# Inquiry into Breastfeeding

Terms of reference

**Submission no. 87**
(supplementary to no. 15)
AUTHORISED: 21/03/07

*How the Commonwealth government can take a lead role to improve the health of the Australian population through support for breastfeeding*

(29 November 2006)

**Summary**

A The physiological functions of human milk breastfeeding and lactation are already well documented. The corollary of problems with formula are also documented. Academics believe it is 'positive' to report the 'benefits of breast feeding' and 'negative' to alert attention to the disadvantages, problems and costs of formula use. There is a need to objectively report results of research.

B There is a word of mouth campaign occurring which encourages mothers to 'buy and try' formula – but they are not warned of the risks in supermarkets. We need labels which WARN this food may be injurious to your infant's health – not a convoluted sentence purporting to promote breastfeeding. That sentence from a WHO document is a 'gift to the formula companies' (reverse advertising because it doesn't sound real). A company does not wish to 'advertise a competitor's product'.

C Morbidity related to formula use needs to be monitored.

D Initiatives need to be local – but there is no dedicated funding. We need micro-budgets for breastfeeding promotion and a reporting system for our success/failure.

E Many current strategies are part of the puzzle but we need to find the missing piece – correction of dysfunctional suck in the first 2 weeks of life is most likely, **IT.** The infant needs to develop coordination from birth as it is vital for all future muscle coordination.

F Breastfeeding is environmentally sustainable, low tech and a positive factor for global warming. The medical system caters to the clients with formula related conditions – but the true health system (preventative) assists families to achieve health through biologically appropriate means, which are low cost and environmentally friendly. Formula use is a high cost, risky option, which warrants its own inquiry.

Submitted by:
Ailsa Rothenbury.

## Introduction

I am having a lot of trouble with the way these terms of reference have been framed, because breastfeeding per se in not the problem. I find that people in significant positions, have trouble with the concept that **'formula is the problem'.** It is like an environmental pollutant, in the way that we should think about it. Not that some children don't need it, but that our society has normalized formula and bottle use. Recently the State Library Service was surprised that I (as a child health nurse) did not want to promote reading program material. sponsored by Rio Tinto and others, with pictures of feeding bottles in the books.

We are currently taking some 20 years to get the lead out of petrol because of the effect on infant/child brains (not the efficiency of the motor), but the research shows that formula use from birth, results in a greater measurable 'loss of IQ' (Dunedin University students). Obviously they were not brain damaged – they were accepted into university but the IQ of 'formula fed from birth'. was 7 points lower than those fed human milk from birth. These students were able to tolerate formula, but knowing that data, if an infant has Down Syndrome, the physiological effects of human milk are really valuable.

How can the government take a lead role in improving the health of the population by minimising the risks of the premature and inappropriate use of:
infant formula (commercial or home made),
weaning food (commercial or home made).

## *a. the extent of the health benefits of breastfeeding;*

At an Australian lactation Consultants Association Conference in 2004, James Akre (recently retired from WHO/UNICEF), and spoke about the futile nature of referring to the 'benefits' of breastfeeding'. Why?...because what can we compare it to – there is no equal, and all individual mothers have unique milk. It is far easier to discuss the problems and morbidity cause by using formula from birth. If the mother is dead and a wet nurse cannot be found and there is no human milk bank – formula is an option, as is home made formula (powdered, evaporated milk plus vitamins). When my first 2 children were born, the official recommendation was to commence full strength cow's milk from 6 months of age – there was never any 'recall' of that advice; just a change to the recommendations and 'new advice'. Consequently women my age either believe there is nothing wrong with that advice or feel guilty about 'doing the wrong thing'.s

The health effects of species specific milk are well documented. Ask a vet why cats shouldn't drink bovine milk or the *threatened species* zoologist about the importance and difficulty of making the 'correct formula'. We humans have been conducting an uncontrolled field trial for the past century – since technology allowed the 'safe use' of cow's milk. Legislation in this country does not require the dairy industry to put 'cow' or 'bovine' on cow's milk products – so we have come to understand that cow's milk is 'normal milk' and human milk is 'other'. Human milk provides the base line for human health. Lack of it – creates a deficit and problems. Breathing oxygen is not a

'benefit': lack of it is a problem. The ability to produce tears is not a benefit – inability to produce tears is a problem. It is all about normal physiology.

