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Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health benefits of breastfeeding

TUESDAY, 17 APRIL 2007

QUEENSLAND

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 17 April 2007

Members: Mr Somlyay (*Chair*), Mr Georganas (*Deputy Chair*), Mr Cadman, Mrs Elliot, Mrs Elson, Mr Entsch, Ms Hall, Mr Johnson, Ms King and Mr Vasta

Members in attendance: Mr Georganas, Ms Hall, Ms King, Mr Somlyay, Mr Vasta

Terms of reference for the inquiry:

To 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.

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Committee met at 1.00 pm**LEE, Dr Amanda, Manager, Nutrition and Physical Activity Health Promotion Unit, Population Health Branch, Queensland Health**

CHAIR (Mr Somlyay)—Welcome. I declare open this public hearing of the House Representatives Standing Committee on Health and Ageing inquiry into the health benefits of breastfeeding. The committee looks forward to hearing evidence provided in the public hearing today and also tomorrow on the Gold Coast. To start the hearing today we welcome Dr Amanda Lee from Queensland Health, who will be followed by the Queensland branch of the Australian Breastfeeding Association. Thereafter, we will hear from lactation specialists and leading academics in the field. In addition, towards the end of the hearing we look forward to hearing from members of the community.

The hearing is open to the public and a transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry or the transcripts, please ask any of the committee staff here. We have a number of submissions to approve for publication. Is it the wish of the committee that submissions Nos 261 to 312 and Nos 318 and 340 to the inquiry into the health benefits of breastfeeding be received as evidence and authorised for publication? There being no objection, it is so ordered. As you can see from that numbering, we expected this to be a short, sharp inquiry. But the response of submissions has been outstanding. We have received over 340 submissions to this inquiry. So it is obviously a topic near and dear to many people's heart.

Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament and that the giving of misleading or false evidence is a serious matter and may be regarded as a contempt of parliament. I now invite you to make a brief introductory statement before we proceed to questions.

Dr Lee—Queensland Health is delighted to have the opportunity to present before the inquiry today. Breastfeeding is probably the most significant issue of public health benefit to be considered within Australia. We know that there is increasing evidence of the benefits of breastfeeding both to infants and mothers. Those details are outlined in our submission. However, we feel that there is a need for greater research into the benefits of breastfeeding. It is a very difficult issue to disattenuate when there are so many other risk factors and behavioural issues affecting our population today. The issues of chronic disease, obesity and malnutrition in a very contemporary sense will produce a crisis in the Australian economy if we do not get on top of the current risks of poor nutritional health throughout our community. Queensland Health supports better research into these effects and specific funding to allow those significant issues in breastfeeding to be assessed.

Queensland Health's recommendations looked at the issue of marketing of breastmilk substitutes. We very strongly endorse the international code of marketing of breastmilk substitutes by the WHO and also the marketing in Australia of infant formula—the MAIF agreement. However, we would like to see the legislation strengthened to enforce all of the WHO coding, including follow-on toddler milk formulas, guidelines for the marketing of bottles and teats and, dare I say, dummies in Australia, and for the code of marketing for retailers,

including pharmacies and supermarkets, and the MAIF agreement, to be mandatory for all infant formula companies.

Queensland Health have invested in several initiatives over the last four years to support this important initiative. All our information is based on evidence and research conducted through state wide CATI surveys and local level surveys. The current breastfeeding rates in Queensland, taken from the 2003 survey, showed that the initiation rate was very high, at 91.8 per cent, but that it dropped off dramatically in that first month to 78.8 per cent; further, to 69.1 per cent at three months and to only 57 per cent at six months. By 12 months, only around 32 per cent of Queensland women are still breastfeeding. This compares quite unfavourably with the NHMRC recommendations of breastfeeding exclusively until the age of six months and to 12 months and beyond.

