclusively on data from the US National Centre for Health Statistics (NCHS) national survey.<sup>44</sup> However, the dataset for infants (birth to 23 months) was not based on the NCHS national survey, but on other US data collected from the Fels Longitudinal Study in Yellow Springs Ohio, which surveyed infants from this middle-income American town between 1920 and 1975. The WHO considered that these growth

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41 Department of Human Services, Victoria, 'Information about the growth charts: Key questions around introduction of the new and revised growth charts for Victorian children (CDC 2000 growth charts)', viewed on 30 July 2007 at [http://www.health.vic.gov.au/childhealthrecord/growth\\_details/qanda.htm](http://www.health.vic.gov.au/childhealthrecord/growth_details/qanda.htm).

42 Phillips S, sub 7, p 2; Deagan T, sub 21, p 2; Cheers A, sub 29, p 5; Jeffery L, sub 34, p 6; Pile C, sub 38, p 6; Donovan P, sub 52, p 1; Hall T, sub 70, pp 6-8; Binns C, sub 86, p 7; Cassar S, sub 113, p 3; Batterham N, sub 118, p 1; Francisco I, sub 125, p 6; Hay L, sub 153, p 8; Buckley M, sub 160, p 6; Public Health Association of Australia Inc, sub 181, pp 7-10; Oei E, sub 191, p 1; Clancy C, sub 195, p 1; Ellis P, sub 197, p 2; Australian Breastfeeding Association (Queensland Branch), sub 207, p 4; Cox E, sub 224, p 3; Bethel S, sub 225, p 13; Eldridge S, sub 214, p 9; Australian Breastfeeding Association (NSW Branch), sub 276, p 11; Stephenson C, sub 278, p 2; Matthews K, sub 287, p 1; Alexander M, sub 289, p 6; Mitchell P, sub 311, p 2; Hogan M, sub 329, p2; Wilson M, sub 336, p 4; Courtwood L, sub 338, p 1; NSW Baby Friendly Health Initiative, sub 339, p 14; Lenne S, sub 362, p 3; Government of Tasmania, sub 364, p 4.

43 World Health Organisation (WHO), A growth chart for international use in maternal and child health care: guidelines for primary health care personnel Geneva, WHO, 1978, p 11.

44 WHO A growth chart for international use in maternal and child health care: guidelines for primary health care personnel, p. 15.

references would be an 'interim' measure and that countries 'might eventually develop local reference standards.'<sup>45</sup>

- 6.38 The model growth chart with reference values for height and weight plotted against age, for use for infants and children up to five years of age, was subsequently published by the WHO in 1978 as *A growth chart for international use in maternal and child health care*.
- 6.39 The NCHS growth reference charts were recommended for use in Australia by the National Health and Medical Research Council (NHMRC) from 1984, and have subsequently been used widely around the world.<sup>46</sup> In 2000 the CDC further updated the NCHS growth charts based on more recent datasets from the National Health and Nutrition Examination Survey (NHANES).<sup>47</sup> This revision also replaced the Fels dataset for measuring infant growth with data derived from the NHANES which included more breastfed infants.<sup>48</sup> These revised charts are sometimes referred to as the CDC 2000 growth charts.

## Development of new growth charts

- 6.40 After the adoption of the NCHS growth reference charts in the late 1970s, concerns were raised over the reliability of the charts. Most of the concerns centred on the quality of the Fels dataset which was used as the basis for the infant growth charts. The major concern was that those infants surveyed for the Fels Longitudinal Study between 1929 and 1975 were from an ethnically homogenous group where breastfeeding was not the norm and formula feeding predominated.<sup>49</sup> In addition, measurements in the Fels study were based on three month intervals that did not easily translate to monthly growth

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45 WHO, *A growth chart for international use in maternal and child health care: guidelines for primary health care personnel*, p. 15.

46 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 246.

47 Centers for Disease Control, 'CDC Growth Charts: United States', viewed on 30 July 2007 at <http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/background.htm>.

48 Kuczumarski RJ et al, 'CDC growth charts: United States' Advance Data, no 314, 4 December 2000, viewed on 30 July 2007 at <http://www.cdc.gov/nchs/data/ad/ad314.pdf>.

49 Kuczumarski RJ et al, 'CDC growth charts: United States' Advance Data, no 314, 4 December 2000, viewed on 30 July 2007 at <http://www.cdc.gov/nchs/data/ad/ad314.pdf>.

points. Other concerns included sample size, length height disjunction, and outdated curve-fitting procedures.<sup>50</sup>

- 6.41 As a result of these concerns in 1993, the WHO established a working group to develop new international standards based on the growth of infants that were breastfed, as recommended by WHO. The WHO Child Growth Standards for infants and young children were released in April 2006. The new standards are based on the breastfed child as the norm for growth and development.<sup>51</sup> The WHO expects these new standards to be adopted worldwide by 2010.

## Australian use

- 6.42 Currently the NHMRC recommends the revised CDC 2000 growth charts for use in clinical practice.<sup>52</sup> Although other growth reference charts could have been adopted (such as from the Netherlands or the UK) the NHMRC viewed these growth charts as being 'the most accessible' and noted the closer resemblance with the US in terms of levels of overweight and obesity.<sup>53</sup> However, the NHMRC also argued that Australia could consider using the international growth reference charts being developed by WHO when they become available.<sup>54</sup> It has also argued that Australia should develop its own growth charts.<sup>55</sup>
- 6.43 Versions of the NCHS/CDC 2000 charts have been used in Australia since 1984.<sup>56</sup> However, adoption of the growth charts has not been uniform across jurisdictions. According to the ABA both the original NCHS charts and the CDC 2000 revision are in use in different jurisdictions.<sup>57</sup> Victoria, the first state to implement the NHMRC

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50 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 246.

51 The WHO Child Growth Standards, viewed on 30 July 2007 at <http://www.who.int/childgrowth/en/>.

52 NHMRC, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*, Canberra, NHMRC, 2003, p. 15.

53 NHMRC, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*, p 13.

54 NHMRC, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*, p 15.

55 NHMRC, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*, p 15.

56 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 246.

57 ABA, 'World Health Organization (WHO) International Child Growth Standards, 2006', viewed on 30 July 2007 at <http://www.breastfeeding.asn.au/bfinfo/whochart.html>.

recommendation to adopt the CDC 2000 growth charts, only adopted the updated growth charts in 2005.<sup>58</sup>

## Issues

- 6.44 The new WHO growth charts are based on a more representative cohort of infants than were used in the original 1978 charts, and include more infants that were exclusively breastfed. The new charts provide an important assessment tool for monitoring infant growth rates in a clinical setting. Women who breastfeed are sometimes concerned that their breastfed infant may be receiving insufficient nutrition if their weight falls below the optimum growth rate, and may seek to supplement breastfeeding with infant formula. By including a larger cohort of breastfed infants in the growth charts a more accurate picture of optimum growth rates for how these infants should grow can be provided. This in turn may reduce maternal concerns and encourage more women to maintain breastfeeding for longer.
- 6.45 The new growth charts differ from the previous versions in both the populations used and the methodology employed to construct the growth curves. According to a WHO background article the new standards indicate how a child *should* grow under optimum conditions rather than just describing how they grow (as the old reference charts did).<sup>59</sup> Significantly, WHO also admits that the new standards for breastfed infants will result in ‘a substantial increase in rates of underweight during the first half of infancy and a decrease thereafter.’<sup>60</sup>
- 6.46 This effect was also observed by Binns and Lee in a recent letter to *The Lancet* where they expressed concern that the ‘real purpose’ of promoting breastfeeding in the first six months may have been ‘lost’ in the development of the new growth charts. They note that the new growth references for the first six months of life are ‘heavier than

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58. Department of Human Services, Victoria, ‘Information about the growth charts: Key questions around introduction of the new and revised growth charts for Victorian children (CDC 2000 growth charts)’, viewed on 30 July 2007 at [http://www.health.vic.gov.au/childhealthrecord/growth\\_details/qanda.htm](http://www.health.vic.gov.au/childhealthrecord/growth_details/qanda.htm).

59. National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 246.

60. WHO, WHO child growth standards: length/height-for-age, weight-for-age, weight-for-length, weight-for height and body mass index-for-age: methods and development, Geneva, 2006, viewed on 30 July 2007 at [http://www.who.int/childgrowth/standards/Technical\\_report.pdf](http://www.who.int/childgrowth/standards/Technical_report.pdf), p xix.

those produced by the US National Centre for Health Statistics'.<sup>61</sup> They further note that the sample population used by the WHO in the Multicentre Growth Reference Study is 'highly selected for the factors likely to promote growth in breast fed infants', and that of those initially surveyed for the MGRS, less than ten per cent were included in the final results.<sup>62</sup> The new charts thus reflect 'maximum growth rates' for breastfed infants under 'optimum conditions', rather than growth rates that can be 'realistically achieved' in the first six months.

- 6.47 The new WHO growth standards have not been endorsed by the NHMRC. It remains to be seen if and when the new standards are adopted in Australian jurisdictions. However, the inconsistent adoption of the NHCS and CDC 2000 growth charts in the past, may indicate that the adoption of the new WHO standards may not be uniform across jurisdictions.
- 6.48 The committee considers that growth charts are one area that could have a significant effect upon a breastfeeding relationship. Health professionals need to be careful to emphasise to mothers that the growth charts present a reference rather than a standard that have to be achieved.
- 6.49 Although the new WHO growth standards have been released, the committee considers it premature to make a recommendation towards their adoption by all states and territories without further detailed consideration by health professionals. At this point, the committee recommends that a single standard growth chart be used nationally.

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### **Recommendation 17**

- 6.50 **That the Minister for Health and Ageing, in consultation with state and territory health ministers, decide on a standard infant growth chart to be used in all states and territories.**

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61 Binns C, Lee M, 'Will the new WHO growth references do more harm than good?' *The Lancet*, Vol. 368, 25 November 2006, p 1869.

62 Binns C, Lee M, 'Will the new WHO growth references do more harm than good?' *The Lancet*, Vol. 368, 25 November 2006, p 1868 -1869.



## Continuity of care

- 6.51 Continuity of care describes the situation of a midwife having responsibility for the care of a caseload of women and following individual women through their pregnancy, birth and the postnatal period to six weeks. Continuity of care and of carers is now accepted in Australia as best practice for all pregnant women.<sup>63</sup>
- 6.52 Some advantages of providing continuity of care are that the woman and her partner are able to develop a relationship of trust with the midwife and the midwife is able to refer the woman to obstetric care if complications arise.<sup>64</sup> A noteworthy advantage is that childbirth free from stress sets the stage for optimal breastfeeding.<sup>65</sup>
- 6.53 This model of care has numerous health benefits, one of which is that it enables education of women throughout the childbirth continuum about the benefits of breastfeeding, and provides timely support to women in the first four to six weeks of their parenting for breastfeeding. This is likely to have an effect on the rate of successful breastfeeding. Currently in Australia less than five per cent of women have access to this model of care, mostly in capital cities.<sup>66</sup>
- 6.54 Continuity of care enables the mother to have consistent advice on breastfeeding in a supportive environment, at the time when it is needed and it also ensures there are less chances of medical intervention which may have an impact on the initiation and duration of breastfeeding.<sup>67</sup>
- 6.55 The committee is highly supportive of the continuity of care model, particularly for women who live outside urban areas. The committee would like to see more women able to access this model of care and encourage health systems to consider the benefits that are available through such a model.

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63 Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), p 4.

64 Conroy S, sub 407, p 1.

65 Flora K, sub 256, p 1.

66 Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 10.

67 Newman P, sub 66, p 1; Brycesson S, sub 96, p 3; Thorp K, sub 101, p 2; Player M, sub 290, p 3.

## Lactation Consultants

- 6.56 International Board Certified Lactation Consultants (IBCLC) are specialists in the management of breastfeeding and lactation issues and are important members of the healthcare team. IBCLCs work with women and their families from pregnancy, through the birth period and beyond in the community. IBCLCs work in the public and private health system as well as in the community and are the only professional body of health professionals who specialise in breastfeeding and human lactation.<sup>68</sup> To maintain the IBCLC qualification they must show evidence of continuing education and research. Every ten years they must re-sit the international exam.<sup>69</sup>
- 6.57 Hospitals may have lactation consultants on staff. Their services may be available by appointment or through clinics. Often these are oversubscribed and women may have a wait of several days or even weeks before they can be seen.<sup>70</sup> Private lactation consultants are available; however, women who are not covered by health insurance usually cannot afford the services of a private lactation consultant and not all health funds provide coverage for private lactation consultants. There is support for lactation consultants to be more available for women who need this specialised assistance.<sup>71</sup>
- 6.58 The committee considers that this is an area of immediate need, where if a mother was able to seek the assistance of an expert such as an IBCLC, who could respond in a timely manner and with up-to-date advice, and with only a minor cost, then more women may be able to gain the expertise needed to persevere with breastfeeding.<sup>72</sup>

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### Recommendation 18

- 6.59 **That the Minister for Health and Ageing provide Medicare provider/registration numbers to International Board Certified Lactation Consultants (IBCLC) as allied health professionals.**

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68 Australian Lactation Consultants Association, sub 4, p 1.

69 NSW Baby Friendly Health Initiative, sub 339, pp13-14.

70 McCulloch M, Sub 2, p 1; Revie S, sub 26, p 2; Drew A, sub 95, p 1; name withheld, sub 399, p 1; Jackson L, sub 400, p 1.

71 Smith J, sub 132, p 1; Cooke J, sub 152, p 1; Garbin C, sub 317, p 2; Thorley V, sub 340, p 1; Mangelson J, sub 342, p 3.

72 Wilkinson D, Gippsland Women's Health Service, sub 75, p 2.

## Regional, remote and Indigenous communities

### Overview

- 7.1 In general, living in a rural or remote area translates to limited access to medical and health professional facilities. Women may not have any choice about how they can deliver their baby, they will have to travel large distances and when they return home and they are unlikely to have services nearby which can help them with breastfeeding. In remote areas, these problems can be even more severe.
- 7.2 Women in rural and remote communities where there is a high level of breastfeeding support such as supportive health staff, a volunteer breastfeeding counsellor or an International Board Certified Lactation Consultant (IBCLC) can find breastfeeding highly successful. Community acceptance, family support and community expectations are relevant in any community and breastfeeding rates are likely to rise according to people's knowledge, expectations and acceptance of what is a normal process.<sup>1</sup>
- 7.3 The health status of the disadvantaged, Indigenous and remote communities within Australia is known to be of a lower standard than the general population. For example, Indigenous Australians have a life expectancy 15 to 20 years shorter, and higher incidences of

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<sup>1</sup> David Q, sub 37, pp 1-2.

all chronic illnesses such as diabetes, heart disease, kidney disease and acute chest infections.<sup>2</sup> The committee considers that breastfeeding needs to be promoted within Indigenous Australian communities as a preventative health measure and that support should be provided to enable successful breastfeeding.