The NHMRC has made a good summary of the 'benefits of breastfeeding' – but really is the **function of human milk in normal development**, which is so relevant. I have stopped talking about advantages and benefits, and now consider human milk to be a natural sustainable resource. The mining industry gets more incentives and tax breaks than the human milk 'industry' ...because it is considered to be an individual choice. Something personal – but the non-exploitation of this resource has national ramifications.

i) Take the advice of the NHMRC as articulated in the Australian Dietary Guideline for Child and Adolescents, 2003.
ii) Implement the recommendations of the WHO Code for the Marketing of Breast Milk Substitutes.
iii) Fund the WHO/UNICEF Baby Friendly Hospital Initiative in all states

Reference:
Akre, James, 1990. Infant Feeding: the physiological basis. WHO/UNICEF, Geneva.

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

*Initiation rates are quite high – duration becomes problematic. Why do women introduce formula: because it seems easy, it is tangible, it is attended by the power of technological advance (marketing), health professionals suggest, recommend and prescribe it. With a crying baby in one hand and a bottle of formula in the other, anybody has the perceived power to answer the baby's need at that moment. We as a species do not like to hear an infant in distress and if possible try to sooth it. Even as a breastfeeding advocate I am aware of this 'power' in that type of scenario with my granddaughter and with her mother absent. As soon as the breasts arrive back home, I am only too happy to restore baby to her rightful position.

During the 50s and 60s when there were many children in care – there was no option but to feed them food other than human milk, it became fashionable in 70s, and now that generation are having their own children. Equal Opportunites legislation and rising education levels encouraged women to remain in the work force and obtain higher educational degrees. It is all very confusing, in a societal context.

*Australia is signatory to the WHO Code, so there is no marketing to parents ante-natally and no advertising for formula designed for infants under 6 months. The formula companies have taken up on this and developed 'new products' for infants over 6 months even though the original one would have been appropriate to 12 months. Now we have toddler formula – it is pure marketing. The idea is to find a weakness or anxiety in the market – then create a product to fill the need. Most toddlers are finicky eaters, parents worry, especially if they have been in extreme circumstances eg refugee, war victim, low income, so now we have a marketing solution available – it is probably contributing to the obesity crisis in later years. We

have had about 50 years of significant formula use; the obesity could be coincidental, or perhaps not.

When there is a war, food aid comes as basic food stuffs, powdered milk is easy to transport, but in our society, formula is a 'fast food' which suits parents/adults, but is not that good for our infants. Disadvantaged infants are doubly disadvantaged by the inappropriate used of formula milks, if they do need it, it should be available for medical reason on prescription so that PBS can monitor it's use (to contribute to normal growth and development). Government needs to take some responsibility for the implications of the Code – as it is: you signed up and expect use to achieve the expected outcomes. It needs to be a team effort, not simply signing up on international agreements without any real plan for implementation. Most health workers (Australian health professionals do not call themselves that) in Western Australia would be unaware that the Code applies to us all, not just midwifery and child health personnel. Hospital administrators don't know about it. Chemists in shopping centres do not think it applies to the pile of formula right at the front of the store advertised at a *sale price*. Pharmaceutical and food companies believe there is a market and have created more new formula products and brands.

Consider the fact that Aboriginal women adequately fed their infants and children for 40,000 years prior to the introduction of dairy animals; and the subsequent morbidity associated with white foods supplied by government – white flour, sugar and milk powder and the subsequent obesity and diabetes. This is just another topic which requires a "SORRY" statement.

Formula is sold in supermarkets and corner stores – obviously, your average person would think it is safe to use or you would only be able to get it from a chemist. There are documented deaths from formula, due to mistakes in manufacture. I do not know of any documented death from the ingestion of human milk. Some formula in Perth was recently found to have metal filings in it – the company gave the mum a whole replacement box of it (as a bribe??). Formula is recommended by the *'the underground method'*. It is word of mouth, and like all 'bad things' it seems more attractive and 'sexy' than the *wholemeal unprocessed product*. It's as if we as a species believe that something from outside of us is of greater benefit than something we produce ourselves. The film, Corporation, was right about all multinational corporations. Formula is a product, it is the bottom line that counts. Why is it that formula is predominantly made by international drug companies, except perhaps for Nestles who have a great range of other obesity inducing, low nutrient products. The companies almost don't need to advertise – the media show bottles as normal, and photographers just love them 'in a shot' – word or mouth is very powerful, even amongst the mothers who attend our child health post natal mother's groups. It is almost a rite of passage – "Has baby had some formula yet – that would help her sleep through the night!"