Our data has shown that we need to target specific members and groups in the community. We found that 23 per cent of our infants are already consuming infant formula by the age of less than four weeks. Seventy per cent of children are given formula regularly. Eighteen per cent of children are given solid foods before four months, whereas the recommendation is not until about six months. We know that one of the major factors influencing women to breastfeed in Queensland is whether the mother has decided before birth to breastfeed. Those mothers are almost 19 times more likely to breastfeed, almost five times more likely to breastfeed for six months and 13 times more likely to breastfeed for 12 months and beyond. These mothers tend to be of a high education level and older—that is, over 30. So we believe that there is a lack of information available to the lower socioeconomic groups and younger mothers within our state. We have targeted all our programs to try to address these issues, particularly for Indigenous women. I understand you have already heard about some of those programs in the inquiry in Cairns.

We know that the provision of information regarding post-discharge breastfeeding support was positively associated with breastfeeding to six months. So Queensland Health has initiated the development of this little booklet entitled *Child Health Information: your guide to the first 12 months*, which outlines the benefits and has very detailed information to support breastfeeding in the first critical weeks after birth. We know that family and friends are identified as major sources of breastfeeding advice. This indicates to us that we need to have wider education programs focusing not just on pregnant women but also on broader community support. We know that mothers who experience problems with breastfeeding have some of the lowest mean rates of durations of breastfeeding. We need to focus on prevention and management and supporting women in those first critical weeks of breastfeeding. Perhaps I could leave that now. I understand you will be asking questions and, hopefully, we can touch on some of the other programs and our recommendations as we go through.

Ms KING—Thank you for your comprehensive submission and for giving us an opportunity to see what is happening here in Queensland. The first recommendation you make is to establish a national committee with representation from all state and territory governments to coordinate a strategic approach to promoting and supporting breastfeeding in Australia. What is wrong with what is currently happening at the Commonwealth level?

Dr Lee—We were all very excited when in 2001 there was the National Breastfeeding Strategy and we thought that was the beginning of a good coordinated approach to breastfeeding

throughout Australia. Unfortunately, that strategy never received adequate implementation support. It never received adequate governance support. There was little coordination around monitoring and surveillance, and the issue of being able to measure the rates of initiation and prevalence is critical to informed policy and practice in this area.

Without coordination we are dependent on the initiatives and priorities of the various states. It is always a very competitive area within public health, as you know. The focus on clinical services means that population health initiatives, including that of breastfeeding promotion, are funded to less than five per cent of the total health budget in the states. There are few resources available in the states and investment in this area becomes dependent on the individual priorities of each state.

Some states do not even have data on which Australia could report to the WHO on any achievements that we have made. In Queensland, we have seen this as a priority and there are some other states that we can compare duration of breastfeeding and other data with but without that we have no way of tracking the impact and the outcome of our interventions. We see this as important if we are going to improve breastfeeding rates throughout Australia; it is just not a Queensland issue.

Ms KING—Other than the issue around data collection and monitoring, what other parts of the National Breastfeeding Strategy are you concerned about having not had enough attention or implementation?

Dr Lee—There are the issues about community education, broader support and social marketing—just getting out information about the facts. Within Queensland Health we find that all our health practitioners tend to breastfeed because we are in a privileged position. Having accessed the information we are able to draw on the evidence and that affects our own personal decisions. We feel that it is a very difficult area to get support for promotional campaigns, to disseminate information where it is most needed—that is, in lower socioeconomic and Indigenous groups throughout Australia. We would like to see more support around public education and awareness.

We also feel that there needs to be more done around the MAIF agreement so that all aspects of the WHO code are addressed and that that agreement should be mandatory for all manufacturers of infant formula. We also believe in the Baby Friendly Hospital Initiative which was alluded to in that strategy. Unfortunately there has been a lack of funding, at a national level, for the baby friendly hospital initiatives and it is very difficult to get the adequate resources and capacity in individual hospitals to conform to the very rigorous requirements of the WHO Baby Friendly Hospital Initiative and attend breastfeeding classes. We would like to see more national support for the coordination of that initiative and simplification to assist hospitals to support baby friendly hospital initiatives.