- 7.4 Many of the issues and actions required in relation to the provision of health services in regional, remote and Indigenous communities were beyond the scope of the evidence that the committee received as part of this inquiry. However, the committee acknowledges there is a real need for breastfeeding support services in these communities and adds its voice to that of a mother from regional Australia, Rebecca Ferluga:

...acknowledge that there is a lack of support which must be impacting on breastfeeding rates in rural communities; that there is not a 'one-size-fits-all solution' across city and country; and that we need specific solutions and increased Government support to fill the gaps so rural mums and babies don't miss out on the professional and community breastfeeding support they need.<sup>3</sup>

## **Factors influencing breastfeeding**

- 7.5 Women in regional and remote communities do not have the same level of breastfeeding support available as women in urban areas. Factors such as distance, lack of health care options, isolation and lack of community breastfeeding support services all have an impact on breastfeeding. Additionally, the factors which impact on the initiation and duration of breastfeeding may vary slightly between rural and urban populations (see Table 7.1). Younger mothers were more likely to breastfeed if they were in a rural area compared to an urban area; however, younger mothers in general were also more likely to cease breastfeeding no matter whether they were in a rural or urban environment. In rural areas the influence of the maternal grandmother was not as strong, compared to urban areas.

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2 College of Lactation Consultants Victoria Inc, sub 142, p 2.

3 Ferluga R, sub 108, p 8.

Table 7.1 Factors associated with the initiation and duration of breastfeeding in a rural population compared with an urban population.

<b>Factors associated with the decision to breastfeed</b>	<b>Factors associated with risk of ceasing breastfeeding</b>
<p>In a Rural area, breast feeding was more likely if:</p> <ul style="list-style-type: none"> <li>• fathers preferred breastfeeding;</li> <li>• mothers were younger;</li> <li>• mothers decided pre-pregnancy to breastfeed;</li> <li>• mothers were primiparous (first pregnancy).</li> </ul>	<p>In a Rural area risk of early cessation of breastfeeding was higher:</p> <ul style="list-style-type: none"> <li>• in younger mothers;</li> <li>• in mothers who planned to breastfeed for less than two months;</li> <li>• where fathers did not prefer breastfeeding;</li> <li>• in mothers who did not decide to breastfeed before becoming pregnant;</li> <li>• in mothers whose infants received complementary formula feeds in hospital.</li> </ul>
<p>In an Urban area, breast feeding was more likely if:</p> <ul style="list-style-type: none"> <li>• fathers preferred breastfeeding;</li> <li>• maternal grandmothers preferred breastfeeding;</li> <li>• mothers decided pre-pregnancy to breastfeed;</li> <li>• mothers were primiparous;</li> <li>• mothers were born in Australia, the United Kingdom, Asia, the Middle East or North Africa;</li> <li>• husbands were professional or administrators.</li> </ul>	<p>In an Urban area, risk of early cessation of breastfeeding was higher:</p> <ul style="list-style-type: none"> <li>• in younger mothers;</li> <li>• in less educated mothers;</li> <li>• in mothers born in Australia, New Zealand or the United Kingdom compared with mothers born in the Middle East or Africa;</li> <li>• in mothers who planned to breastfeed for less than four months;</li> <li>• when maternal grandmothers were ambivalent or preferred formula feeding;</li> <li>• when mothers received conflicting advice on infant feeding while in hospital</li> </ul>

Source: National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia*, (2003), p 9

## Regional and remote communities

7.6 The Australian Rural Nurses and Midwives argues that the social fabric of rural communities has changed. They consider there has been a change from the extended family networks previously seen, leading to people becoming socially isolated. If family support is not available and if it cannot be supplemented with professional support then these communities face a double disadvantage.<sup>4</sup>

Parents may have limited support from family and friends if they have recently moved to a rural area for work or lifestyle reasons. Parents are likely to have to travel further for both specialist and essential health services (especially those that

4 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 3.

reside on outlying agricultural properties). Additional demands may be present including lack of financial security (for example the impact of drought and industry deregulation on some primary producers) and commitments to livestock (i.e. poses problems for travelling where others are not available to monitor stock).<sup>5</sup>

- 7.7 Bush nursing communities still operate in some areas in Victoria; however, there is a trend for services in rural and remote areas to be cut back with staff doing less travel out to those remote areas. There is an expectation that rural people will travel in to the services, which can mean that some people become quite isolated, if they do not have the means to enable them to travel.<sup>6</sup> Breastfeeding problems, such as mastitis, that could be treated quickly and effectively if a service was close, can often escalate with a time delay in treatment, a travel component and associated expense.

A woman from our community could have to travel over 200km round trip to access ultrasound – after referral from her GP (if there is a GP in her town!!) whilst suffering from debilitating infection accompanied by fever, rigors, exhaustion and at least one very unhappy baby. This is very emotionally distressing and would require a very strong constitution not to "give up" breastfeeding and use artificial formulas.<sup>7</sup>

- 7.8 Rural towns are not always seen as being 'breastfeeding friendly' by mothers. In a breastfeeding study in rural South Australia, 92 per cent of breastfeeding mothers in the study stated that breastfeeding was not well supported within the community.

There are excellent places available in Adelaide but all my breastfeeding friends agree, it's impossible, facilities in [regional town] are practically non-existent.<sup>8</sup>

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5 Western Australian Country Health Service – South West Dietitians, sub 308, p 1.

6 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 6.

7 Willis R, sub 193, p 2.

8 Stamp G and Casanova H, 'A breastfeeding study in a rural population in South Australia', *Rural and Remote Health* (2006), vol 6, issue 2, article no 495.

## Staff workforce and workplace issues

- 7.9 Staff workforce issues are a major factor in the provision of services in the medical and allied health areas in rural and remote areas. The Australian Rural Nurses and Midwives noted that there are difficulties in the recruitment and retention of midwives to rural and remote areas. A particular issue is ensuring midwives have access to continuing education and professional development. This is often difficult, primarily due to the lack of available staff to backfill core staff.<sup>9</sup> Additionally, it can be difficult to gain access to a wide enough variety of experiences because midwives are not able to practise across their scope of practice.
- 7.10 For childbearing women in rural Australia the provision of maternity services continues to be hampered by shortages of GP obstetricians and midwives and closures of smaller maternity units with 130 units having closed in the past ten years. This is despite recent studies showing that birthing in small, rural Australian maternity units is not associated with adverse outcomes for low risk women or their newborn babies.<sup>10</sup>
- 7.11 Continuity of care in rural and remote areas is not always available (see chapter 6). Many women do not have the option of giving birth in their local community hospital as obstetric services have been centralised in major centres. This results in some mothers being discharged back in to their local community, away from the health service staff with whom they may have developed rapport through their involvement with the birth and in the initial stages of feeding, and often before breastfeeding is established.<sup>11</sup>

## Advice

- 7.12 People who live in more remote areas may not have any choice in the health services they can access. If they are having problems or need some advice on a breastfeeding issue, they may only have one place where they can access help or advice. It can be quite difficult and expensive to seek a second opinion, so they may simply follow the advice given. If this advice is to supplement or change to infant

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9 Australian Rural Nurses and Midwives, sub 299, p 4.

10 Australian Rural Nurses and Midwives, sub 299, p 4.

11 Western Australian Country Health Service – South West Dietitians, sub 308, p 1.

formula, they may not be advised of the effect upon their milk supply and premature weaning may be the unintended result.

- 7.13 Even quite straightforward solutions such as the Australian Breastfeeding Association's helpline can become more complex and expensive in rural and remote areas. It may require two STD phone calls to reach a counsellor and then with the call being timed, it becomes expensive.<sup>12</sup>

## Indigenous health status

- 7.14 The origins of poor health for Indigenous people can in part be traced to early life. Poor nutrition during pregnancy and childhood is a determinant of poor health and social outcomes in adulthood, including chronic disease, poor school attendance and reduced learning. Low birth weight, growth failure and iron deficiency are indicators of poor nutritional status which have shown little improvement over the past decade. According to the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) they are a salient reminder of the increasing health disparity between Aboriginal and non-Aboriginal populations.<sup>13</sup>
- 7.15 The poor health status of Aboriginal and Torres Strait Islander people indicates that they are the most disadvantaged population group in Australia<sup>14</sup> and the committee was particularly interested in gaining more information on the rates of breastfeeding amongst the Aboriginal and Torres Strait Islander people.

## Breastfeeding rates in Indigenous populations

- 7.16 The latest Indigenous breastfeeding statistics were obtained in the 2004-05 National Aboriginal and Torres Strait Islander Health Survey. It found that the majority of Indigenous women, 84 per cent, aged 18-64 years who had had children reported having breastfed them. This rate was higher in remote areas, (92 per cent) than non-remote areas

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12 Ward K, sub 56, p 4.

13 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 2.

14 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 2.



(80 per cent).<sup>15</sup> Traditionally, breastfeeding babies was normal practice for Indigenous women and breastfeeding was thought to continue until the child reached several years of age. Breastfeeding has been a normal part of Aboriginal culture and mature Aboriginal women living in remote and rural parts of Australia tend to follow more traditional lifestyles and breastfeed more often and for longer.<sup>16</sup>

- 7.17 Breastfeeding rates in Indigenous populations are likely to vary depending on rural, remote or urban setting. The South Australian Government noted that studies conducted in several different states of Australia have shown breastfeeding prevalence by Aboriginal women decreases by increasing proximity to urban areas and is similar to that for women of low socio-economic background.<sup>17</sup>
- 7.18 The Northern Territory Government noted that a small number of studies have been conducted to measure current breastfeeding rates in Indigenous populations. However, like many current studies, comparison of data is difficult due to variations in breastfeeding definitions and sampling methods. Anecdotal evidence suggests that the rate of breastfeeding amongst Indigenous women in the Northern Territory may be decreasing.<sup>18</sup>
- 7.19 The committee considers that any significant improvement in the rates of breastfeeding in Indigenous communities will require at the very least, the collection of Indigenous breastfeeding data as part of a national monitoring system. This will enable an accurate measure of the current state of breastfeeding in Indigenous communities and allow for the development of appropriate breastfeeding promotion and support.

### Recommendation 19

- 7.20 **That the Department of Health and Ageing provide leadership in the area of monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas.**

15 Australian Bureau of Statistics, *2004-05 National Aboriginal and Torres Strait Islander Health Survey* (2006), cat no 4715.0, p 20.

16 Government of South Australia, sub 274, p 8.

17 Government of South Australia, sub 274, p 8.

18 Northern Territory Department of Health and Community Services, sub 334, p 3.

## The critical importance of breastfeeding

- 7.21 The protection of breastfeeding is one health promotion activity that has potential for short and long-term improvements in Indigenous health. Breastfeeding should be encouraged, promoted and supported in Indigenous populations as it will result in substantial benefits to the health care system.<sup>19</sup>
- 7.22 Indigenous communities are already marginalised in terms of health status, and breastfeeding is one way to ensure that health benefits are passed onto children. For example, rates of recurrent otitis media in Aboriginal children are ten times higher than in the general population as the NSW Centre for Population Health Nutrition indicates.<sup>20</sup> Recurrent otitis media leads to hearing problems in children which can lead to learning difficulties - perpetuating a cycle of disadvantage. The evidence that breastfeeding provides protection against otitis media is very strong (see chapter 3). For this reason alone breastfeeding should be encouraged in Indigenous populations.

## Barriers to breastfeeding

- 7.23 The Australian Rural Nurses and Midwives indicated that two of the main barriers to breastfeeding are the lack of support services in remote communities and the breakdown of the social structure. Where breastfeeding would have been traditionally modelled and supported by the community, social breakdown in remote Indigenous communities means that breastfeeding is less prevalent and less supported.<sup>21</sup>

That is an issue that was raised with the women yesterday. They talked about the impact of not having mothers—of mothers either dying or being from the stolen generation—and how that has affected them. They talked about the lack of support that they have had and how they have looked to the community for support.<sup>22</sup>

- 7.24 As noted in chapter 5, the length of postnatal hospital stay has significantly decreased over the last decade in Australia, despite evidence to support links between quality postnatal care and sustained breastfeeding. The NSW Aboriginal Maternal and Infant
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19 NSW Centre for Public Health Nutrition, sub 178, p 9.

20 NSW Centre for Public Health Nutrition, sub 178, p 9.

21 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 4.

22 Hall J MP, transcript, 4 April 2007, p 22.

Health Strategy (AMIHS) considers that discharging women home early does not have to be an issue if there is effective, sustained home visiting by qualified health professionals and family support for the woman. The barriers to breastfeeding for Indigenous women are similar to non Indigenous women;<sup>23</sup> however, the difficulties can be magnified if Indigenous women do not have a supportive environment.<sup>24</sup>

## The marketing of infant formula

- 7.25 On its visits to two remote Indigenous communities in Queensland, the committee saw no evidence of direct marketing of infant formula; however, the committee acknowledges this was not a representative sample of communities in Australia.
- 7.26 The community store in Pormpuraaw, which is the main provider of formula, stocks three brands and sells an average of two tins of each brand every month for a population of 700 people in the town of Pormpuraaw and the 12 Homelands Outstations. Feedback generated during the 2005 Northern Territory infant feeding guidelines project, however, indicated that the use of infant formula in remote communities was becoming more common, particularly amongst young mothers.<sup>25</sup>
- 7.27 Formula was more expensive in remote communities than urban environments; however, the cost of infant formula did not seem to be a barrier to its use. For people on lower incomes, infant formulas are very expensive but whilst it may seem to equate to the fact that breastfeeding is an attractive option in lower socioeconomic groups, it is not always the reality according to the Australian Rural Nurses and Midwives.<sup>26</sup> Queensland Health noted that in Aboriginal and Torres Strait Islander communities, correct information regarding breast milk substitutes should be provided to families as misinformation can accompany the marketing, making the promotion of these products highly successful and commonly used.<sup>27</sup>
- 7.28 Additionally anecdotal evidence from health practitioners in Queensland and the Northern Territory suggests the regular use of

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23 Government of South Australia, sub 274, p 8.

