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The Secretary of the Committee
House of Representatives Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
Canberra ACT 2600
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Dear Secretary,

Re: Inquiry into Breastfeeding

I am pleased the House of Representatives Standing Committee on Health and Ageing are investigating this important health issue for all Australians.

I am a mother with two children; a toddler and a six month old baby. I am the current president of the Queensland branch of Maternity Coalition, and a member of the Australian Breastfeeding Association and the Childbirth Education Association. Maternity Coalition is a national maternity consumer advocacy organisation and we are working towards developing a woman-centred, community based maternity care system to better suit the individual needs of women, babies and their families.

I would like to focus on just the one point from the terms of reference, "e: examine the effectiveness of current measures to promote breastfeeding."

Key points

- The most effective form of breastfeeding promotion is the one-on-one advice between a woman's birth worker (obstetrician, midwife, doula) and the woman. If the birth worker does not value or understand the 'mechanics' of breastfeeding then this is a stumbling block towards a successful breastfeeding relationship.
- Breastfeeding information and education should form an intrinsic part of every couple's birth preparation provided by their primary birth carer. Midwifery is the profession that is best able to fulfil the dual role of primary birth carer and breastfeeding coach/counsellor.
- Childbirth and breastfeeding are intrinsically linked. The care provided for women during childbirth can affect their breastfeeding relationship with their child.
- High levels of medical intervention, in particular the high caesarean section rate, creates more obstacles to establishing breastfeeding.
- Inappropriate post-natal care and support mechanisms, and a lack of continuity of birth carer, means that breastfeeding success has more to do with good luck than good care.
- The gap between hospital and community care dislocates women and babies seeking breastfeeding advice and practical help.

Key recommendations

- Introduce one-to-one community midwifery care as the norm for maternity care across Australia irrespective of a woman's postcode. Women should see their known midwife from conception through to 6 weeks postnatally.
- Consumers must play an active role in their health services and health promotion initiatives. Maternity care services (new and current services) should be developed, managed and evaluated by a steering group including at least one consumer representative who reports back and is accountable to their consumer group.
- Integrate pregnancy care better with community care including child health and other health services. Integrated care with community child health and other health services including lactation consultants.
- Women accessing the services of private midwives and lactation consultants should not have to pay for these essential services out of their own pockets. Medicare provider numbers should be provided for both midwives and lactation consultants.
- Fund peer-support groups such as the Australian Breastfeeding Association and Maternity Coalition's Birthing and Babies Support Group (BaBs) so grass-roots organisations can provide information, support and education for women in their local communities.
- Promote and advocate models of maternity care that minimise unnecessary medical intervention and hence the concentration of workforce on caring for acute 'patients' following childbirth and freeing more midwives to provide one-on-one breastfeeding support.
- All public and private hospitals in Australia who operate a maternity service should either have Baby Friendly Hospital Initiative accreditation, or demonstrate they are working towards such accreditation, as part of their funding agreements.

Childbirth and breastfeeding are intrinsically linked. The care provided for women during childbirth, and the way in which they birth, plays a critical role in their breastfeeding relationship with their child. The following is an excerpt from the submission made by the Queensland branch of Maternity Coalition to Queensland's review of maternity services in 2004.

> *High Levels of Medical Intervention*
> There are high levels of medical intervention in the current maternity system in Queensland. A statewide caesarean rate of 31% (Queensland Health, 2003) places the Queensland system at over twice the maximum recommended by the World Health Organization as necessary for safe childbirth. Private hospitals have even higher caesarean rates, many of them around 50%. Other forms of intervention (epidural anaesthesia, labour induced or augmented with oxytocin, forceps or vacuum extractions, episiotomy) 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.
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> In addition to being expensive and unsustainable, the current high rates of intervention indicate high rates of consequent injury and trauma. They also mean that increasingly staff resources are allocated to acute care tasks. Workforce skills and resources are focused on the crisis end of the spectrum rather than in the problem prevention and early intervention areas.