Human milk and formula are still presented as an 'equal choice'. The balance needs to shift: Plan A, then B, then C, then D, and so on – human milk at the breast (A), human milk by IGT (B), human milk by cup (C), human milk by bottle (D), human milk plus complementary feed of formula (E), 50/50 human milk/formula (F), formula (G). Unless baby has a mal-absorption syndrome eg phenylketonuria, there should be a lot of activity before we get to 100% formula use; or the mother is totally against the

concept of human milk feeding and is prepared to approach her GP for assessment and obtain the formula required on a prescription. I think it would be less than 1% mothers who would choose that option in the first 4 months of life. Mothers want the best for their infants, want to take professional advice that works and would use all our best practice strategies to achieve the goal if they were available. Babies need to be checked for suck efficiency if the mother is experiencing difficulty in the first 4 weeks of life.

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

**How much data do you need**? There is plenty of data to demonstrate that human milk is the basis of normal growth and development. Even vets don't suggest that you give your cat, the milk of another mammal.

The impact on the health of Australians, is caused by the early introduction of formula. Frequently mothers are advised, in hospital, that baby needs a top up, because your milk is slow to come in (probably had a Caesarean). Well, colostrum is the vital food for the first 4-5 days and babies don't need milk in that time. Babies need to be close to the mother 24/7, to maximise the physiological benefits of skin-to-skin contact and achieve normalcy in feeding as needed. Other methods eg wrapping baby help to calm a fractious infant. Donated human milk could paly a valuable role here.

i) Conduct an audit of the formula related morbidity in infants/children aged 0-5 years.
ii) Enable annual feed back from paediatric hospitals to child health centres about the category of paediatric hospital admission which are formula related. (If I was able to feed back to my clients the diseases which were occurring in my catchment area, I would have more credibility with the mothers, to be able to promote the factors in human milk which protect against specific disease conditions eg uti, gastroenteritis.)

### *d. initiatives to encourage breastfeeding;*

Initiatives need to be local. Develop the budget allocation, then advise community health regions that money is available – perhaps $2 for every baby born, on an annual basis. That would mean I would be able to access about $300 annually. I have several initiatives in my child health clinic, which involve stars, achievement certificates, specific problem solving, emergency lactation kits, parent education, being nice to people, suggesting chocolate once a day, making breastfeeding the easy option, seeing the whole picture, never making the decision for the mother when she chooses to wean, being eternally optimistic, suggesting short cuts and common sense, involving dad, being an advocate in face of medical ignorance, using humour as appropriate, targeted referral (maybe more that I forgot). Currently, they are my individual, personal initiatives – certificates cost $6 for 20, stickers $2 for 20-25 (depends which ones you get), blusher brush for facial stimulation about $5, electric facial stimulator $15 (not the medical one – it's $70), ideas, smiles, advocacy are all 'free' within the context of my child health role. My energy and enthusiasm are

difficult to cost, but there is a 'down side' to being consistently optimistic, if I can't feel that the Health Department and I are on the 'same side'. This cognitive dissonance does not occur (for me)with promotion of childhood immunization, even though many mother are sure 'it causes autism' – it is a definite policy and parents are 'paid to comply'.

It would be a good idea to have formula as a 'prescription only item'. The rationale for this is: human milk is the normal food for human infants, WHO states, infants fed formula from birth should be considered 'an at risk group'; if they are 'at risk' the use of the harmful agent needs to be monitored and not sold as a 'grocery item'. The present arrangement is costing Australian millions of dollars annually (NHMRC, 2003) in unnecessary health care costs, parent time lost from work, early use of oral contraceptives, paediatric prescriptions and more.

Appropriate assessment and correction of tongue tie is a neglected area of infant function in Perth. Current medical fashion promotes the idea that surgical correction is 'controversial' – but not more than the alternative of non-correction and the attendant morbidity: low weight gain , falling milk supply, distressed mother, distressed infant, increased health costs for correction at later age (anaesthetic, hospitalisation, parent time lost from work, speech pathology). A frustrated mother who got the 'run around with the medicos, told me, 'I just thought somebody would *do the right thing* by my baby.' Data presented at the ABA conference in Hobart, 2005, showed that tongue tie does matter, and generally does not resolve with age. In UK there are at least 2 lactation consultant/midwives who have been trained to 'correct tongue tie' (snip with sterile scissors). We need this ability here – and to be covered by Medicare.

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

If the current measures were 'working' – there would be no need for this enquiry.