Ms KING—Thank you.

Mr GEORGANAS—Thank you for your submission. It is really appreciated. In one of your recommendations, you spoke about how the legislation needs to be strengthened with marketing and importing et cetera. Are there any examples you have of where and why the legislation needs to be strengthened?

Dr Lee—We are concerned about the recent advent in follow-on formula marketing. The National Health and Medical Research Council guidelines, which are consistent with the WHO guidelines, show that at 12 months of age infants are best suited to adopt family foods. There is no need for special infant formulas beyond the age of 12 months. Cows' milk and alternative milks are more than adequate for children's nutritional requirements at that stage, so we feel that this new advent in follow-on formulas, which are very expensive, tailored and unnecessary products, can be a real financial drain on families who are struggling to make ends meet. So that is one example. Another example is that often baby bottles and teats are used in advertisements as an indicator or suggestion of breastmilk substitutes, and you even see that in posters around our hospitals, I am sorry to say. So while that does not directly contradict the MAIF agreement, it certainly does not support the tenure of the WHO code.

Mr GEORGANAS—You also mentioned having a look at the import legislation. Do you want to tell us about that and where the legislation needs to be tightened?

Dr Lee—I am sorry; I am not familiar with that as part of our recommendations. I can look into it and get back to the committee if required. I understand that that is an issue, but we did not raise it specifically in our submission.

CHAIR—How can we make the workplace more breastfeeding friendly? We all know that by necessity some people have to return to work very early but at the same time a lot of them want to keep breastfeeding.

Dr Lee—The first issue is to have very flexible maternity leave conditions. In Queensland Health we have three months paid maternity leave, two years leave without pay with a flexible return policy and, more recently, women can come back to work part time for five years and then, if they wish at five years, go back to full-time work. So very flexible maternity leave encourages women to stay home and have access to feeding their baby.

For those who wish to express milk, we have a policy that allows up to one hour a day of paid lactation breaks. We have a policy to provide suitable rooms where breastmilk can be expressed but also stored safely. So there are washing facilities and dedicated refrigerator facilities. We also think that there is a cultural issue about convincing management to provide support for breastfeeding mothers. So for example if you had someone on your team who needed to express at a regular time, you would not organise meetings around that time specifically but consult them about their needs and organise the work area aspects to suit their timing. Those sorts of things need to be developed more broadly but they are part of our policy.

CHAIR—Do you think the government needs to encourage the private sector workplace to be equally as friendly?

Dr Lee—Definitely. We would like to see, particularly in public places, a lot more signage and provision of facilities to support breastfeeding mothers, and better education campaigns saying that breastfeeding is a natural state. There have been a lot of issues about various restaurants not encouraging breastfeeding. I remember when I was visiting the American club in Japan, I was told off for breastfeeding my baby in public. Their excuse was that you were not allowed to bring prepared food onto the premises. But definitely more tolerance of breastfeeding

in a public place and more exposure to children that breastfeeding is a natural state would be something we would like to see supported in the private sector.

Ms HALL—I would also like to congratulate you on your submission; it is a very good submission. In Queensland hospitals when a mother is discharged is she given a baby packet with bottles and teats and things like that?

Dr Lee—It varies. There is a bounty bag, as we call them here. It has been a bone of contention. We have policy guidelines that stipulate the types of articles that are recommended for inclusion in those bags. But I cannot guarantee that those recommendations are always followed by hospitals. There is certainly a lot of pressure from commercial companies to make their products available. Also sometimes information is provided in those bags in magazines. We have been disappointed to see advertising in some of those magazines which would not be consistent with the MAIF voluntary agreement. So while the bulk of information in the magazines provided is very good and evidence based we still see that sometimes they are used as a conduit for inappropriate information.

Ms HALL—Obviously there is a contact point between people employed in the health service and people supplying the bags. What is the procedure? What information is given to the people to put together those bounty bags?