24 NSW Pregnancy & Newborn Services Network, sub 171, p 2.

25 Northern Territory Department of Health and Community Services, sub 334, p 2.

26 Malone G, Australian Rural Nurses and Midwives, transcript, 23 May 2007, p 5.

27 Queensland Health, sub 307, p 5.

alternate products to infant formula in Aboriginal and Torres Strait Islander communities. This includes cow's milk, reconstituted powdered milk and soft drink via infant bottles in infants less than 12 months of age and highlights the need for additional strategies to promote breastfeeding.<sup>28</sup> Evidence indicates that Indigenous mothers are also more likely to introduce unmodified cow's milk before 12 months of age than non-Indigenous mothers.<sup>29</sup>

## Education

7.29 The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) considers there is a need for further antenatal education for mothers and their support network. Some women are unable to breastfeed due to pressure from families and males who do not understand the benefits for mother and baby.<sup>30</sup>

Education and support is also required from other members of the health care team including General Practitioners. GP's find it easy to switch to bottles as everyone knows what they are getting. Many women are unaware of implications of bottle feeding and partners are unsupportive due to perceived 'ownership' of woman's body.<sup>31</sup>

## Cultural factors

7.30 The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) Training and Support Unit (TSU) noted that Aboriginal community culture can play a part in decision-making about how an infant will be fed as the infant belongs to a large family from birth.<sup>32</sup> If the grandmother of an infant did not breastfeed she may encourage the mother to bottle feed as this allows the grandmother to have control of the infant and gives the mother the freedom to go out.<sup>33</sup>

7.31 The committee noted that on the site inspection to the remote community of Kowanyama, the male members of the committee were asked to leave a gathering of women discussing breastfeeding.

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28 Queensland Health, sub 307, p 5.

29 Binns C, sub 86, p 5.

30 NSW Pregnancy & Newborn Services Network, sub 171, p 1.

31 NSW Pregnancy & Newborn Services Network, sub 171, p 2.

32 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

33 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

- 7.32 The South Australian Government notes that Aboriginal women also tend to be younger mothers than non-Aboriginal women and adolescent Aboriginal mothers may be less inclined to breastfeed their first child as breastfeeding impacts on their freedom, body image, social interaction, education and lifestyle choices.<sup>34</sup>

The issues we see are; young mothers too shy to breast feed in public but their social life is at the local shopping centre.<sup>35</sup>

- 7.33 Societal pressures and changes also play a part with health workers identifying the ease of bottle feeding from a young woman's perspective.

Aboriginal women like to be out and about doing other things and feel that it is much easier to make a bottle and take it with them than to spend the time breastfeeding it just takes too much time.<sup>36</sup>

## Housing

- 7.34 The committee noted when undertaking a site inspection in the remote communities of Pormpuraaw and Kowanyama, that the lack of housing was an issue. Anecdotal evidence indicated that there could be up to 25 people living in the one house. The Royal Flying Doctor Service (RFDS) consider that environmental factors such as overcrowding in houses have a huge impact.
- 7.35 Young Indigenous women are often shy about their bodies and it may be impossible to breastfeed in private in overcrowded conditions. An overcrowded house does not provide a place where a new mother can breastfeed in a clean and safe environment, and thus may be a factor in why a mother may choose not to breastfeed.

## Travel

- 7.36 In many instances women from remote areas of Australia are required to travel long distances for the birth of their babies and this can cause financial hardship and social disruption. Typically, pregnant women will leave their communities between 36 to 38 weeks gestation to await birth, usually alone, in a regional centre. The facilities in these settings vary but are often very simple. Mookai Rosie in Cairns,

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34 Government of South Australia, sub 274, p 8.

35 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

36 NSW Pregnancy & Newborn Services Network, sub 171, p 3.

provides accommodation support services, health support services and advocacy to the mothers and women that travel from remote communities to Cairns for prenatal, antenatal and medical services. At Mookai Rosie the health workers educate and encourage the women to breastfeed, by talking about the positive benefits and how it is the best way to care for the baby.

As a health worker, I take care of clients' appointments and their education on whatever it may be: breastfeeding, nutrition, diabetes. I also do their dressings, I will escort people to appointments if they need me there and I will be with them in the birth suite. Anything that they need me to do, I will do for them.<sup>37</sup>

- 7.37 Women may have to leave other children behind while they are away giving birth. This can lead to high levels of anxiety as there may be social issues in the community such as domestic violence and alcohol abuse which can lead to a mother having very valid concerns about her children who remain in the community.<sup>38</sup> Women may also be concerned about not being able to give birth 'on country'.
- 7.38 The Patient Assistant Travel Scheme (PATS) is a Commonwealth program which is administered locally with the states and territories.<sup>39</sup> It provides financial assistance for people who need to travel for medical reasons. Women from Cape York communities in Queensland who are required to travel to give birth are also able to be accompanied by an escort of their choice paid for by PATS. Other states have different rules for escorts. This leaves Indigenous women in the position where they may not have any support during the time before and after the birth which may impact on breastfeeding. Mothers from the remote community of Kowanyama indicated to the committee that escorts were very important and should be available to all women who need to travel to give birth.

## Low birth weight – compounding issues

- 7.39 Under nutrition and poor growth among Aboriginal infants is well reported within remote communities. More Aboriginal children

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37 Simpson B, Mookai Rosie Bi-Bayan, transcript, 4 April 2007, p 12.

38 Yates K, Cairns Base Hospital, transcript, 4 April 2007, p 35.

39 The committee notes that the Senate Community Affairs Committee is currently undertaking an inquiry into the Patient Assistant Travel Scheme. Information can be found at the Senate Community Affairs Committee website, viewed on 30 July 2007 at [http://www.aph.gov.au/Senate/committee/clac\\_ctte/pats/index.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/pats/index.htm).

present with low birth weights (12.5 per cent) than non Indigenous children (6.2 per cent).<sup>40</sup> Despite widespread and prolonged breastfeeding by Aboriginal mothers in remote areas, their infants have poor growth patterns after six months and suffer recurrent infections.

- 7.40 Low birth weight (LBW) is an extremely important factor in infant mortality. US data indicates that only 0.5 per cent of babies born with normal weight die in the first year of life compared to 10.2 per cent of babies born under 2500g and 45.3 per cent of babies born under 1500g. Besides its impact on infant mortality, LBW is associated with increased childhood ill health including that from respiratory illnesses, impaired growth after birth and brain development problems. Although these complications increase in frequency with decreasing birth weight, even children at the upper end of the LBW range, who require no intensive care, have poorer outcomes than children with normal birth weight.<sup>41</sup>
- 7.41 In October 2005 rates of underweight children under the age of five years in remote communities across the Northern Territory (NT) were reported to be between eight per cent and 18 per cent (compared to an expected rate of three per cent). Across the NT, nine per cent of children were recorded as wasted, with some regions recording rates of up to 14 per cent. It has been said that international relief agencies regard a prevalence of wasting of children more than eight per cent as a nutritional emergency. Poor growth is a serious problem among Aboriginal infants in remote communities across Australia. Within this context breastfeeding provides protection against infections and the cycle of growth faltering.
- 7.42 However, the importance of appropriate solids introduced at an appropriate time to complement breast feeding should not be overlooked. Although breastfeeding helps to protect against infection such as gastroenteritis, it cannot be expected to completely prevent such infections in the context of poor living conditions and food insecurity. Continued breastfeeding is beneficial for Aboriginal infants and their health would probably be much worse if they were bottle fed on infant formula in unhygienic living conditions.<sup>42</sup>

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40 The Royal Australasian College of Physicians, sub 174, p 5.

41 Australian Medical Association, sub 358, p 8.

42 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, pp 3-4.

- 7.43 The RFDS noted that solids are often not introduced at the recommended six month mark. Either breastfeeding continued beyond six months or infant formula was introduced but no solids were introduced. This can lead to issues of anaemia and failure to thrive, especially at seven to eight months old and onwards.<sup>43</sup>

## Successful strategies to encourage breastfeeding in Indigenous communities

- 7.44 There are programs that are working in Indigenous communities. A significant achievement of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) has been the inclusion of 'nutrition' as a core unit in the new national Aboriginal and Torres Strait Islander Health Worker competencies, which form part of the Health Training Package released in February 2007. This means every Health Worker undertaking the 'practice' stream at a Certificate IV level around Australia will study nutrition as part of their training. There will also now be the opportunity for Health Workers to specialise in nutrition within the new national competencies at the Certificate IV and Diploma levels.<sup>44</sup>
- 7.45 Queensland Health has developed a package called Growing Strong for Aboriginal and Torres Strait Islanders. The 'Growing Strong' resources provide information about nutrition during pregnancy and early childhood, with a specific focus promoting breastfeeding and supporting mothers with common breastfeeding issues. Regular in-service training targeting community based Aboriginal and Torres Strait Islander Health Workers is delivered by nutritionists in partnership with Aboriginal Nutrition Promotion Officers.<sup>45</sup>

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43 Felsch J, RFDS, transcript, 4 April 2007, p 3.

44 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 7.

45 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 8.



Figure 7.1 Extract from “Young Mums - Growing Strong: Feeding you and your baby”

Being pregnant and having a baby can be challenging times for all mothers, especially young Mums. It is good to ask for help when you are pregnant and after your baby is born and while your baby is growing up.



Source Queensland Health, exhibit 10, p 2.

- 7.46 In response to requests from remote store managers and health centre staff, the NT Feeding Guidelines project of 2005 developed a set of guidelines to selling infant formula in remote stores. The guidelines suggest that stores do not promote infant formula and bottles, and stock only one type of both. Stores are encouraged to stock and promote a range of infant feeding cups.<sup>46</sup>
- 7.47 NATSINSAP recommends that there needs to be more family focussed nutrition promotion, resourcing programs and disseminating and communicating 'good practice'. In this context

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<sup>46</sup> National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 4.

'good practice' as defined by the community and health professionals, includes understanding community priorities, family, culture, preferred methods of communication and learning, in addition to an up-to-date knowledge of the prevention and management of diet related disease. However, across Australia identification and dissemination of 'good practice' nutrition and breastfeeding information currently occurs in an ad hoc manner and resources to implement this important area have so far been limited.<sup>47</sup>

- 7.48 Given the proven short and long-term health benefits that breastfeeding provides, the committee considers it crucial that the Commonwealth Government take a lead role in promoting breastfeeding within Indigenous Australian communities.

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### **Recommendation 20**

- 7.49 **That the Commonwealth Government promote breastfeeding within Indigenous Australian communities as a major preventative health measure.**

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47 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee, sub 302, p 10.

## The impact of breast milk substitutes

### Overview

- 8.1 The availability and marketing of breast milk substitutes or infant formula is a contentious issue for many public health organisations, health professionals and breastfeeding mothers. However, when breast milk in any form is not available the only suitable alternative nutrition for infants is infant formula.

### What is infant formula?

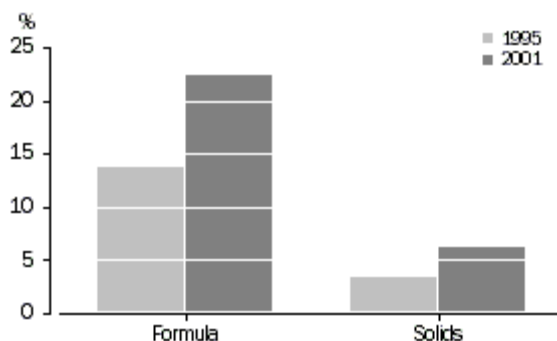
- 8.2 Infant formula is an industrially produced milk product designed for infant consumption; an infant is defined as being a person aged up to 12 months. Usually based on cow's milk, formula has added vitamins and enzymes and different fats that infants need. Infant formula is not equivalent to breast milk. It lacks many of the factors present in breast milk, including numerous types of living cells, cholesterol, polyamines, free amino acids, glycosamine and enzymes and other bioactive substances.<sup>1</sup>
- 8.3 The most recent data on rates of infant formula use is from the National Health Survey in 2001. This data showed that there was an

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<sup>1</sup> National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 391; Rothenbury A, sub 15, p 3.

increase in formula and solids use from 1995 to 2001 in infants three months or less in age (see Figure 8.1).

Figure 8.1 Proportion of infants aged 3 months or less currently breastfeeding and receiving formula and solids – 1995 and 2001



Source: Australian Bureau of Statistics, *Breastfeeding in Australia, 2001, 2001*, cat no 4810.0.55.001, p 3

8.4 The Queensland Health *Infant and Child Nutrition in Queensland* report released in 2005 found that 12 per cent of children commenced regular formula use on the first day of life and 23 per cent had commenced regular consumption before four weeks of age.<sup>2</sup>

8.5 There is a wide range of infant formula available and most of them are of similar quality and nutritional value although there is some evidence that suggests formula with added long chain poly-unsaturated fatty acids (LCPUFAs), naturally found in breast milk, assists in brain development.<sup>3</sup> It should be noted that any benefits that LCPUFAs in infant formula offer for cognitive development are smaller than the advantage of breast milk over formula for infants.<sup>4</sup>

8.6 Critical to the safe use of infant formula are the following requirements:

- a safe water supply;
- sufficient family income to meet the costs;
- effective refrigeration;
- clean surroundings; and

2 Gabriel R, sub 259, p 1.

3 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 394

4 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 394

- satisfactory arrangements for sterilising and storing equipment.<sup>5</sup>
- 8.7 Standards for the quality, composition and labelling of infant formula sold in Australia are regulated through Standard 2.9.1 in the joint Australia and New Zealand Food Standards Code. Standard 2.9.1 provides for the compositional and labelling requirements for foods intended or represented for use as a substitute for breast milk. This Standard applies to all infant formula products whether in powder, liquid concentrate or 'ready to drink' forms. This standard also provides for infant formula products intended for infants with special nutritional requirements. Infant formula products are regarded as a special purpose food and as such have both specific and stringent standards that infant formula manufacturers need to follow regarding composition and labelling.
- 8.8 There is a second standard for foods for infants, Standard 2.9.2. This covers products that are not milk based; for example, canned infant foods, infant cereal products and products that may be sold in jars. This standard indicates that the label on a package of food for infants must not include a recommendation, whether express or implied that the food is suitable for infants less than four months old. Currently Food Standards Australia New Zealand (FSANZ) is reviewing the minimum age labelling requirements of foods for infants under standard 2.9.2. The purpose of this review is to align the labelling requirements for infant foods currently prescribed in the code with the NHMRC Dietary Guidelines, which recommend exclusive breastfeeding for six months. FSANZ noted that it hopes to have this completed by the end of 2007.<sup>6</sup>
- 8.9 The committee considers that the minimum labelling requirement of foods for infants should be changed to reflect the NHMRC infant feeding guidelines. The committee notes that several participants to the inquiry provided evidence of the labelling of infant foods as being suitable for four to six months of age;<sup>7</sup> there was concern that this labelling clearly contradicted the NHMRC Dietary Guidelines that recommend a baby should be exclusively breastfed for the first six months.