The problem with the current measures, which aim to promote breastfeeding, is that they are getting a little dated. We spent the last 12 years teaching mothers a lot about sitting comfortable, positioning and attachment. The mothers *get this OK*. Now we need to address the problems of the infant and the efficiency of the suck. The mechanical analogy is entirely relevant – if your carburettor is not efficient the car does not run well. Fathers frequently say things like – "Ah, so he has a leaky gasket then!?" Exactly.

The mothers want to breastfeed, the fathers are generally supportive, BUT some of the babies are not being cooperative in the execution of the plan. In my role as a child health nurse/lactation consultant, I have been working for the past 8 years in conducting a formalised process of **infant suck assessment**, then teaching the parents how to use the strategy. Babies less than 4 weeks of age generally learn the technique in 2-3 days. The assessment and teaching session takes 60-90 minutes – specific problems eg ankyloglossia are referred to a paediatric surgeon, unresolved positional turns to physiotherapy. Maternal issues/problems recede significantly within 1-2 weeks (sore nipples, blocked ducts, mastitis, low supply). The infant really has an *8 week apprenticeship* available – it needs to have a coordinated suck-

swallow-breathe cycle established before the milk ejection reflex (MER) starts to diminish.

Why is this assessment not part of the routine discharge assessment? But realistically it can be a new role for all child health nurses. I believe that historically 'it fell through the crack'. In pre-industrial society, the baby feed well, maybe had a wet nurse if the mother died or you could afford one, or it gradually got malnutrition/disease and died. Infant mortality in Australia for non-breast fed infants was the same as for developing countries prior to the introduction of safe water and good sewage systems. Midwives observe the baby feeding from the outside; explain to mother the signs of good attachment and swallowing. Doctors check for abnormalities which require medical attention. Apparently, in San Francisco they check pre-mature infants for suck efficiency, but we do not check full term normal infants for the suck-swallow-breathe cycle. It is a bit like – how did we check for cervical dilation prior to the invention of an internal examination to estimate the centimetres of dilation.

Even then we tend to say some things that are incorrect eg. "Baby is really sucking well, see how the chin is going up and down". Well, if you have jaw surgery and the jaw is wired 'shut', it is still possible to suck. Suck and bite are different muscle actions: *bite* involves the Masseter muscle, and *suck* the Buccinator. Suck requires that the tongue comes forward over the gum and with the cheeks creates and airtight seal around the breast, then the action of buccinators creates a vacuum in the mouth. Laws of physics state that fluid flows from high pressure area to low pressure area– so it is with the infant mouth when feeding. The MER starts to diminish. We have a 4 week window available to us to 'get breastfeeding right'.

We need to utilise good nursing practise – ask the patient, collect a good history and apply the knowledge we have. Scenario: midwife observes mother and baby feeding – she says the attachment is good, nicely flanged lips, no clicking, slurping or leaking, you can hear the baby swallowing every 2$^{nd}$ suck, how does it feel? Mother says that it still feels sore and when baby comes off the breast there is a pinched line across the nipple. The midwife advises her to use anhydrous lanolin, ensure the infants head is extended when attaching at the next feed, and don't worry about the soreness, 'baby will soon learn'. Twenty years ago I would have said that – today, I have the benefit of tertiary education and professional development, so I now think "**why** has the mother got sore nipples, if she is '*doing everything right*, as the midwife instructed her'?" What other factor is involved in this situation? I deduce that the high distribution of sensory nerve endings in the nipple (not for sexual anything) are to alert the mother to a problem with the baby and ultimately to ensure child survival. This pain is sore severe, it has the power to keep the male of the species at arm's length.

For baby, the only it can communicate that it has a dysfunctional suck or significant gastro-oesophageal reflux, is through nipple pain and an 'alarm cry' (about 4,000 Hz on the DAN scale). Some babies have both. When baby has a positional turn, associated muscles pain may interfere with normal suck functioning. When baby cries, we suggest that mother feeds more often or longer, then the nipples get worse: grazed nipples change to broken skin, staph get into the ducts, blockages occur due to poor drainage, there is a focus for infection, an abscess may form, antibiotics are

prescribed, the abscess may need to be surgically drained, mother needs pain relief/anaesthetic/hospitalisation. I am in the community – in child health – I get about 25 referrals per month from other child health nurses, some midwives and the very occasion medical practitioner. One third of these infants have a positional turn, 1 or 2 have tongue tie, about 5-6 also have gastro-oesophageal reflux. Rarely – 1-2 annually we find a medical problem which shows up because baby is unable to elicit the correct suck (1x cerebral palsy, 1x motor neurone atrophy in 2006). This is useful because the condition is diagnosed earlier than it would be if the baby was simply put on the bottle and the issue considered a nutrition problem rather than a developmental problem. The cerebral palsy was diagnosed at 7 months (usually about 15 months) and the neurone atrophy at 9 weeks rather than 6 months (from what I can see on the www).