Dr Lee—My understanding is that they are advised of Queensland Health recommendations to ensure that all the information and material provided are consistent with the MAIF agreement and with the WHO and NHMRC code.

Ms HALL—But there is no real oversight of that process?

Dr Lee—No. We have raised the issue repeatedly with individual hospitals, and we would like to see more conformity.

Ms HALL—That is something we could look at in our recommendations. Once again I am talking about post discharge. Once a mother leaves the hospital and is one of the 90-odd per cent who are breastfeeding, is any outreach service provided by Queensland Health to assist them during the first period?

Dr Lee—There are home visits that are particularly targeted to women in identified high-risk groups, but there is also a child health information hotline that is available to all women to ring with any concerns whatsoever during the first weeks—and, in fact, for the life of their child right through to adulthood. We make women aware of the support services in the community, arrange for follow-up visits for those at greatest risk and refer to appropriate agencies within the communities during that time.

Ms HALL—But it is not routine; it is only for certain groups of mothers?

Dr Lee—That is right. It is not routinely available to all mothers, because various mothers do not wish to have that service. Usually the higher socioeconomic mothers rely on their own resources and know who to contact in the private sector or the public sector if they needed additional support.

Ms HALL—I was interested in the comments you made about research. You referred to behavioural issues associated with whether or not to breastfeed. I had not thought of that before; would you like to expand on that, please?

Dr Lee—What I was really trying to get at there is that, in terms of the health benefits, although we have health outcomes, various risk factors influence health outcomes. So whether or not to breastfeed may also depend upon other practices conducted in the family—for example, early introduction of solids and the beliefs within the family about the appropriate introduction of solids. The point I was trying to make is that it is difficult to desegregate the various behavioural characteristics and identify breastfeeding as a single issue of interest when we are conducting research.

Ms HALL—Has there been any research that looks at the incidence of ADD and ADHD in relation to children who are breastfed and children who are not?

Dr Lee—I understand there has been some work in New South Wales but I am not particularly familiar with the literature. We certainly have not conducted any research in Queensland through Queensland Health here that I am aware of.

Ms HALL—So it is NSW Health?

Dr Lee—I understand that that is the case.

Ms HALL—What sort of research have you conducted here in Queensland?

Dr Lee—In terms of health outcomes?

Ms HALL—Yes.

Dr Lee—We are more interested in looking at ways in which we can increase breastfeeding uptake and duration, so our programs have focused more on intervention research: looking at the provision of information, the provision of support and evaluating those to know what will have an effect.

There is overwhelming evidence that breastfeeding has many positive health benefits. As a health service provider, I think it behoves us to try to the quite low rates of breastfeeding at three months and six months so that we know that the women and infants involved will benefit from the health outcomes. Our program has been looking at the effect of optimum nutrition policy guidelines, and these outline some of the policies I have discussed with you. We have been looking at infant nutrition practices and the influences of those so that we can better refine our practices and policies to improve breastfeeding rates.

Through the health promotion unit in Queensland we have funded two breastfeeding support programs to the tune of \$500,000 over three years. One of those is located on the Gold Coast and looks at targeting better provision of services and support to women with a high need. The other area of high need is in Caboolture—the Caboolture Mums and Bubs program. Again, they focus on intervention and research—how we can support and provide better services for those women and babies.

Ms HALL—A common theme through most of the submissions I have read for today's hearings is that women tend to make the decision as to whether or not they are going to breastfeed before they have the baby and that the information they receive antenatally is very important. Has Queensland Health started to introduce early antenatal programs in the first trimester?

Dr Lee—The area we want to concentrate on is lower socioeconomic and Indigenous women. You may have heard about the Growing Strong program in Cairns—Growing Strong: Feeding You and Your Baby.

Ms HALL—Yes.

Dr Lee—We conduct training for health workers to assist them in ways to talk about breastfeeding, infant nutrition and maternal nutrition with young Indigenous women even before they become pregnant. I think there is evidence that we need to start even before the antenatal period in some of these groups. We also work through maternity services and child health services to support young women. There are programs that are conducted through the education sector, for example, for young teenage pregnant women. Our programs are targeted at supporting the women who we know are most at risk—trying to increase their decisions before their baby is born.