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5 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 395

6 Hazelton J, Food Standards Australia New Zealand, transcript, 13 June 2007, p 16.

7 Pollock R, sub 60, p 1; Perris H, sub 129, p 6; Foster M, sub 147, p 1; Hay L, sub 153, p 9; Tresize J, sub 205, p 2; Courtwood L, sub 338, p 1; Thorp K, sub 358, pp 1-2.

**Recommendation 21**

- 8.10 That Food Standards Australia New Zealand change the labelling requirements for foods for infants under Standard 2.9.2 of the Food Standards Code to align with the NHMRC Dietary Guidelines recommendation that a baby should be exclusively breastfed for the first six months.**

**Infant formula information**

- 8.11 The Director General of the World Health Organisation reported to the World Health Assembly in 1992 on infant and young child nutrition. In this report, it was pointed out that even from a viewpoint of fostering competition, direct advertising to mothers with infants in the first four to six months of life was singularly inappropriate because:
- advertising infant formula as a substitute for breast milk competes unfairly with normal, healthy breastfeeding, which is not subject to advertising, yet which is the safest and lowest cost method of nourishing an infant; and
  - advertising infant formula as a substitute for breast milk favours uninformed decision making, bypassing the necessary advice and supervision of the mother's physician or health worker.<sup>8</sup>
- 8.12 In this respect, the Director General's report concluded, it can be considered that advertising of infant formula fails to achieve the objectives of ensuring best quality and the lowest cost and creating an informed public, which are among the benefits assumed to be a result of direct advertising.<sup>9</sup>
- 8.13 Infant formula manufacturers contend that they need to be able to provide information to mothers who have made the choice to use infant formula.<sup>10</sup> Nestlé notes that:

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8 World Health Organisation website viewed on 7 August 2007 at [http://www.who.int/nutrition/infant\\_formula\\_trade\\_issues\\_eng.pdf](http://www.who.int/nutrition/infant_formula_trade_issues_eng.pdf)

9 World Health Organisation website viewed on 7 August 2007 at [http://www.who.int/nutrition/infant\\_formula\\_trade\\_issues\\_eng.pdf](http://www.who.int/nutrition/infant_formula_trade_issues_eng.pdf)

10 Infant Formula Manufacturers Association Australia, sub 328, p 2.

- their website contains positive and supportive information and advice on breastfeeding;
  - information on infant nutrition and products is shown on the website only after visitors read and accept a statement on the positive health benefits and superiority of breastfeeding; and
  - the website does not promote, through pictures or words, formula over breastfeeding, but does provide factual information on the use of formula should individuals make the choice to do so.
- 8.14 Heinz Australia are concerned that the use of formula is being politicised and would like to see ‘...the use of formula milk be depoliticised and treated objectively as a routine aspect of baby care, rather than as a moral issue ...’ and that while breastfeeding is encouraged, mothers who do not breastfeed are not made to feel inferior.<sup>11</sup>
- 8.15 Breastfeeding advocates and consumers have criticised the marketing of infant formula in Australia where it is marketed as a remedy for common infant behaviour, such as loose bowel motions, not sleeping and being hungry.<sup>12</sup> Professor Colin Binns notes that an authoritative guide, the Dietary Guidelines for Children and Adolescents in Australia, to the use of infant formula has been prepared and is readily available. He contends that infant formula companies could assist by publicising its existence and by distributing reprints.<sup>13</sup>

## WHO Code

- 8.16 An International Code of Marketing of Breast-milk Substitutes, commonly called the ‘WHO Code,’ was established in 1981 by the World Health Organisation in response to concerns over a perceived decline in breastfeeding, and as a ‘minimum acceptable requirement’ for the marketing of breast milk substitutes.<sup>14</sup> The aim of the WHO

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11 Heinz Australia, sub 141, p 3.

12 Hall T, sub 70, pp 7-8; McDonald R, sub 203, p 10; Stocks C, sub 218, p 1; Brook B, sub 236, p 1; Gribble K, School of Nursing, University of Western Sydney, sub 251, p 3-12; Government of South Australia, sub 274, p 9; Australian Breastfeeding Association (NSW Branch), sub 276, p 6; Sgambelluri M, sub 292, p 1; Thorp K, sub 352, p 2.

13 Binns C, sub 434, p 2.

14 Mork T, ‘Statement by the Representative of the Executive Board to the Thirty-fourth World Health Assembly on the Subject of the Draft International Code of Marketing of Breast-milk Substitutes’, 20 May 1981.

Code was to protect and promote breastfeeding and to ensure that marketing of breast milk substitutes, feeding bottles and teats is appropriate. The Code applies to all products marketed as partial or total substitutes for breast milk for infants up to four to six months of age, including infant formula, other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented as suitable for use as a partial or total replacement of breast milk, as well as feeding bottles and teats. More than 70 governments around the world have all or many of the Code's provisions as law.<sup>15</sup> The Code applies to both companies and governments.

#### 8.17 The WHO Code:

- bans all advertising and promotion of products to the general public;
- bans samples and gifts to mothers;
- requires information materials to advocate for breastfeeding, warning of the risks of artificial feeding and not containing pictures of babies or text that idealise the use of breast milk substitutes;
- bans the use of the health care system to promote breast milk substitutes;
- bans free or low-cost supplies of breast milk substitutes;
- allows health professionals to receive samples but only for research purposes and bans gifts;
- demands that product information be factual and scientific;
- bans sales incentives for breast milk substitutes and contact with mothers;
- requires that labels inform fully about the correct use of infant formula and the risks of misuse;
- requires labels to not discourage breastfeeding.<sup>16</sup>

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15 International Baby Food Network Action Network (IBFAN), 'United Kingdom code violations: a survey of the state of the International Code of Marketing of Breastmilk substitutes and subsequent WHA resolutions,' Fact sheet, viewed on 30 July 2007 at <http://www.ibfan.org/english/pdfs/lwtduk04.pdf>.

16 IBFAN, 'United Kingdom code violations: a survey of the state of the International Code of Marketing of Breastmilk substitutes and subsequent WHA resolutions,' Fact sheet, viewed on 30 July 2007 at <http://www.ibfan.org/english/pdfs/lwtduk04.pdf>.



8.18 Subsequent World Health Assembly resolutions have added clarification to aspects of the code including, for example, resolution 47.5 (1994) which addressed the provision of samples, to ensure that there are no donations of free or subsidised supplies of breast milk substitutes and other products covered by the International Code of Marketing of Breast-milk Substitutes in any part of the health care system.<sup>17</sup>

## **The Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement**

8.19 Australia has not fully implemented the WHO code even though it was one of the early signatories. Instead, in 1992 the Commonwealth Government introduced the Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement, to set out the obligations of manufacturers and importers of infant formulas in Australia. The MAIF Agreement is a voluntary self-regulatory code of conduct between manufacturers and importers to Australia of infant formula. It was authorised in 1992 under the *Trade Practices Act 1974*<sup>18</sup> but is not legally binding.<sup>19</sup>

8.20 The MAIF Agreement covers the marketing in Australia of infant formulas when such products are marketed or represented to be suitable for use as a partial or total replacement to breast milk. It also covers the quality and availability of such products and the provision of information concerning their use. It applies only to manufacturers and importers of infant formulas for use up to 12 months of age, not to retailers or distributors and does not include other milk products, foods, beverages or feeding teats.

8.21 The aim of the MAIF Agreement is to help ensure safe and adequate nutrition for infants:

- through the protection and promotion of breastfeeding;

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17 IBFAN, 'World Health Assembly Resolution 47.5 – Infant and young child nutrition', viewed on 30 July 2007 at <http://www.ibfan.org/english/resource/who/whares475.html>; Justice and International Mission, Uniting Church in Australia, sub 156, p 9.

18 Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), *Annual Report 2003-04*, Department of Health and Ageing, 2004, p 53.

19 APMAIF, *Annual Report 2003-04*, p 53.

- by ensuring the proper use of breast milk substitutes when they are necessary<sup>20</sup> on the basis of adequate information; and
- through appropriate marketing and distribution.<sup>21</sup>

## The WHO Code and MAIF - differences

8.22 The major points of difference between the MAIF and the WHO Code were recently described by the International Baby Food Action Network (IBFAN) (See Figure 8.2).

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20 The word 'necessary' is used to include mothers who have made an informed choice to use breast milk substitutes.

21 Department of Health and Ageing *Marketing in Australia of infant formulas: Manufacturers and Importers Agreement* (2003).

Figure 8.2 The WHO Code versus MAIF

<b>The International Code versus MAIF</b>	
<b>Some notable differences:</b>	
<b>International Code</b>	<b>MAIF Code of Practice</b>
<ul style="list-style-type: none"> <li>• Applies to all countries and companies as a minimum standard.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Coverage is limited to six major baby food companies – Heinz Watties, Nestlé, Nutricia, Wyeth, Abbott and Snow Brand. Others are not bound to follow MAIF.</li> </ul>
<ul style="list-style-type: none"> <li>• Applies to all breast milk substitutes including other milk products, foods and beverages marketed to replace breast milk, feeding bottles and teats.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Applies only to infant formula. Products such as baby cereals, infant meals and drinks are not covered even if marketed for infants below 6 months of age. MAIF does not cover feeding bottles and teats.</li> </ul>
<ul style="list-style-type: none"> <li>• Covers “retailers” under its definition of “Distributor”, and forbids promotion at retail level.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Distributors are not covered and MAIF is silent on promotion at the retail level.</li> </ul>
<ul style="list-style-type: none"> <li>• Governments have the responsibility to ensure that objective and consistent information is provided on infant feeding.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ No equivalent responsibility exists. Information materials by companies are often distributed through health care systems and usually contain conflicting messages about breastfeeding.</li> </ul>
<ul style="list-style-type: none"> <li>• No point-of-sale advertising or any other promotion device such as special displays, discount coupons, premiums, special sales, loss leaders and tie-in sales at the retail level.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ No equivalent provision on promotion at the retail level. Thus promotion at the retail level is not forbidden.</li> </ul>
<ul style="list-style-type: none"> <li>• Health authorities have the responsibility to encourage and protect breastfeeding and promote the principles of the Code.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ No equivalent responsibility exists.</li> </ul>
<ul style="list-style-type: none"> <li>• Free or subsidised supplies are banned in any part of the health care system (WHA resolution 47.5 [1994]).</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Allows certain free supplies as it is based on 1981 Code Article 6.6 which is superseded by WHA resolution 47.5.</li> </ul>
<ul style="list-style-type: none"> <li>• Information to health professionals should be restricted to scientific and factual matters, and should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Requires companies to give health care professionals product information reflecting current knowledge and responsible opinion which are clearly identified with company and brand names.</li> </ul>
<ul style="list-style-type: none"> <li>• Governments have overall responsibility to implement and monitor the Code. Monitoring should be carried out in a transparent and independent manner.</li> </ul>	<ul style="list-style-type: none"> <li>◀▶ Advisory Panel which administers MAIF and decides on complaints is partly represented and funded by industry, giving rise to conflict of interests.</li> </ul>

Source: IBFAN Exhibit 32, p 4.

## Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF)

8.23 A government advisory panel, the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), has been established to monitor compliance with, and advise the Government on, the Marketing in Australia of Infant Formula: Manufacturers and Importers (MAIF) Agreement. The panel comprises an independent Chair, a community and consumer representative, a public health and

infant nutrition expert, and an industry representative. The Commonwealth Minister for Health and Ageing has responsibility for the appointment of all members except the representative of the infant formula industry.<sup>22</sup>

8.24 The APMAIF's terms of reference are to:

- receive and investigate complaints regarding the marketing in Australia of infant formulas;
- act as a liaison point for issues relating to the marketing in Australia of infant formulas;
- develop guidelines on the interpretation and application of the MAIF Agreement; and
- provide advice to the Commonwealth Government Minister for Health and Ageing, on the operation of the Agreement.

8.25 Anyone can lodge a complaint about an alleged breach of the MAIF Agreement. Breaches of the MAIF are reported in the APMAIF annual reports which are tabled in Parliament. The latest Annual Report for the period 2003-04 was tabled in March 2005.

8.26 Between 1999 and 2005 the APMAIF recorded 13 breaches of the Agreement.<sup>23</sup> However, more than 180 complaints were received between 2002 and 2004. Of these complaints 138 concerned retail activity (which is beyond the scope of the MAIF). In addition, where a breach has been found to have been committed by a signatory to the agreement, the panel has no powers to impose a penalty as it can only recommend remedial steps.<sup>24</sup>

**Box 8.1 How complaints to the APMAIF are processed**

Complaints to the APMAIF are processed by the APMAIF secretariat. The secretariat considers whether the complaint involves: a MAIF signatory, retailer activity, feeding bottles or teats, dummies, toddler milk or other baby food. The secretariat is also guided by whether the same or similar complaints have been previously determined by the APMAIF to be outside the scope. Some complaints about retail activity may require further information to be sought and the secretariat may send

22 Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), *Annual Report 2003-04*, Department of Health and Ageing, 2004, p 11.

23 Hon Tony Abbott MP, 'Response to Questions in Writing: Breastfeeding' (Question no. 3807), House of Representatives *Hansard*, 26 February 2007, p 186.

24 McVeagh P, 'The World Health Organization Code of Marketing of Breast milk substitutes and subsequent resolutions (The WHO Code),' *NSW Health Bulletin* vol 16 (3-4), 2005, pp 67-68.

letters to retailers to inform them about the MAIF signatories' obligations and ascertain whether there has been any involvement from MAIF signatories in the matter. If a complaint is likely to be out of scope but there is room for doubt, it is referred to the APMAIF for consideration. Out of scope complaints that concern new or unusual marketing activity may also be drawn to the attention of the APMAIF for information.