It is now over ten years since Rebecca Glover, in Western Australia, developed her chart on successful breastfeeding – that was a part of the puzzle, as was the Hands Off Technique (HOT) developed by Heather Harris. Kangaroo care is a great idea, and anhydrous lanolin for closed wound healing, all had a part to play. Many health professionals push technological solutions to problems like super dooper breast pumps, various cushions, ultrasound, and they may help in a particular situation – but really we need to take a page out of the *Aboriginal Breastfeeding Book* – with their experience over 40,000 years. Breast feeding does not show in their paintings – in 20 years of searching I have only found one pictorial dreaming reference, from Central Australia – and really it was about oxytocin, the most useful hormone for successful feeding. Mothers, need to teach mothers – we learn by experience, academia helps, but the main thing is visual learning. We should be supporting the Australian Breastfeeding Association as a routine practise – because they are doing much of the work of the Department for us, and maintaining a public profile. (How is it that there is no Bottle feeding Association – to promote all the benefits and be eligible for Lotteries grants, etc……?)

I now consider that the breastfeeding baby is a sort of 'diagnostic tool'.
A problem with breastfeeding, generally shows there is something wrong with baby. We cannot continue to arbitrarily give up and go for the bottle: *breastfeeding too difficult, use the bottle*, we then miss the problems that are highlighted by dysfunctional suck. I try to compare the mother/baby team to the Australian cricket team – if part of the team is not working properly, then they seek remediation at the spin bowling clinic, or the catching session or the dynamics of catch and roll (??!) they don't just say – "Oh well, you aren't any good at this bit, so you will have to chose another sport". Our babies health and comfort is more important than sport but we are not focusing on the basic coordination required for 'life'. If fact, I was shocked to discover that the **occupational therapists say that suck-swallow-breathe is the most important muscle coordination, because all future coordination depends on it.** What implications does that have for sport and perhaps, ability to swallow tablets in later life (geriatrics still have problems)? I now feel that a lot of the solutions to breastfeeding problems/challenges are 'after the horse has bolted'. **We need to assess the infant suck in the first 2 weeks of life, and correct the problems we find.** We will need to train community nurses to do this and fathers can do it as well, if not better than the mother. Suck training is a very short term intensive intervention which the sport literature shows is more effective than longer term general training programs. The suck assessment is achieved on an

adult finger then quickly transferred to the breast. If mother is absent the father can give baby a feed, ensuring the correct breastfeeding suck, within 10-20 minutes.

**The media is another problem.**
It tends to report infant feeding as an equal choice, because it believes that it is 'presenting both sides of the story'. Somehow, being unbiased!!! We used to think that cigarettes were OK; now we don't. We used to think asbestos was safe, now we don't. We used to use heptachlor – now it is not imported to this State. The fact that high levels of heptachlor were found in breast milk, made the front page of the West Australian some years ago, with the implication that we should not breastfeed. The advice in most cases of environmental pollution, is to 'keep feeding' – then fix up the environment. Supplementary feeding is useful in the case of malnutrition or disease, to save life. Australia has an obesity crisis, part of it due to parents thinking that formula will 'make the child sleep long', or just to see if he will take it, or because they think the mother's milk is somehow inadequate. We need better strategies for the changing physiology of the infant and what caregivers can do to 'fill the gap'.