Ms HALL—What about the relationship and crossover between health and education and programs targeting older teenagers—in about years 11 and 12, I think—within schools? In Cairns we heard of programs where the students are given bottles and dolls to feed, with the implication that that might help them in later life in deciding to breastfeed.

Dr Lee—We are certainly not aware of those programs. It is certainly not an issue that has been raised with us by our education colleagues. We have a joint work plan with Education Queensland in a number of health areas: one is sexual health and one is the promotion of nutrition and physical activity. Under both of those areas, nutrition practices that are consistent with dietary guidelines are encouraged. So if that is the case it has certainly not been brought to our attention. We would be concerned about the use of bottles in that situation.

Ms HALL—You might like to investigate it or talk to your education colleagues and get back to us with that. That would be useful.

CHAIR—This is the economist coming out in me. We talk about the benefits of breastfeeding. Has any research been carried out on the costs of not breastfeeding?

Dr Lee—Not that I am aware of. Health economics is a very difficult area anyway, and we are talking about something that is as multifactorial as breastfeeding. To work out the health economics of a situation, you have to have a good understanding of population attributable fractions: what is the effect of doing something or not doing something, and what are the health outcomes associated with that? We work out burden of disease as a consequence of looking at individual risk factors and bringing them down to a population level. No-one has yet been able to do that for breastfeeding. The World Health Organisation has attempted it on several occasions, but there are so many confounding factors and they have not been able to work out

reliable estimates for the cost of breastfeeding or not breastfeeding. Globally, the estimation is that the cost is many billions of dollars. That is the closest they have been able to come.

Ms KING—You said that five per cent of Queensland Health’s health budget is spent on population health or health promotion and prevention of disease; is that correct?

Dr Lee—Health promotion: prevention and protection. That includes environmental health.

Ms KING—The definition of public health depends on your—

Dr Lee—That figure is about average for Australia.

Ms KING—That is, within the Population Health Branch. What percentage of that five per cent—I assume it is within the nutrition area—would go to breastfeeding initiatives?

Dr Lee—Our breastfeeding initiatives are treated very much as part of the normal nutrition program, so it is hard to look at the proportion—

Ms KING—We can get this from your report, but what is your budget in terms of nutrition?

Dr Lee—Our budget on nutrition promotion and prevention components is probably about \$20 million. Obviously it is much higher for clinical treatment and management. When you look at our programs such as *Growing Strong* or, more recently, our partnership with the Australian Breastfeeding Association to do a specific social marketing campaign, the amount—in terms of FTE times for our people, because in this information you mostly do not want papers, you want people to talk and promote—would be about \$1 million a year.

Ms KING—Have you seen any breaches of the MAIF agreement? You are obviously concerned about it needing to capture more elements of the WHO code and you are concerned about it being mandatory. In order for us to do something like that, we would be interested to hear about the breaches. And, whilst it is a voluntary code, has there been any enforcement in relation to those breaches?

Dr Lee—There was a very interesting case in Queensland. It did not involve infant milk, per se, but A2 milk. I do not know if you are aware of A2 milk.

Ms KING—I do remember.

Dr Lee—A2 milk producers were advertising that their product was better than mothers milk. Queensland Health initiated dialogue with manufacturers and, unfortunately, it had to go to legal processes, but it won the case.

Ms KING—Correct me if I am wrong, but that was not so much a breach of the MAIF agreement, although it could have been; it was a breach of the food standards code.

Dr Lee—That is right, but it also related to the idea of inappropriate milk substitutes. That was a secondary concern for us. We were very upset that milk would be advertised as better than mother’s milk. There has been no other—

CHAIR—Sorry to profess my ignorance, but what is A2 milk?

Ms KING—It is a type of milk that was claimed to have some supplements in it and be better.