Complaints requiring consideration by the APMAIF are summarised by the secretariat using a standard format to present the key information relevant to making a decision. The secretariat does not anticipate or recommend a finding. The complainants' identities are not included in the summaries to protect against bias in consideration of the complaint and to protect complainants' privacy. At APMAIF meetings members have access to the summary sheets, exhibits (e.g. brochures, magazine clippings, and posters) and the complainants' de-identified letters or complaint forms. The APMAIF considers these materials and may ask the secretariat to seek further information. When a decision is made, both the complainant and the subject company are advised of the final outcome of the complaint, including reasons for the decision.

*Source: APMAIF Secretariat*

## Review of MAIF and APMAIF

- 8.27 The MAIF Agreement and the APMAIF were the subject of an independent review in 2000.<sup>25</sup> The subsequent report was known as the Knowles report and it made a number of recommendations.<sup>26</sup> The Knowles report indicated that if the recommendations in the report were implemented it would enable Australia's commitment to the WHO Code to be honoured through a voluntary agreement. If the changes do not achieve such an outcome, then the Knowles report considered it necessary to consider a legislated statutory framework.<sup>27</sup>
- 8.28 The Knowles report recommended among other things, that the Commonwealth with the states and territories establish a Public Health Partnership to develop strategies to promote breastfeeding but also provide support to mothers who decide not to breastfeed. A

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25 Hon. Michael Wooldridge MP 'Advice sought on how to improve current marketing arrangements for infant formula sold within Australia' Press Release, 9 November, 2000.

26 Rob Knowles *Independent advice on the composition and modus operandi of APMAIF and the scope of the MAIF Agreement* Department of Health and Ageing (2003), p 1.

27 Rob Knowles *Independent advice on the composition and modus operandi of APMAIF and the scope of the MAIF Agreement* Department of Health and Ageing (2003), p 3.

further recommendation was the establishment of an Infant Nutrition Coordinator at the national level, to be advised by an expanded APMAIF panel. The Knowles report also recommended that retailers, including supermarkets and pharmacies, develop a voluntary code of practice.<sup>28</sup>

- 8.29 The Government implemented a number of recommendations in the Knowles Report, but did not accept the recommendation to establish a Public Health Partnership, or the development of a voluntary code of practice for retailers.<sup>29</sup> The Knowles report noted that there was 'basic disagreement' on the purpose of the MAIF Agreement with key stakeholders and that this was reflected in the differing views of the advocates of breastfeeding and the local infant formula industry.
- 8.30 The Australian Breastfeeding Association (ABA) has criticised the MAIF Agreement, arguing it is nowhere near as extensive or powerful as the WHO code because it applies only to manufacturers and importers of infant formulas but not to retailers. Furthermore, it only covers infant formulas and not other milk products such as follow-on milk for toddlers, or feeding bottles and teats. The ABA is also critical of the voluntary nature of the agreement.<sup>30</sup>
- 8.31 Infant formula manufacturers view the agreement as providing a 'framework' for the provision of information to both mothers who breastfeed and those who use infant formula to feed their infants. A case in point raised in the Knowles report was the issue of samples. Industry was adamant that the provision of samples to health professionals for evaluation was consistent with the Agreement, whereas breastfeeding advocates argued the provision of such samples would result in women being given them free, which would lead to the undermining of breastfeeding.<sup>31</sup>

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28 Rob Knowles *Independent advice on the composition and modus operandi of APMAIF and the scope of the MAIF Agreement* Department of Health and Ageing (2003), pp 10-15.

29 The recommendations agreed to are outlined in APMAIF *Annual Report 2002-03*, p. ix.

30 Australian Breastfeeding Association, 'World Breastfeeding Week 2006', viewed on 30 July 2007 at <http://www.breastfeeding.asn.au/news/wbw.html>.

31 Rob Knowles *Independent advice on the composition and modus operandi of APMAIF and the scope of the MAIF Agreement* Department of Health and Ageing (2003), pp 1-2.

## The Australian context

- 8.32 Significant evidence was provided to the committee that demonstrated infant formula manufacturers in Australia advertise their products in a manner which would clearly breach the WHO Code.<sup>32</sup> Although the WHO Code is not currently implemented in Australia the committee considers the Commonwealth Government should be doing more to protect breastfeeding and the limited scope of the MAIF Agreement falls short of providing an appropriate level of protection.
- 8.33 As an example, the committee is quite concerned by the practice of manufacturers using health professionals as surrogate marketers of their products via distribution of free infant formula sample packs to new mothers. The committee considers that the implicit endorsement of a product given when a health professional provides a free sample to a person should not be underestimated. The committee received consistent evidence that samples of infant formula are being made available to mothers through health professionals such as early childhood nurses, doctors and hospitals.<sup>33</sup>

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32 See for example; Hartley M, sub 8, p 1; Jeffery L, sub 34, p 4; Pile C, sub 38, p 7; Propadalo L, sub 40, p 9; Wighton M, sub 41, p 1; Hall T, sub 70, p 6; Sands B, sub 73, p 3; Dawson P, sub 98, p 3; Gill P, sub 123, p 1; Justice and International Mission, Uniting Church in Australia, sub 156, pp 2,6,8,9; College of Lactation Consultants Vic, sub 158, p 4; Australian College of Midwives Baby Friendly Health Initiative, sub 185, p 4; Berry N, sub 196, p 1; McDonald R, sub 203, p 10; Trezise J, sub 205, p 2; Eldridge S, sub 214, p 4; Hewitt S, sub 215, p 1; Dietitians Association of Australia, sub 223, p 4; Brook B, sub 236, p 2; Davis A, sub 237, p 5; Gribble K, School of Nursing, University of Western Sydney, sub 251, p 4; Heppell M, sub 291, p 2; Parker L, sub 304, p1; Australian Breastfeeding Association, sub 306, p 18; Women's Electoral Lobby, sub 310, p 3; Volders E, sub 350, p 1.

33 Hartley M, sub 8, p 1; Warner B, sub 14, p1; Thorp W, sub 28, p 2; Vane C, sub 36, p 2; Parker E, sub 54, p 2; Ward K, sub 56, p 3; Hall T, sub 70, p 6; Robinson L, sub 90, p 1; Francisco, sub 125, p 5; Browne C, sub 144 p 3; Hay L, sub 153, p 3; Justice and International Mission, Uniting Church in Australia, sub 156, pp 7-22; City of Wodonga, sub 168, p 5; Public Health Association of Australia, sub 181, p 3; Curtis C, sub 188, p 1; Marazakis M, sub 202, p 2, McDonald R, sub 203, p 10; Trezise J, sub 205, p 2; Sneddon A, sub 210, p6; D'Ath C, sub 211, p 1; Goodlet D, sub 213, p 1; Hewitt S, sub 215, p 1; Fuller R, sub 228, p 2; Smith D, sub 234, p 1; Davis A, sub 237, p 5; Forde L, sub 243, p 3; Gribble K, School of Nursing, University of Western Sydney, sub 251, p 4, 6-7; Saxby C, sub 263, p 1; Australian Nursing Foundation, sub 271, pp 11-12; Government of South Australia, sub 274, p 9; Sgambelluri M, sub 292, p 3; Australian Breastfeeding Association, sub 306, p 22; Women's Electoral Lobby, sub 310, p 3; NSW Lactation College, sub 333, p 3; Bowen M, sub 337, sub 3; Bellybelly.com.au, sub 349, p 2,4; Green C, sub 354, p 23; Nielsen L, sub 355, pp 1-3.

- 8.34 The marketing practices of retailers such as pharmacies and supermarkets are also worrying. As mentioned earlier, from the 180 complaints received by the APMAIF between 2002 and 2004, 138 concerned retail activity which is outside the scope of the MAIF Agreement. These marketing practices are likely to be in breach of the WHO Code if it was implemented. The marketing of bottles and teats is also of concern, with the Knowles report encouraging the Government to develop an appropriate agreement on marketing of bottles and teats to reflect the WHO Code as closely as possible.<sup>34</sup>
- 8.35 The committee also received a wide range of evidence of the ineffectiveness of the MAIF Agreement,<sup>35</sup> although it must be noted that many of the issues described in evidence are beyond the scope of the MAIF Agreement. There were a total of 170 complaints about possible breaches of the MAIF Agreement made to the APMAIF in 2002, which resulted in only one breach. The following year 60 complaints were made, again resulting in one breach. The Justice and International Mission Unit of the Uniting Church in Australia was informed that both complaints were submitted by a competing company in the infant formula industry who is also a member of the APMAIF.<sup>36</sup>
- 8.36 The committee was very unimpressed with the timeliness of APMAIF, including their investigating time and reporting to the Commonwealth Parliament. It is not satisfactory to the committee that the most recent report is the 2003-04 report which was tabled in 2005. Another concern is a perception that there is a potential lack of independence from the industry in the APMAIF. Currently, 70 per cent of the APMAIF is sponsored by the infant formula industry, and the industry has a representative on the panel of four people.<sup>37</sup>
- 8.37 There is strong support for the scope of the MAIF Agreement to be expanded to the level of the WHO Code.<sup>38</sup> The MAIF Agreement,

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34 Rob Knowles *Independent advice on the composition and modus operandi of APMAIF and the scope of the MAIF Agreement* Department of Health and Ageing (2003), p 15.

35 See for example Pile C, sub 38, pp 8-9; Hall T, sub 70, p 7; Heads J, sub 74, p 1; Moyhu Community Health Centre, sub 122, p 4; Australian Breastfeeding Association (Tasmanian Branch), sub 172, p 4; Curtis C, sub 188, p 1; Berry, N, sub 196, p 1; Goodlet D, sub 213, p 1; Brook B, sub 236, p 2; Gribble K, School of Nursing, University of Western Sydney, sub 251, p 4; Saxby C, sub 263, p 1; IBFAN-ICDC, sub 275, p 2.

36 Justice and International Mission, Uniting Church in Australia, sub 156, p 6.

37 Justice and International Mission, Uniting Church in Australia, sub 156, p 6.

38 See for example Alexander N, sub 5, p 1; Smith S, sub 31, p 1; Hall N, sub 79, p 1; Volders E, Royal Children's Hospital, sub 85, p 3; Thorley V, sub 97, p 7; Berkowitz R, sub 136, p 1; Justice and International Mission, Uniting Church in Australia, sub 156, pp 2-9; Day S,



being a voluntary self regulatory code of conduct between manufacturers and importers, cannot be simply expanded to the level of the WHO Code. For this to happen, a new and entirely different agreement would need to be developed.

- 8.38 Additionally when the MAIF Agreement was developed, some aspects of the WHO Code were not feasible to implement because some of the pricing restrictions contained in the WHO Code could not be authorised under the *Trade Practices Act 1974*. In 1988 the Trade Practices Commission concluded that ‘the voluntary implementation of a self-regulatory scheme, based on the full WHO Code, was not feasible. The pricing restrictions contained in the WHO Code amounted to breaches *per se* of the Trade Practices Act and could not be authorised in any circumstances’.<sup>39</sup>
- 8.39 In contrast, infant formula manufacturer Nestlé does not consider that there is any evidence to support the introduction of new measures with respect to marketing of infant formulas.<sup>40</sup>
- 8.40 The Justice and International Mission Unit of the Uniting Church in Australia provided a recent legal opinion that challenges the ruling of the Trade Practices Commission. The opinion states that the Commonwealth Parliament would not be restricted from passing legislation which enacted the WHO code by virtue of the Trade Practices Act provided the instrument introducing the WHO Code complies with the National Competition Principles Agreement (CPA). The CPA is an intergovernmental agreement which was signed by the Commonwealth and all states and territories in 1995. The agreement provides that legislatures can pass legislation which restricts competition, as long as they have undertaken an analysis and formed the conclusion that the public benefits of the restriction outweigh any potential detriment that may flow.<sup>41</sup> The committee considers that there is clear evidence of significant public benefit through the introduction of the WHO Code.

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sub 157, p 3; City of Wodonga, sub 168, p 12; Trezise J, sub 205, p 2; Sneddon A, sub 210, pp 3,6; Hewitt S, sub 215, p 1; Barber B, sub 233, p 1; Alexander M, sub 289, p 6; Sgambelluri M, sub 292, p 2; Australian Breastfeeding Association, sub 306, p 5; Borg B, sub 315, p 1; Baby Friendly Hospital Initiative (Queensland), sub 360, p 16; NSW Health, sub 479, p 5.

39 Department of Health and Ageing, sub 450, p 18.

40 Nestlé Australia Ltd, sub 335, p 6.

41 Daniels J, Clayton Utz, transcript, 7 June 2007 p 22.

## Implementation of the WHO Code

- 8.41 The World Health Organisation has consistently stated that the appropriate marketing and distribution of breast milk substitutes is only one of several important factors when considering the protection of healthy practices of infant feeding, such as breastfeeding.<sup>42</sup> The committee agrees that any strategy to improve the rates of breastfeeding in Australia needs to consider the provision of support and advice to expectant and new mothers in addition to providing protection for breastfeeding.
- 8.42 In light of the earlier recommendations, the committee considers it is time to make a decisive and clear statement of the importance of breastfeeding to the Australian community by implementing the full WHO Code and subsequent WHA resolutions.<sup>43</sup> The committee notes that there are two main forms in which the WHO Code and subsequent WHA Resolutions could be introduced into Australian law. These are:
- Commonwealth legislation; or
  - a prescribed mandatory industry code of conduct under the Trade Practices Act.<sup>44</sup>
- 8.43 The committee recognises that the implementation of the WHO Code is a significant action but believes that if the Commonwealth Government wants to achieve the goal of 80 per cent of mothers exclusively breastfeeding for the first six months of their baby's life, the WHO Code needs to be implemented in Australia. The committee recommends accordingly.