| **Age** | **Physiological need** | **Social strategy** | **Medical need** |
|---|---|---|---|
| Day 1-4 | Colostrum | Dummy at parent request if baby unsettled | BFHI recommendations<br>Assess family history of allergies<br>Availability of human milk bank, milk. |
| Day 5 -14 at home | Human milk | Boiled water 20 mls from cup or spoon, when mother absent or human milk supplement consumed.<br>Water not to exceed 40 mls per day. | Jaundice management<br>Lactose intolerance rare.<br>Assessment of suck efficiency to ensure hind milk consumption.<br>Availability of human milk bank, milk.<br>Check family history of allergies eg cow's milk |
| Week 2-18 | Human milk | Ensure lactation management skills – learn hand expression, storage and use of human milk.<br>Awareness of human infant physiology at 5 months: tongue extrusion reflex diminishes – readiness for food, types of food | Assessment of medical conditions as required. |
| Week 18-26 | Human milk | Tastes of foods – social learning for infant. | Amylase not secreted until 18 weeks – so cooked carbohydrates goes undigested prior to this age. |
| Week 26 52 | Human milk and educational diet | Tastes of foods;<br>Human milk remains a valuable protein/calcium/probiotics source.<br>Adults should consider the 'baby foods' which they continue to consume – mashed potato, custard, pureed anything. (all about function and taste preference) | Checking for allergies, food sensitivities<br>Remember that human milk has no 'use by date' – biological components helpful in disease conditions and to promote healing post surgery. |

| Years 1-2 | Family foods: human milk if preferred | Social compliance with eating skills and food selection.<br>Human milk now has a social role for the toddler and helpful if child is ill. | Checking for normal development/obesity/ physical activity |
|---|---|---|---|
| Years 2-5 | Universal foods (beyond the home): | Ability to 'eat out', acceptance of foods which may not be a home preference.<br>Human milk still has a social role in the mind of the child. Highly integrated with the environment of the maternal/infant dyad – represents everything warm and fuzzy/love/cause I like it. | Check medical conditions as required.<br>Modification of hospitals and staff attitudes to enable long lasting feeding if it is the preference of the child/mother/father. |

We need recognition that the **WHO criteria for BFHI are for hospitals not for the community**. They were established to set up the hospital environment to be conducive to establishing breastfeeding. Parents need to be advised of the risk s of formula as stipulated in the Code. Health professionals need to be tested on their knowledge of the risks and associated morbidity and mortality associated with formula feeding. What infants drink in the first 8 days of life affects obesity in later life (forget the reference – big study).

In the 1960s the hospital policies and staff attitudes, **were the problem** – health professionals recommended bottle feeding with great frequency and disparagingly told mothers they just were '*not built to breastfeed or the milk was too thin, or they did not have enough, so give up now'*. We had single women and nuns to advise us about how to feed our babies – no real experience of how to solve the problems. Mothers need more help with establishing LACTATION SKILLS; hand expression (not pump first), common sense about storage and use of her own milk; promotion of the 'you-beaut' items uniquely found in human milk eg 130 oligiosaccharides – 5 types of lactobacillus (don't need the commercial ones), macrophages (great as a physiologically appropriate eye drop). What would an advertising company choose to promote as the 'feel good' factors in human milk, lactation or breastfeeding? They don't even market cow's milk as 'bovine mammary secretion' – they give it 'sexy names' (Moove, etc). Social marketing strategies will be useful so long as the resources are available and there is appropriate follow up.

**Obvious by its absence - Breastfeeding merchandising.**
In PNG my husband and I designed and printed 5,000 or so t-shirts with 2 different slogans – in Pidgin English. They sold really well. Triple J presenters often talk about breastfeeding issues – but no shirts yet. I did 1,000 promotional pens with *Western Australia the Breast State*, printed on it – sold some gave the rest away. But when my colleague rang the Health Department to find out what we could get for World Breastfeeding Week, she was told that "Breastfeeding is not really a program, well, I suppose its nutrition". So depressing.

There is merchandising for Care for my Air, or Quit, and Drink Safe – we also need it for human lactation? Breastfeeding mothers are stressed and need nail files, sticky notes, t-shirts, caps, beer holders, etc and the babies need bibs, or wipes, or anything else. There is even a house race sponsored by WA Health Department –

Fruit and Veg Stakes or something – how does that make us eat more vegies? Not sure how they justify the expense. If that stuff 'works' for other programs it should work for human lactation.

**Why is that breastfeeding/lactation is not a program area in its own right?** It is more than nutrition and we need the mother's cooperation to act as an advocate for her child. Our culture is not very supportive to the woman who does put in the time and effort to achieve success. When a man's car does not run efficiently, he does not 'blame himself, think it must be something he ate, or didn't sit properly on the seat or hold the steering wheel correctly'. He rightly believes there is something wrong with the car – he calls the mechanic, they replace the gasket and adjust whatever, the car runs efficiently. My friend (male)suggested that we need Tit Mechanics.