Dr Lee—It had a different type of casein. There are two different types of casein in milk. Casein is a protein in milk. Some dairy producers have developed cows that have a particular type of casein called A2.

Mr GEORGANAS—A2 is not a brand; it is some form of—

Dr Lee—No, it is a type of casein. They have been making claims around the nutritional superiority of that milk.

Ms KING—Does Queensland Health take some responsibility for monitoring the MAIF agreement within your state or is it totally the responsibility of the industry to police itself?

Dr Lee—No, we take responsibility for doing that. All our staff are aware of what the MAIF agreement is and, if there was a breach of that agreement, they would alert us to that.

Ms KING—Do you have a process whereby members of the public can bring your attention to those breaches? How would a member of the public know whether what they were seeing in their supermarket did constitute a breach?

Dr Lee—We would encourage members of the public to write letters to Queensland Health—to the minister, the Director-General or us—if they saw one. I think the implication of your question is that members of the public are not commonly aware of the MAIF agreement. We would support any move to make that agreement well-known throughout the general population.

Ms KING—Thank you.

CHAIR—That is one of our aims on this committee. Regarding the role of dads in breastfeeding, I have noted that we have had three or four public hearings and we are yet to see a dad in the audience. How important is the role of dads in breastfeeding in educating males as well as females?

Dr Lee—There have been various results to research questions on this point. In the Perth infant feeding study the role of the partner was seen to be critical in the woman's decision whether to breastfeed or not early on in pregnancy, and as we have seen that can predict successful breastfeeding outcomes strongly. In Queensland, our data did not support the role of men to quite the same degree. It was more family, friends and mothers that were seen to be most important in Queensland. I am surprised about those contrasts. The questions were asked in slightly different ways, and this again exemplifies the difficulty with making state comparisons when we do not have standard questions and approaches and a coordinated response. It is difficult to interpret the different responses to that data but my hunch would be that men are very important members of that family and friends group that our women in Queensland identified as critical to their support.

Ms HALL—I would like to ask a question around the MAIF agreement. Catherine brought out a few things that were important. Do you see as an issue the fact that it is voluntary and that not all producers are signed up to it, and also the fact that it does not cover baby foods, bottles and teats?

Dr Lee—We see that as a critical issue. We believe that the MAIF agreement should be mandatory for all producers of infant formula and we believe that it should cover teats, bottles and dummies. They are an important part of that as well.

Ms HALL—And the baby food.

Dr Lee—Yes, and the baby food. I believe that very strongly.

CHAIR—You gave us a very comprehensive submission. You gave us a lot of information, which we appreciate. We have had a reasonable dialogue in questioning. If later on in the inquiry we need to get back to you we will do so, if that is okay with you. I want to put on the public record that I appreciate Queensland Health's cooperation in this inquiry and that the public ought to note that there is cooperation between different levels of government from time to time. Thank you for appearing before us.

Dr Lee—Thank you very much.

HAMILTON, Ms Robyn Anne, Queensland Branch President, Australian Breastfeeding Association

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter that may be regarded as a contempt of parliament. Do you wish to make a brief introductory statement before we proceed to questions?

Ms Hamilton—I have provided you with a number of things in a little bag which might be useful to talk to. I want to say how delighted ABA is to appear at this inquiry. We have been waiting in ABA for something such as this for many a long decade and it is great to be here. I want to talk about ABA. I think we are now—given recent membership rises—the largest support group for women in Australia. We have 14,000 subscribers and rising. As the Queensland Branch President, I oversee the activities of over 200 trained breastfeeding counsellors all over Queensland and about 60 or so community educators. So we have a large volunteer workforce all over Australia and we are there to support women to breastfeed. To that end, we offer a number of services.