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### Recommendation 22

- 8.44 **That the Department of Health and Ageing adopt the World Health Organisation's International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.**

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42 World Health Organisation website viewed on 7 August 2007 at [http://www.who.int/nutrition/infant\\_formula\\_trade\\_issues\\_eng.pdf](http://www.who.int/nutrition/infant_formula_trade_issues_eng.pdf)

43 Information on the International Code of Marketing of Breastmilk Substitutes, commonly called the WHO Code can be found at [http://www.who.int/nutrition/publications/code\\_english.pdf](http://www.who.int/nutrition/publications/code_english.pdf) viewed on 8 August 2007. WHA resolutions can be found at [http://policy.who.int/cgi-bin/om\\_isapi.dll?infobase=wharec-e&softpage=Browse\\_Frame\\_Pg42](http://policy.who.int/cgi-bin/om_isapi.dll?infobase=wharec-e&softpage=Browse_Frame_Pg42) viewed on 8 August 2007

44 Justice and International Mission, Uniting Church in Australia, sub 156, p 13.

## Breastfeeding information – other sources

- 8.45 According to *The Sydney Morning Herald* newspaper, Australians spent over \$38 million on books in the Family, Health and Relationships category. Of those, 25.4 per cent had titles about pregnancy and parenting.<sup>45</sup> The impact that information from books can have on prospective or new parents is significant. Some inquiry participants raised concerns about the accuracy of information about breastfeeding in pregnancy and parenting books and the effect these books might have.<sup>46</sup>

I have felt it mostly in the plethora of sleep training books available, and the implicit holy grail of parenting, i.e. if your baby is not sleeping through the night by 3-4 months of age, you have failed as a parent. I have read several of the most popular ones, and the breastfeeding information in these is inaccurate, and in many cases would lead to a mother unable to breastfeed as it would interfere with her milk supply, or feeling that she has to stop breastfeeding as it interferes with the child sleeping for longer stretches.<sup>47</sup>

- 8.46 Online parenting websites and forums have also become increasingly popular. There is an increasing range of these, both based in Australia and internationally. They can be linked to a commercial interest, such as the *Mother and Baby* magazine or run by organisations such as the ABA. Forums are a source of information and peer support for many mothers. However, they are often a place where myths about both breastfeeding and infant formula can be observed.<sup>48</sup>
- 8.47 EMAP, a publisher of parenting magazines in Australia, noted that their news stand magazines and commercial discharge packs, as of April 2007, will not contain any sales promotion of infant formula or related products which encourage alternatives to breastfeeding.<sup>49</sup>

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45 Tait A, ' \$38 million worth of advice' *The Sydney Morning Herald, Essential Magazine*, 31 May 2007, pp 10-11.

46 Jeffery L, sub 34, pp 1, 6; Gifford J, sub 42, p1; Clayton-Smith D, sub 43, p 1; Ward K, sub 56, p 6; McKone K, sub 226, p 1; name withheld, sub 232, pp 2, 4; Australian Breastfeeding Association (South Australian/Northern Territory Branch), sub 281, p 3; Australian Institute of Family Studies, sub 301, p 8; BellyBelly.com.au, sub 349, p 7.

47 Name withheld, sub 232, p 2.

48 BellyBelly.com.au, sub 441c, p 5.

49 EMAP, sub 180, p 2.

They will continue to contain educational material which actively encourages breastfeeding. EMAP estimated that they have so far turned away advertising revenue of approximately \$1 million.<sup>50</sup> There were some participants in the inquiry who were disappointed by this decision as they feel that it further marginalises women who, for whatever reason, use infant formula and removes a source of potential information and advice.<sup>51</sup>

- 8.48 EMAP is also responsible for the majority of distribution of Bounty bags in Australia. These commercial discharge packs are a means of providing mothers with samples of useful products. Bounty bags are provided to mothers at three stages during the pregnancy. There is a mother-to-be bag, a new mother bag and a new baby bag.
- 8.49 Although these bags are very popular with mothers, research has found that the distribution of written material has been ineffective in increasing breastfeeding rates. Additionally the distribution of commercial discharge packages that contain samples of infant formula or promotional material for infant formula given to mothers as they leave hospital increases the likelihood of infant formula being used over breast milk.<sup>52</sup> Concern was expressed that new mothers in hospital should not be seen as a 'captive' market for advertisers, being bombarded with large quantities of information and advertising when they were extremely vulnerable.<sup>53</sup>
- 8.50 The committee commends the action of companies such as EMAP in becoming WHO Code compliant across their portfolio and welcomes this proactive stance to protect and promote breastfeeding as the normal way to feed a baby.

### Toddler milks

- 8.51 The recent advent of 'toddler milks' into the marketplace is of great concern to many inquiry participants.<sup>54</sup> Toddler milks are typically powdered cow's milk that has been fortified with vitamins and
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50 Runciman J, EMAP, transcript, 4 June 2007, p 57.

51 Name withheld, sub 390, p 1; Fogarty K, sub 427, p 1; Houston A, sub 446, p 1; Pantours R, sub 451, p 1.

52 Centre for Community Child Health, *Breastfeeding Promotion Practice Resource* (2006) p 10; NSW Baby Friendly Health Initiative, sub 339, p 8.

53 Community statements, transcript, 4 June 2007, p 83.

54 Jeffery L, sub 34, pp 4-5; Pile C, sub 38, pp 7-9; Ward K, sub 56, pp 1-3; Hall T, sub 70, p 7; Rieger M, sub 109, pp 3-4; Northern Sydney Central Coast Health Breastfeeding Promotion Committee, sub 163, p 3; Lording R, sub 186, pp 1-5; Evans A, sub 187, p 1; Brook B, sub 236, p 2; Saxby C, sub 263, p 1; Taylor H, sub 346, pp 1-4.

minerals marketed at the 12 months plus age group. The Infant Formula Manufacturers Association notes that toddler milk products can play an important public health role in fulfilling the nutritional needs to young children when their diets are unsatisfactory, particularly in the instance of iron deficiency.<sup>55</sup>

- 8.52 The Australian Lactation Consultants Association gave evidence to the committee that into the second year of life, milk is actually a subsidiary and solids start to take the primary role. They stated that if a child was given a large amount of milk with high protein and high fat content such as toddler milk, the child was not hungry for the rest of the feed. The result can be eating disorders, where parents force their children to eat, using sweets to reward and keep them eating because they think they are starving, or the child is missing a vital opportunity to learn a variety of diet.<sup>56</sup>
- 8.53 The NSW Government considers that 12 months is not a recommended end point for breastfeeding and commercial formulas promoted for toddlers from 12 months may be regarded as breast milk substitutes. They consider that there is no nutritional requirement to provide toddlers with commercial artificial milk substitutes; however, these products are being strongly marketed due to limitations of the MAIF agreement. The NSW Government believes that measures are needed nationally to address this problem, particularly through strengthening the national codes and agreements.<sup>57</sup>
- 8.54 Concern has been expressed about how toddler milks are advertised.<sup>58</sup> Toddler milks are not subject to the MAIF Agreement so they can be advertised. It has been comprehensively reported to the committee that toddler milks are in similar packaging and have similar names to infant formula, often with the toddler milk being branded as number 3 (where infant formula and follow-on formula are 1 and 2). Participants to the inquiry consider that this may create an incorrect perception about the necessity of toddler milk and are concerned that it could also lead to brand recognition.

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55 Infant Formula Manufacturers Association of Australia, Sub 375, p 7.

56 Moody G, Australian Lactation Consultants Association, transcript, 4 June 2007, p 32.

57 Develin L, NSW Health, transcript, 4 June 2007, p 77.

58 See for example Burns N, sub 81, p 1; Dawson P, sub 98, p 4; Beyer L, sub 105, p 1; Bell C, sub 116, p 1; Cassels S, sub 131, p 1; D'Ath C, sub 211, p 1; Davis, A, sub 237, p 5; Barnwell M, sub 255, p 4; Radel E, sub 286, p 1; Heppell M, sub 291, p 1; Bellybelly.com.au, sub 349, p 4; De Vries L, sub 359, p 2; Elliott-Rudder M, sub 371, p 3; Cheers A, sub 445, p 1; Cawthera J, sub 453, p 2.

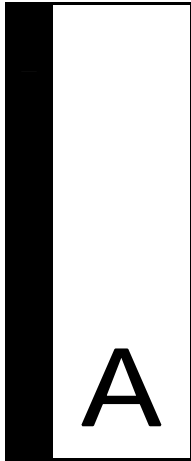
- 8.55 Toddler milk is beyond the scope of the inquiry and so the committee will not be making a recommendation. However, during the course of the inquiry the committee observed the concern that many in the community have about the promotion and marketing of toddler milks. The committee concludes that it is vitally important that infants are exclusively breastfed for six months and then appropriate solids are introduced after this point following the information provided in the Dietary Guidelines chapter *Enjoy a wide variety of nutritious foods*.<sup>59</sup> Unless there is a medically indicated condition such as low-birthweight, toddlers should be obtaining the required nutrients from a balanced and appropriate diet, rather than a nutritional supplement such as toddler milk.

**Hon Alex Somlyay MP**

**Chair**

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<sup>59</sup> National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), pp 52-55.



## Appendix A – Submissions<sup>1</sup>

1	Ms Janette Wallis	17	Mrs Karina Ryan
2	Ms Melanie McCulloch	18	Ms Carolyn Hastie
3	Ms Anne Mackay	19	Robyn Thompson, Melbourne Midwifery Pty Ltd
4	Australian Lactation Consultants Association	20	Dr Alison Walsh
5	Ms Nicolle Alexander	21	Trish
6	Ms Catherine Werner	22	Hunter New England Area Health Service
7	Ms Sarah Phillips	23	Mr David Mussared
8	Ms Myrna Hartley	24	Isabel Field, Child Advocate Class Action
9	Mrs Beryl Jackson	25	Ms Margaret Eldridge
10	Ms Nicole Gray	26	Ms Stacey Revie
11	Ms Sylvie Jackson	27	CONFIDENTIAL
12	Queensland Government	28	Ms Wendy Thorp
13	Ms Rhona Jones	29	Ms Anna Cheers
14	Ms Bronwyn Warner	30	Ms Gaenor Dixon
15	Ms Ailsa Rothenbury		
16	Ms Carmen Simpson		

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<sup>1</sup> In the above list (supp) indicates supplementary submission

- |    |   |    |   |
|----|---|----|---|
| 31 | Ms Sue Smith                                  | 58 | Ms Kelly Middlebrook  |
| 32 | Mrs Trish Dyson                               | 59 | Ms Narrissa Wheatley  |
| 33 | Ms Yvette O'Dowd                              | 60 | Ms Rosemary Pollock   |
| 34 | Ms Lisa Jeffery                               | 61 | Ms Julie Weller   |
| 35 | National Health & Medical<br>Research Council | 62 | Ms Susie Forster  |
| 36 | Ms Cherise Vane                               | 63 | Ms Federica<br>Rasmi Sakulsuvarn  |
| 37 | Ms Querida David                              | 64 | Ms Kelley Stewart   |
| 38 | Ms Charndra Pile                              | 65 | Ms Tamar Boas   |
| 39 | CONFIDENTIAL                                  | 66 | Mrs Pooja Newman  |
| 40 | Ms Lilea Propadalo                            | 67 | Prof Ellen McIntyre<br>Department of General<br>Practice, Flinders University |
| 41 | Ms M Wighton                                  | 68 | Roslyn Giglia   |
| 42 | Ms Judy Gifford                               | 69 | Ms Sharon Green   |
| 43 | Ms Donna Clayton-Smith                        | 70 | Ms Tracey Hall  |
| 44 | Ms Bronwyn Kelleher                           | 71 | Ms Sherylee Tutt  |
| 45 | Name withheld                                 | 72 | Ms Angie Christoff  |
| 46 | Jodi Cleghorn, Down to<br>Birth               | 73 | Ms Bianca Sands   |
| 47 | Ms Sheridan Leng                              | 74 | Ms Joy Heads  |
| 48 | Ms Janice McCormack                           | 75 | Gippsland Women's Health<br>Service Inc, Victoria                             |
| 49 | Ms Rachael Austin                             | 76 | Ms Susanna Psalios  |
| 50 | Dr Julie Robins                               | 77 | Ngala Family Resource<br>Centre   |
| 51 | Ms Susanna Scurry                             | 78 | Ms Annabelle Daniel   |
| 52 | Ms Pascal Donovan                             | 79 | Ms Naomi Hull   |
| 53 | Ms Yvonne Campbell                            | 80 | Ms Helen Long   |
| 54 | Ms Erica Parker                               | 81 | Ms Nicole Burns   |
| 55 | Mr Brian Smith                                | 82 | Ms Lalitha Chelliah   |
| 56 | Ms Kathryn Ward                               |    |   |
| 57 | Mrs Janet Bayldon                             |    |   |



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| 83  | Mrs Natalie McKeown  | 109 | Ms Melanie Rieger                                  |
| 84  | Ms Melanie Robertson   | 110 | Ms Aileen Smith                                    |
| 85  | The Royal Children's<br>Hospital, Victoria                         | 111 | Ms Sherilyn Mathewson                              |
| 86  | Prof Colin Binns, School of<br>Public Health, Curtin<br>University | 112 | Ms Keryn Foley                                     |
| 87  | Ms Ailsa Rothenbury (supp)   | 113 | Ms Sam Cassar                                      |
| 88  | Ms Sophie Clapperton   | 114 | Ms Melissa Bull                                    |
| 89  | Ms Kathleen Kelly  | 115 | Ms Theona Hinkley                                  |
| 90  | Ms Lisa-Marie Robinson   | 116 | Ms Clare Bell                                      |
| 91  | Ms Louise Ayre   | 117 | Stacey   |
| 92  | Mr Richard Brown   | 118 | Ms Narelle Batterham                               |
| 93  | Ms Jan Greentree   | 119 | Ms Karen Gaskill                                   |
| 94  | Ms Carol Chapman   | 120 | Australian Association for<br>Infant Mental Health |
| 95  | Ms April Drew  | 121 | Ms Louise Brown                                    |
| 96  | Ms Shani Brycesson   | 122 | Dr Fiona Clements                                  |
| 97  | Ms Virginia Thorley  | 123 | Ms Penny Gill                                      |
| 98  | Ms Prue Dawson   | 124 | Ms Natasha Davis                                   |
| 99  | Ms Deborah Boswell   | 125 | Ms Irene Francisco                                 |
| 100 | Ms Crystel Poggioli  | 126 | Ms Nerida Carter                                   |
| 101 | Ms Karin Thorp   | 127 | Ms Anna Ng   |
| 102 | Ms Elizabeth Moore   | 128 | Ms Margot Trinder                                  |
| 103 | Ms Glenna Grove  | 129 | Mrs Helen Perris                                   |
| 104 | Ms Lynette Huckstadt   | 130 | Ms Tracey Oliver                                   |
| 105 | Ms Lisa Beyer  | 131 | Ms Shona Cassels                                   |
| 106 | Ms Helen MacDonald   | 132 | Ms Jacqueline Smith                                |
| 107 | Ms Nicole Edwards  | 133 | Ms Sarah Smith                                     |
| 108 | Mrs Rebecca Ferluga  | 134 | Ms Alicia Flock-Kone &<br>Cheikh Kone              |
|     |  | 135 | Ms Kate Taylor                                     |