We could go for multidisciplinary teams which contain vets, sports psychologists and economists to broaden our view of the lactation issues. The plan needs to be black and white like it is with immunisation. We need the government to give leadership. We want all our babies to have human milk for the first 18 weeks of life, at least. To this end a breastmilk bank is established in each state and mothers encouraged to donate milk – certificates are given for donations. Parents are encouraged to write in the child health book any instance of hospitalization which was 'human milk preventable'. Costs of formula should be included in budgeting for low income families and the associated costs acknowledged. By not using formula, and continuing breast feeding to 12 months the average family will save more than $1,000. With the current concerns of global warming, women create far less gas, eg methane, than the cows which are required to make the milk for the formula. The costs of formula production have been calculated and are significant and detrimental.

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

**Human milk is a sustainable resource. It is largely untapped and under utilised.**
A woman has 2 breasts with the capacity to produce about one litre of milk per baby per day (1-3 litres). Of course there will be individual variations (check with the dairy industry), but if there was the political will it would be relatively easy to recruit women into donating milk to a bank just as we do with blood. Breast milk is similar to blood in that it can be tested for pathogens and rejected or treated if unsafe (check with Red Cross). Human milk is ingested, not injected (blood is very dangerous in this regard) and is subject to the rigors of digestion prior to absorption by the body. Cow's milk was contaminated with TB for many years – but we solved that problem. It seems that 'breastfeeding is just too hard for government'. Basically, you should just do the sums – can we afford to 100% formula feed – if not why not? Never mind what mother's *want* in the first instance, just work out what babies *need* and how can we give it to them. Even in prudish Victorian England wet nursing was common – otherwise babies died. The technology of formula manufacture is not the answer to infant health, but smart humans should be able to work out what is 'best for baby'.

This is a really peculiar term of reference!! Do you mean that if human milk ingestion increases, there is less gastroenteritis, upper respiratory tract infections, otitis media,

urinary tract infections, diabetes, asthma, etc that the system will collapse. There would be less use of antibiotics and reduced paediatric hospitalisation, doctors's incomes will decrease, health professional parents will loose less time at work, oral contraceptives could be appropriately delayed a few months. I know that after three years in the one clinic, with a stable population, my work load decreased, because the babies are rarely seriously ill and mothers are confident to attend or ring as necessary.

Again, we get back to the proposition that formula use and ingestion is the problem. There are no instructions on how to use a bottle correctly a) on the bottle at purchase b) on the Raising Children website, c) in the Infant Feeding Guidelines. Maternity staff are not talking about the use of bottle/teats, because of BFHI, because the literature shows that there are problems with returning to feeding if you use them. Most of that research comes from America, the home of artificial feeding and the genesis of the paediatrician (no child health nurses there , even now). The home of free enterprise invented the 'problem with breastfeeding'; then supplied the solution in the form of formula/bottles. Artificial feeding is very un-Australian – if we can get something for nothing we will, and this principle applies in government as well. It was mothers who wanted to breastfeed in opposition to medical/health advice in 1964, and it was NMAA who gave out the most useful advice for about 30 years. The system did not take up that advice as they did with SIDS and we are still having this academic argument about the value of human milk, breastfeeding and lactation. We need a National Strategy – just as we need a national water strategy.

I like many proponents of child health get tired of pushing the barrow which we believe should by now be common practise. Why did I hear about this inquiry from a friend and not through my workplace? Why am I writing this in my own time? Why can't I get acknowledgement for my expertise within the nursing structure? Why is there no budget allocation nationally, at state level and in my community health work place? Why does BFHI only have a part time project officer? Why is there no National Breastfeeding Advisor (as there is in Scotland)?

These are the sort of questions that many health professionals, breastfeeding counsellors and lactation consultants ask. We came to understand the government was going to act on **the evidence**, that nursing and medical practise would be **evidence based** – but even when we get, reliable evidence it is not acted upon quickly (Raine Study in WA). Personal anecdotes from clients leave us shaking our heads, especially when it is medical personnel perpetuating the myths. My daughter thought she may need an appendicectomy – the surgeon said she would have to stop feeding for 2 weeks! (Oh yes and do what? Then he would have to advise her of the risks of formula, but he didn't). Paediatricians often suggest lactose free formula to see if baby is 'lactose intolerant' – they are all physiologically lactose intolerant at less than 13 weeks. It is a developmental issue, there is insufficient lactase being produced – this is why normal babies do not get constipated. However the baby with a dysfunctional suck, may be relying on the MER and getting a lot of foremilk and little hind milk – explanation of this and expression of some milk prior to feeds, soon helps to solve the problem; parents understand it and begin to develop critical thinking skills). True lactose intolerance in babies is rare – I have seen one in the last 10 years, and they present as failure to thrive.