All of this impacts on a woman's ability to breastfeed. Physically, it is difficult to learn to breastfeed when you are recovering from major abdominal surgery following a caesarean section, or from any of the other 'common' interventions used in our hospitals. A painful abdomen causing a new mother trouble to lift her baby to the correct breastfeeding position, feeling physically exhausted and disoriented does nothing to aid successful breastfeeding.

A shortage of skilled staff to devote to new mothers to help them to establish correct positioning and attachment in the early days following their child's birth, again is a major obstacle for successful breastfeeding. It takes time to establish breastfeeding, and this means time on behalf of the mother as well as the midwifery staff. But with midwifery staff increasingly having to focus their attention on women recovering from major surgery, it cuts short the time they can devote to breastfeeding.

In Queensland, it is now possible for registered nurses to work in post-natal wards with no midwifery skills including breastfeeding skills (unless they are/have been a breastfeeding mother themselves). This lack of experienced, skilled breastfeeding care is a major concern and one I believe needs to be resolved; not only for increasing breastfeeding uptake but also in providing the necessary care to women immediately after they have birthed.

The following is an excerpt from the submission made by the Queensland branch of Maternity Coalition to Queensland's review of maternity services in 2004.

> *Inappropriate Postnatal Care and Support Mechanisms*
> Another widespread problem is that cost cutting has meant that women are leaving hospital sooner after birth, sometimes without having even established breastfeeding. The rationale for shorter hospital stays is driven more by economic pressures than by the idea that it is better for the health of both mother and baby to be at home. Most healthy mothers and babies are better off in their communities post birth but the mechanisms to provide appropriate and adequate emotional, practical breastfeeding and social support are currently not in place to support this transition.
> Our current system gives women a message that their mothering role is not important enough for them to receive the care and support that they need to best meet the needs of their baby.
> ***"The post-natal care was nothing short of horrific. The public labour ward was full and understaffed. There was no support from nursing staff who refused on several occasions to take my baby to the nursery so I could rest and recover from ABDOMINAL SURGERY. When I complained to the head nurse, my treatment at the hands of these nurses only worsened to the point where in the nursery I went to ask for help changing my babies nappy one nurse turned her back to me and said to the three other nurses in the nursery ".this one here doesn't know what she's doing'. She keeps feeding it hoping it will shut-up." To which they all laughed and carried on as if I were not in the room. I checked myself out against medical advice the next day. Being home alone without help was preferable to the care I was getting at the [...] hospital. This experience left me not wanting to have any more children again".***

Re-Birthing: Report of the Review of Maternity Services in Queensland (March 2005) identified three priorities of change for Queensland's maternity care system: one of these was to resolve the "dearth of post birth care in the community and the transition from hospital to community care."

Page 23 of *Re-Birthing* states: "A lack of information about post-birth care and new baby care and feeding goes hand in hand with the lack of access to care in this period. Breastfeeding is raised in a number of submissions, mostly in terms of the lack of helpful, consistent advice and support to establish breastfeeding in hospital and to maintain it once home. It seems some hospital nurseries work against breastfeeding, 'My baby was placed in a special care unit for 6 days, given formula and a dummy.'

Re-Birthing recommends: "The transition from hospital and birth care to community must be seamless for the consumer and achievable for carers. In urban areas, this will be much easier if smaller teams of carers in smaller homelike environments have responsibility for smaller numbers of women than n the current large systems that process pregnancy rather than care for families in many public hospitals. For each woman, pregnancy, birth and post-birth care should involved the

same small team of carers. Fro women in private or pubic care, there should be another seamless transition from post-birth care to long-term primary family care."

"Government has recognised the key role played by the first year of life in later health. It is important that all relevant agencies work together to achieve outcomes that improve the health of mothers and babies. Data need to be collected on health effects of maternity care in the first year of life and the connection these have to pregnancy and birth experiences."

I hope you can clearly see the link and inter-dependent relationships between ante-natal education, the birth experience, expert post-natal care and breastfeeding coaching and counselling. They all go hand-in-hand and should be focused on the woman and her baby instead of the isolated silos of care which is the trademark of Australia's current maternity care system.

I hope this inquiry makes a difference to the health of Australian babies and subsequent health of generations of Australian families to come.

Yours sincerely,

Joanne Smethurst