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|-----|--|-----|--|
| 136 | Ms Ruth Berkowitz  | 159 | Ms Trish Makarian  |
| 137 | Ms Lee Jones   | 160 | Mrs Michelle Buckley   |
| 138 | Mrs Lois Jeffrey   | 161 | Mrs Anthea Nicholls  |
| 139 | Ms Melinda Rose  | 162 | Ms Emily Dickson   |
| 140 | Miss Fiona Myers   | 163 | Northern Sydney Central<br>Coast Health Breastfeeding<br>Promotion Committee |
| 141 | H J Heinz Co. Australia<br>Limited                                 | 164 | Ms Joanne Mahony   |
| 142 | Network of Australian<br>Lactation Colleges                        | 165 | Ms Asphyxia  |
| 143 | Mrs Rowena Fordes  | 166 | Australian Lactation<br>Consultants Association,<br>Victorian Branch         |
| 144 | Ms Cheryl Browne   | 167 | Ms Leonie Johnson  |
| 145 | Ms Carolyn Artlett   | 168 | City of Wodonga Maternal &<br>Child Health Nurses                            |
| 146 | Ms Michelle How  | 169 | Mrs Nina Hooper  |
| 147 | Ms Megan Foster  | 170 | Ms Lana van Galen  |
| 148 | Ms Claire Nussey   | 171 | NSW Aboriginal Maternal &<br>Infant Health Strategy                          |
| 149 | Ms Janet Bellinger   | 172 | Australian Breastfeeding<br>Association, Tasmania<br>Branch                  |
| 150 | Ms Judy Evans  | 173 | Ms Carlene Tyler   |
| 151 | CONFIDENTIAL   | 174 | The Royal Australasian<br>College of Physicians                              |
| 152 | College of Lactation<br>Consultants Western<br>Australia Inc       | 175 | Australian Federation of<br>AIDS Organisations Inc                           |
| 153 | Mrs Lynda Hay  | 176 | Ms Tanya Bertolli  |
| 154 | Pharmaceutical Society of<br>Australia                             | 177 | Ms Julie Hayes   |
| 155 | Ms Honi Virgo  | 178 | NSW Centre for Public<br>Health Nutrition                                    |
| 156 | Uniting Church in Australia<br>(Synod of Victoria and<br>Tasmania) |     |  |
| 157 | Mrs Susan Day  |     |  |
| 158 | College of Lactation<br>Consultants Victoria Inc                   |     |  |

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179	Ms Beth Stickney & Andy Bravo	203	Mrs Rachel Anne McDonald
180	EMAP Australia Pty Ltd	204	Ms Penelope Curtis
181	Public Health Association of Australia Inc	205	Ms Jenny Trezise
182	National Council of Single Mothers & their Children Inc	206	Ms Suzanne Miller-Mustard
183	Ms Bernadette Anderson	207	Australian Breastfeeding Association, Queensland Branch
184	Division of Nursing and Midwifery, La Trobe University	208	CONFIDENTIAL
185	Australian College of Midwives, Baby Friendly Health Initiative	209	Ms Wilani Smit
186	Ms Ros Lording	210	Ms Alison Sneddon
187	Ms Ann Evans	211	Mrs Charise D'Ath
188	Ms Christine Curtis	212	Childbirth Education Association (Brisbane) Inc
189	Ms Melinda Tustian	213	Mrs Donna Goodlet
190	The Maternity Coalition Inc	214	Mrs Sally Eldridge
191	Ms Elizabeth Oei	215	Mrs Shirley Hewitt
192	Ms Rosalie Stafford	216	Telethon Institute for Child Health Research
193	Ms Raquel Willis	217	Mothers Milk Bank Pty Ltd, John Flynn Private Hospital, Queensland
194	Ms Elizabeth Harris	218	Dr Christine Stocks
195	Ms Caroline Clancy	219	Mrs Elizabeth Nitschke
196	Ms Nina Berry	220	Mrs Rachael Torepe
197	Ms Penelope Ellis	221	CONFIDENTIAL
198	Ms Vera Peirce	222	Mrs Claudia Stephenson
199	Ms Amanda Tattam	223	Dietitians Association of Australia
200	CONFIDENTIAL	224	Mrs Elizabeth Cox
201	Mr Ros Fleetwood	225	Mrs Stephanie Bethel
202	Ms Michelle Marazakis	226	Ms Alice Campbell

- 227 Mrs Christina Bailey
- 228 Mrs Rachel Fuller
- 229 Mrs Christine Poste
- 230 Ms Ailsa Rothenbury (supp)
- 231 Mrs Mary Anne Patton
- 232 Name withheld
- 233 Mrs Bronwyn Barber
- 234 Mrs Del Smith
- 235 Mrs Marita Linkson
- 236 Mrs Bernadine Brook
- 237 Mrs Anne Davis
- 238 CONFIDENTIAL
- 239 Mrs Joanne Smethurst
- 240 Mrs Clare Kendall
- 241 CONFIDENTIAL
- 242 Ms Carlene Tyler
- 243 Mrs Leila Forde
- 244 The Royal Women's Hospital, Victoria
- 245 Mrs Peta Oates
- 246 Mrs Florence Kolb
- 247 Mrs Naomi Sirio
- 248 Mrs Rachel Stevens
- 249 Mrs Sandra Eales
- 250 Mrs Robyn Hodge
- 251 Dr Karleen Gribble, School of Nursing, University of Western Sydney
- 252 Mrs Carol Boomsma
- 253 Ms Toni Ormston
- 254 Ms Penny Austin
- 255 Ms Marjorie Barnwell
- 256 Ms Katrina Flora & Di Diddle
- 257 Mr Paul & Mrs Maja Valente
- 258 Mrs Deborah Lewis
- 259 Ms Ros Gabriel, Lifestyle Education & Training Services
- 260 Ms Clare Colman
- 261 Mrs Melissa Ballantyne
- 262 Mr Maurice Hendriks
- 263 Ms Claire Saxby
- 264 Mrs Shoena Messner
- 265 Ms Maureen Kelly
- 266 Mr Bruce Cameron
- 267 Ms Lee Jones
- 268 Ms Maria Addison
- 269 Mrs Julieanne Hensby
- 270 Ms Shao Zhou, Ms Maria Makrides, Prof Robert Gibson
- 271 Australian Nursing Federation
- 272 Dr Helen Watchirs, ACT Human Rights and Discrimination Commissioner
- 273 Mrs Evelyn Maack
- 274 Government of South Australia

- 275 The International Baby Food Action Network International Code Documentation Centre, Malaysia
- 276 Australian Breastfeeding Association, New South Wales Branch
- 277 Ms Michelle Marazakis (supp)
- 278 Mrs Claudia Stephenson (supp)
- 279 Health Promotion Team, Brisbane Northside Population Health Unit
- 280 Tresillian Family Care Centres, New South Wales
- 281 Australian Breastfeeding Association, South Australia/Northern Territory Branch
- 282 Mses Anne Rae, Gemma Mcleod, Wendy Baker, Pushpa Sivakumar, Women and Newborn Health Service, King Edward Memorial Hospital, Western Australia
- 283 Ms Michelle Leonard
- 284 Ms Suzanne Groom
- 285 Ms Janelle De Lacey
- 286 Ms Emma Radel
- 287 Ms Katrina Matthews
- 288 Ms Rachael Dean
- 289 Ms Meredith Alexander
- 290 Ms Michelle Player
- 291 Mrs Margaret Heppell
- 292 Ms Maria Sgambelluri
- 293 Victorian Maternal & Child Health Coordinators Group
- 294 Key Centre for Women's Health in Society, University of Melbourne
- 295 Dr Julia Moore
- 296 Mrs Aeron Coombes
- 297 Mrs Jane Toxward
- 298 Mrs Bernadine Brook (supp)
- 299 Australian Rural Nurses & Midwives
- 301 Australian Institute of Family Studies
- 302 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Steering Committee
- 303 Ms Jane McKellar
- 304 Ms Melissa Fellows
- 305 Ms Louisa Parker
- 306 Australian Breastfeeding Association
- 307 Queensland Health
- 308 West Australian Country Health Service - South West Dietitians
- 309 Mr Ben Dawson
- 310 Women's Electoral Lobby Australia Inc

- 311 Dr Penelope Mitchell
- 312 Dr Wendy Brodribb
- 313 Dr Julie Smith
- 314 CONFIDENTIAL
- 315 Ms Bindi Borg
- 316 Ms Juliet Allen
- 317 Ms Cathy Garbin
- 318 Ms Robyn Noble, Bayside  
Breastfeeding Clinic
- 319 Dr Julie Smith and Dr Peta  
Harvey
- 320 Ms Wendy Wright
- 321 Ms Debbie Schafer
- 322 Ms Madeleine Love
- 323 Ms Elspeth Binckes
- 324 Ms Narelle Greenlees
- 325 Ms Kate Louis
- 326 Ms Heather Hirsch
- 327 Ms Margaret Levin
- 328 Infant Formula  
Manufacturers Association  
of Australia, Inc.
- 329 Ms Monica Hogan, Dale  
Hansson, and Ms Louise  
Duursma
- 330 CONFIDENTIAL
- 331 Pharmacy Guild of Australia
- 332 Clare Boucher, Bubboo
- 333 New South Wales Lactation  
College Inc
- 334 Northern Territory  
Department of Health &  
Community Services
- 335 Nestle Nutrition
- 336 Ms Maxine Wilson
- 337 Ms Marion Bowen
- 338 Ms Lee Courtwood
- 339 NSW Committee of the Baby  
Friendly Hospital Initiative
- 340 Ms Virginia Thorley (supp)
- 341 Ms Sally Barnett
- 342 Ms Jan Mangleson
- 343 Ms Marion Huntly
- 344 Ms Jan Brown
- 345 Mookai Rosie-Bi-Bayan  
Aboriginal and Torres Strait  
Islanders Corporation
- 346 Ms Helen Taylor
- 347 Mrs Anne Davis (supp)
- 348 Ms Helen Sieker
- 349 BellyBelly.com.au
- 350 Ms Evelyn Volders (supp)
- 351 Logan Hospital, Queensland
- 352 Ms Karin Thorp (supp)
- 353 Ms Karen van Harskamp
- 354 Ms Chloe Green
- 355 Ms Lisa Nielsen
- 356 Ms Linda Price
- 357 Lactation Resource Centre,  
Australian Breastfeeding  
Association (supp)

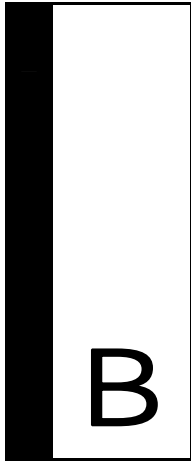
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|-----|--|-----|-------------------------|
| 358 | Australian Medical Association                                   | 384 | Ms Sonia Ozanne         |
| 359 | Ms Linda de Vries  | 385 | Ms Michelle Galilee     |
| 360 | Baby Friendly Health Initiative, Queensland                      | 386 | Ms Melissa Shorten      |
| 361 | Ms Alice Campbell  | 387 | Ms Collette Beck        |
| 362 | Ms Suzanne Lenne   | 388 | Ms Stacey De Villiers   |
| 363 | Ms Michelle Moss   | 389 | Ms Danielle Pedrana     |
| 364 | Government of Tasmania   | 390 | Name withheld           |
| 365 | Ms Madeleine Love (supp)   | 391 | Name withheld           |
| 366 | Ms Beth Hartley  | 392 | Ms Beatrice Gill        |
| 367 | Mrs Anne Davis (supp)  | 393 | Ms Hollie Richards      |
| 368 | Ms Belinda Nichols   | 394 | Ms Melissa Pearce       |
| 369 | Ms Simone Halpin   | 395 | Ms Pauline Martin       |
| 370 | Ms Diana Royds   | 396 | Ms Catherine McCarthy   |
| 371 | Ms Megan Elliott-Rudder  | 397 | Name withheld           |
| 372 | Janette Roberts, Well4life                                       | 398 | CONFIDENTIAL            |
| 373 | Ms Phillipa Martin   | 399 | Name withheld           |
| 374 | Name withheld  | 400 | Ms Laura Jackson        |
| 375 | Infant Formula Manufacturers Association of Australia Inc (supp) | 401 | Name withheld           |
| 376 | Ms Cass Proudfoot  | 402 | Ms Margaret Christopher |
| 377 | Ms Christine Stephens  | 403 | Ms Eileen Jeffree       |
| 378 | Ms Christy Janssen   | 404 | Name withheld           |
| 379 | CONFIDENTIAL   | 405 | Name withheld           |
| 380 | Name withheld  | 406 | Ms Anna Grindley        |
| 381 | Name withheld  | 407 | Ms Sue Conroy           |
| 382 | Ms Sonia Cuff  | 408 | Name withheld           |
| 383 | Ms Esther Liu  | 409 | Name withheld           |
|     |  | 410 | Name withheld           |
|     |  | 411 | Name withheld           |