In 1986 I became the first certified lactation consultant in WA, of my own volition and being prepared to foot the bill for all the associated costs. It is not a requirement of my workplace even though it is highly relevant. Twenty years later I am still footing the bill for all the required education, but my employer seems to think that it is OK to promote a breastfeeding service to clients which require a certified Lactation consultant. Once I wrote to my member of parliament, Bob Kucera, about the issues and seeking help. His reply was less than useful and suggested that I 'talk to my Director of Nursing'. I spoke to her and she suggested I might like to write up a program for staff development/education – so my line manager and I started one. It became a team effort with Fremantle Women and Children's Health Service, resulting in the Lactation Advisors Program (LAP) – it was for 24 hours of education and covered 12 discipline areas (parallel with the international exam matrix). Fremantle proceeded to sell the program for $400 – our health service never got any money from it. Eventually, I got tired and worn out and depressed abut the whole thing. I talked about it too much, my husband left for Tasmania, I was harassed at work (they don't think they are harassing me), I got counselling (courtesy of work) and eventually got burnt out and resign from voluntary positions as BFHI educator and assessor. I haven't quite resigned form breastfeeding promotion or my child health position, but there is a personnel cost which goes unnoticed in staff – we get so exasperated. Other lactation consultants have resigned, and several have developed diseases such as cancer and fibromyalgia – it seems suspicious in such a small group of health professionals. The research on stress shows that unresolved stress does result in dis-ease. Well, obviously, I am giving it one last shot – a colleague suggested I had a lot to contribute, but this is anecdotal – **the real evidence is out there and it seems such a waste of time to be having an Inquiry when we just need to get on with the job. You guys have had 20 years to consider what was needed following the signing of the Code (1985) in 1986.**

A few months back I was a bit fed up about some lactation problem at work then the WA government announced that it was to spend $86 million on a football stadium – sure it is jobs, etc, but this is when we are being told at work that 'there is no money' for specific breastfeeding programs. So depressing.

I started this submission with the intention of being quite formal, but it is difficult. It is Sunday, it is my day off, and 'there is nothing in this for me'. I am writing this and submitting it because there is the health of our children at stake, and because I was deceived by the medical profession back in 1971, when I was told my baby didn't need breastmilk any more as there was 'not enough nutrition in it now' (at 10 months). I don't want my children and grandchildren to have the same problems that I had back in 1970s. I deal with these problems every day. They are much the same as they were then. Mothers in tears. Stupid 'advice' from health professionals. Fathers powerless/distressed. Babies uncomfortable or in pain and unable to feed properly. The personal anecdotes matter, because they highlight what is wrong with the system.

When I was working in Papua New Guinea in 1975, it was really simple to promote breastfeeding. It was **government policy**. There were no infant feeding bottles in the hospital. They got rid of the cots in the paediatric ward and put in beds with short legs so that mother could be on the bed and feed the baby/child even when it was sick. If expatriates wanted a bottle they had to get a prescription. PNG had signed

up on the ILO Convention No 3 (later 156) which covered breastfeeding breaks in the work place as well as maternity leave. Breastfeeding was normal. A Papuan father told me that 'only babies drink milk – not adults'. However, I went there as a teacher's wife, I brought my cultural mores with me. I did not expose by breasts in public, I did not feed the baby in sight of the school boys. In a science class one day my husband asked the boys 'what do you feed babies?' They said 'Tinned milk'. It made me realise the importance of education through observation – if they never saw me feed the baby, how would they know I did it. They knew their mothers, sisters and aunties did but had to give teacher the 'right answer'. Then they began to make assumptions: breastfeeding is for black people, poor people, etc, white women don't do it. There is 'something' about the power of technology – we humans like something in our hands. Almost like the power of the rosary – something tangible.

For 45 years breast feeding in Australia has been considered a choice -just about me and my baby – if baby fails, I fail. If baby knows what to do right from the start, I am a success and can't understand what all the fuss is about. In any area of human physiology there are low, average, and high areas of functioning – some of us need help. Today this help has been refined through the use of technology (ultra-sound studies, breast pumps, etc), through education and research, and the feedback from mothers. The solution to the breastfeeding rate, needs to be a structural one: it requires a top down approach, not a personal one. And we need somebody to do the cost benefit analysis – human milk does not show on the GDP radar (formula does).