- 412 Name withheld
- 413 Name withheld
- 414 Ms Molly Tinsley
- 415 Ms Rebecca Crosbie
- 416 Name withheld
- 417 Ms Fiona Walker
- 418 Ms Mandy Gibbens
- 419 Sarah
- 420 Ms Natalie Gardiner
- 421 Ms Madeleine Love (supp)
- 422 Ms Heidi Hendry
- 423 Ms Lynn Healy
- 424 Name withheld
- 425 Ms Gayle Webb
- 426 Ms Deb Mackellin
- 427 Ms Kelly Fogarty
- 428 Ms Jenny Stanger
- 429 Ms Donna Emery
- 430 Ms Fiona Thomme
- 431 Ms Eslpeth Rollason
- 432 Ms Melissa Brown
- 433 Ms Christine Stavrakis
- 434 Prof Colin Binns (supp)
- 435 Prof Colin Binns (supp)
- 436 Ms Kelly Gough
- 437 Name withheld
- 438 Ms Madeleine Love (supp)
- 439 Name withheld
- 440 Ms Naomi Irvin
- 441 BellyBelly.com.au (supp)
- 442 BellyBelly.com.au (supp)
- 443 Ms Kirsty Taylor
- 444 Name withheld
- 445 Ms Anna Cheers (supp)
- 446 Ms Amanda Houston
- 447 Ms Rebekah Blake
- 448 Name withheld
- 449 Ms Heidi Attard
- 450 Department of Health and Ageing, Australian Government
- 451 Ms Robin Pantours
- 452 Ms Jo Anderson
- 453 Ms Jo Cawthera
- 454 Advisory Panel on the Marketing in Australia of Infant Formula
- 455 Ms Sonja Mercer
- 456 Dr Sarah Buckley
- 457 CONFIDENTIAL
- 458 Ms Kylie Hopkinson
- 459 Ms Sharon Gwyn
- 460 Ms Jackie Phillips
- 461 Hon Roger Price MP
- 462 Ms M Every
- 463 Ms Sansha Johnson
- 464 Ms Madeleine Love (supp)
- 465 CONFIDENTIAL



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- |   |                                     |
|---|-------------------------------------|
| 466 Ms Danielle Corbett                         | 475 Government of Western Australia |
| 467 Australian Breastfeeding Association (supp) | 476 Ms Sarah Charge                 |
| 468 Ms Sarah Godfrey-Lea                        | 477 Name withheld                   |
| 469 Name withheld                               | 478 Ms Madeleine Love (supp)        |
| 470 Ms Amanda McCue                             | 479 Government of New South Wales   |
| 471 Ms Jo Clinton                               |                                     |
| 472 Ms Sharon Mulheron                          |                                     |
| 473 Leut Lee Kormany                            |                                     |
| 474 Dr Julie Smith (supp)                       |                                     |





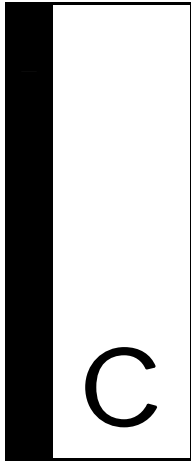
## Appendix B – Exhibits

1. Australian Breastfeeding Association, *Breastfeeding Confidence*. Received 4 April 2007 from Regional Maternity Services, Cairns Base Hospital.
2. Australian Breastfeeding Association, *Diary Dates and Group News, October 2006 to March 2007*. Received 4 April 2007 from Regional Maternity Services, Cairns Base Hospital.
3. Queensland Health, *Consent for Complementary Feeding*, form (MR 66A). Received 4 April 2007 from Regional Maternity Services, Cairns Base Hospital.
4. *Breast or Bottle. What will you choose?* Received 4 April 2007 from Regional Maternity Services, Cairns Base Hospital.
5. Cairns Base Hospital, *Infant Feeding Antenatal Discussion Guide*, form. Received 4 April 2007.
6. Cairns Base Hospital, *Breastfeeding A Healthy Choice*, form. Received 4 April 2007.
7. Queensland Health, *Healthy Mums*, draft booklet. Received 4 April 2007
8. Queensland Health, *Pregnancy Issues*, draft booklet. Received 4 April 2007
9. Queensland Health, *Keeping Food Safe*, draft booklet. Received 4 April 2007.
10. Queensland Health, *Young Mums*, draft booklet. Received 4 April 2007.

11. Queensland Health, *Diabetes During Pregnancy*, draft booklet. Received 4 April 2007.
12. Queensland Health, *Alcohol, Tobacco and Other Drugs During Pregnancy*, draft booklet. Received 4 April 2007.
13. Queensland Health, *How Grandparents Can Help*, draft booklet. Received 4 April 2007.
14. Queensland Health, *How Dads Can Help*, draft booklet. Received 4 April 2007.
15. Queensland Health, *Breastfeeding, Good for Baby, Good for Mum*, draft booklet. Received 4 April 2007.
16. Queensland Health, *Formula Feeding Your Baby*, draft booklet. Received 4 April 2007.
17. Queensland Health, *How to Breastfeed*, draft booklet. Received 4 April 2007.
18. Queensland Health, *Expressing Breastmilk*, draft booklet. Received 4 April 2007.
19. Queensland Health, *Sanitising Bottles*, draft booklet. Received 4 April 2007.
20. Queensland Health, *Iron Rich Foods*, draft booklet. Received 4 April 2007.
21. Queensland Health, *Healthy Drinks for Baby*, draft booklet. Received 4 April 2007.
22. Queensland Health, *Healthy Foods for age 1-4 years*, draft booklet. Received 4 April 2007.
23. Queensland Health, *Healthy Drinks for age 1-4 years*, draft booklet. Received 4 April 2007.
24. Queensland Health, *Baby's Growth Spurts*, draft booklet. Received 4 April 2007.
25. Queensland Health, *Overweight and Obesity in Children*, draft booklet. Received 4 April 2007.
26. Queensland Health, *Growing Strong: Feeding You and Your Baby*. Received 4 April 2007.

27. de Onis, M. *The Use of Anthropometry in the Prevention of Childhood Overweight and Obesity*, International Journal of Obesity 2004, vol. 28, S81-S85. Received 4 April 2007 from Queensland Health.
28. Queensland Health, *GAA Boys Growth Chart, Plotted Growth Curves of Breastfed Boys*, chart. Received 4 April 2007.
29. Queensland Health, *GAA Girls Growth Chart, Plotted Growth Curves of Breastfed Girls*, chart. Received 4 April 2007.
30. Queensland Health, *GAA Boys Growth Chart*, chart. Received 4 April 2007.
31. Queensland Health, *Girls Weight/Girls Length*, draft chart. Received 4 April 2007.
32. IFBAN, *Australia Code Violations 2007: A Survey of the state of the International Code of Marketing of Breastmilk Substitutes and Subsequent WHA Resolutions*. Received 18 April 2007 from John Flynn Private Hospital.
33. *BFHI History in New Zealand*. Received 7 May 2007 from the Australian College of Midwives.
34. Rickards, Dr Sandra, *Benefits of a Private Lactation Consultant, 31 May 2007*, correspondence. Received 4 June 2007 from Australian Lactation Consultants' Association.
35. Britten, Mr Tony, *Re: Benefits of a Private Lactation Consultant, 30 May 2007*, correspondence. Received 4 June 2007 from Australian Lactation Consultants' Association.
36. Unicef, *Formula for Disaster*, DVD, Received 7 June 2007 from the Uniting Church of Australia.





## Appendix C – Public Hearings and Inspections

### **Public Hearings**

Monday, 26 March 2007 – Canberra, ACT

#### **Individuals**

Charndra Pile

#### **Australian Centre for Economic Research on Health**

Dr Julie Smith, Research Fellow

#### **Department of Health and Ageing**

Ms Jennifer Bryant, First Assistant Secretary, Population Health Division

Mr David Learmouth, Deputy Secretary

Ms Lesley Paton, Director, Nutrition Section

#### **National Health & Medical Research Council**

Prof Colin Binns, School of Public Health, Curtin University

Mrs Cathy Clutton, Acting Executive Director, Policy and Practice Branch

Wednesday, 4 April 2007 – Cairns, QLD

**Individuals**

Mrs Sandra Eales

Ms Ros Gabriel

**Cairns Base Hospital**

Ms Rita Ball, Nurse/Midwife Educator, Integrated Women's Health Unit

**Mookai Rosie-Bi-Bayan - Aboriginal and Torres Strait Islanders Corporation**

Ms Constance Archer, Acting Chief Executive Officer

Ms Sian Dalua, Project Officer, Building Healthy Communities

Ms Barbara Simpson, Health Worker

**Royal Flying Doctor Service**

Ms Jacinta Felsch, Senior Flight Nurse

**Tropical Population Health Unit**

Ms Dympna Leonard, Director, Public Health Nutrition

Ms Aletia Moloney, Senior Public Health Nutritionist, Public Health Nutrition

Ms Kani Thompson, Nutrition Promotion Officer, Indigenous Health

**15 Community Statements**

Tuesday, 17 April 2007 – Brisbane, QLD

**Individuals**

Prof Desley Hegney

Ms Maxine O'Brien

Ms Virginia Thorley

**Australian Breastfeeding Association, Queensland Branch**

Ms Robyn Hamilton, President

**Bayside Breastfeeding Clinic**

Ms Robyn Noble, Lactation Consultant



**Queensland Health**

Dr Amanda Lee, Manager - Nutrition and Physical Activity Health  
Promotion Unit, Population Health Branch

**6 Community Statements**

Wednesday, 18 April 2007 - Gold Coast, QLD

**Individuals**

Dr David McMaster

**Gold Coast Hospital**

Mrs Lyn Ahearn, Lactation Consultant

Dr Peter Schmidt, Staff Specialist Paediatrics, Paediatric Department

**John Flynn Private Hospital**

Ms Gaylene Hardwick, Registered Midwife

Mrs Sandra Penfold, Registered Midwife and Lactation Consultant

Mrs Adrienne Wheatley, Registered Midwife and Lactation  
Consultant

**Logan Hospital**

Ms Hazel Brittain, Nursing Director Women's and Children's Services

Ms Margaret Wendt, Clinical Midwife Lactation Consultant

**Mothers Milk Bank**

Ms Jenny Jones, Early Childhood Director

Ms Marea Ryan, Director

**9 Community Statements**

Monday, 7 May 2007 – Canberra, ACT

**Individuals**

Mrs Sally Eldridge

**Australian College of Midwives**

Ms Ros Escott, Consultant

Dr Barbara Vernon, Executive Officer

**Dietitians Association of Australia**

Ms Nerida Bellis-Smith, Professional Services Director

Ms Evelyn Volders, Member

**Pharmaceutical Society of Australia**

Mrs Lorraine Smith, Member Delegate

**Women's Electoral Lobby Australia Inc.**

Ms Ingrid McKenzie, Maternity Services and Breastfeeding Working Group

Ms Natasha Pollock, Maternity Services and Breastfeeding Working Group

Wednesday, 23 May 2007 – Canberra, ACT

**Australian Rural Nurses and Midwives**

Mrs Geri Malone, Executive Director

Monday, 4 June 2007 – Sydney, NSW

**Advisory Panel on the Marketing in Australia of Infant Formula**

Mr John Kain, Acting Chair

**Australian Lactation Consultants Association**

Ms Louise Duursma, Member

Ms Gwen Moody, President

**Core of Life**

Mrs Melissa Hoye, Central Coast Facilitator and Co-Coordinator

**EMAP Australia Pty Limited**

Ms Megan Baker, Hospitals Manager

Mrs Joanne Runciman, Publisher Parenting Division

**Infant Formula Manufacturers Association of Australia, Inc.**

Ms Janet Carey, Executive Director

Dr Jeanette Fielding, Chair, Technical Committee

Mr Peter Kelly, President

**New South Wales Health**

Ms Elizabeth Develin, Director, Centre for Chronic Disease  
Prevention and Health Advancement

**NSW Centre for Public Health Nutrition**

Dr Debra Hector, Representative

**Public Health Association of Australia Inc.**

Dr Lisa Amir, Member

Dr Debra Hector, Member

**Tresillian Family Care Centres**

Ms Wendy Carter, Outreach Team Leader, Clinical Nurse Specialist  
and Child and Family Health Nurse

Ms Julie Maddox, Clinical Nurse Consultant

**4 Community Statements**

Thursday, 7 June 2007 – Melbourne, Vic

**Australian Breastfeeding Association**

Ms Nina Berry, National Manager, Community and Government  
Relations

Ms Margaret Grove, National President

Ms Sue McIvor, Executive Officer

Ms Kate Mortensen, Manager, Lactation Resource Centre

**BellyBelly.com.au**

Mrs Cailin Thompson, Administrator-Moderator

Ms Kelly Zantey, Director

**Clayton Utz**

Ms Joanne Daniels, Partner

Ms Nicole Smith, Articled Clerk

**Key Centre for Womens Health in Society, University of Melbourne**

Dr Lisa Amir, Lecturer

Ms Amanda Cooklin, PhD Candidate and Research Assistant

Ms Amanda Tattum, former Community Liaison Officer

**Post and Antenatal Depression Association**

Ms Lisa Hanlon, Project Coordinator

Mrs Zelinda Hoyle, Volunteer Coordinator

**The Royal Women's Hospital**

Ms Kaye Dyson, Manager, Breastfeeding Education and Support Services

Ms Anita Moorehead, Clinical Midwife Consultant (Lactation)

**Uniting Church in Australia (Synod of Victoria and Tasmania)**

Dr Mark Zirnsak, Director, Justice and International Mission Unit

Ms Sarah Bearup, Social Justice Officer, Justice and International Mission Unit

Ms Cath James, Environmental Project Officer, Justice and International Mission Unit

**Victorian Maternal and Child Health Coordinators' Group**

Mrs Joanne Fittock, Minute Secretary

Ms Wendy Jones, Chairperson

Mrs Helen Rowe, Member

**6 Community Statements**

Wednesday, 13 June 2007 – Canberra, ACT

**Australian Breastfeeding Association**

Ms Sally Eldridge, National Manager, Breastfeeding Friendly Workplace Accreditation Program

Ms Margaret Grove, National President

Mrs Nicole Maruff, Project Officer, Breastfeeding Friendly Workplace Accreditation Program

**Food Standards Australia New Zealand**

Mrs Jenny Hazelton, Acting General Manager, Food Standards Canberra

Mr Dean Stockwell, Acting Chief Executive Officer

## Site Inspections

Tuesday 3 April 2007, via Cairns, QLD

Pormpuraaw

Pormpuraaw Aboriginal Council

Pormpuraaw Health Action Group

Thachkunpar Health Centre

Kowanyama

Kowanyama Aboriginal Council

Kowanyama Health Action Group

Wednesday 18 April 2007, Gold Coast, QLD

Mothers Milk Bank, John Flynn Private Hospital

Ms Marea Ryan, Director, Mothers Milk Bank and Nurse Unit  
Manager, John Flynn Private Hospital

Monday 4 June 2007, Sydney, NSW

Westpac Head Office

Ms Ilana Atlas, Group Executive for People and Performance

Ms Monica Murray, Manager, Government and Industry Affairs