Probably the core business for ABA is our seven-day help line, in each state and territory. We also offer mother-to-mother support group meetings all over the country at which trained breastfeeding counsellors give mothers the opportunity to come together and share their experiences and talk about breastfeeding or non-breastfeeding issues—just parenting issues—helping them continue a breastfeeding relationship with their child. We offer breastfeeding education classes all over the country. All of this is on a volunteer basis, I might add. None of us are paid to do this lovely job. We are just there because we are very passionate about breastfeeding and what it means for us, our children and Australia. We see it principally as a health issue but breastfeeding for most of us is so much more than that.

We run breastfeeding education classes as we can, sometimes as separate meetings, sometimes in conjunction with other health activities. We seek collaboration with health professionals of all kinds in whichever way we can manage it as volunteers. We have annual health professional seminars around the country to bring evidence based education about breastfeeding management to health professionals.

We are also a registered training organisation. We have recently developed a certificate for a course in breastfeeding education with two streams, either counselling or community. So that is now a nationally accredited course. That is mainly for our own people but we have been given approval to develop a diploma course which will be targeted much more at health professionals, and you could certainly help us out there by helping us to fast track that. That would be great because I would like to talk later about the necessity for some standard education across Australia. I might open up to questions now because there is a lot to talk about. We could have a look at the submission and I have lots of show and tell.

CHAIR—Thanks. As distinct from the national body that we have met with a number of times, Queensland has specific problems—and we included those in our terms of references—

the disadvantaged, Indigenous and remote communities. What is the role of the ABA in that area?

Ms Hamilton—Again, we just have local groups. Our forays into Indigenous areas are not as much as we would like. We try to extend our services as far as we can. Local groups have meetings. We take a fairly passive role in that mothers have to come to us in many ways. Because we are volunteers, there is only so much we can do. There is only so far we can extend. We can try and be a presence in hospitals. We do hospital visits if we can, when resources allow, to hand out free literature and put our brand and our name out there in the community. Local group meetings tend to be fairly regular and the state is divided into big regions. We have a structure where counsellors are looked after by other counsellors at a regional level, so we all keep track of each other's activities.

We have online counselling for those who are in remote and rural areas. We have an online forum. Probably the most active part of the ABA website is the forum. We have the helpline, which is always there, seven days a week, 24 hours a day and we advertise as much as we can, given our limited resources. Queensland is quite a decentralised state and there are some very rural and remote areas. We wish we had the resources to target them, support them more and be out there more. Some counsellors live in rural areas and are always on hand. In the past we have had some regional helplines, but we are moving towards a national helpline in ABA which hopefully will be up by the end of the year. At the moment we receive Queensland health funding to fund our state helpline.

Mr GEORGANAS—Thank you, Robin, for your submission. You spoke earlier about targeting health professions. How do you find the advice given? Firstly, do doctors refer mums on to your association?

Ms Hamilton—Some do, some do not.

Mr GEORGANAS—And do you find that the information that mothers are getting from their local GPs is up-to-date, correct information, or is it conflicting at times?

Ms Hamilton—It is a bit conflicting.

Mr GEORGANAS—Do you want to tell us about it?

Ms Hamilton—It varies. I have printed off a couple of sheets here. Last week, in preparing to talk here, I thought I would put out a little request on ABA Chat, which is an email forum for counsellors, community educators and trainees to share ideas, talk to each other about interesting counselling cases and alert each other to things that are going on. I asked if people could send me some examples that demonstrated inconsistent or conflicting advice from health professionals, because 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. So they phone us; that is a big problem. We offer a lot of support in that area; a

tremendous amount of reassurance is required to mothers who phone the helpline. You can read these later.

CHAIR—For the record, can you run us through each one of those?

Ms Hamilton—I will read a couple because some of them are absolute corkers and I thought they might be interesting to note. Here is a good one:

A very good friend told last month at her 6 week check up by GP that her breasts were too small to breastfeed, even though baby all well and growing fine.

I am presuming the weight gains were fine, but somehow the mother was told her breasts were too small to breastfeed. That is just plain wrong.

Mr GEORGANAS—This was a doctor?

Ms Hamilton—This was a GP, yes. But can I say on the record that I am not here to say anything dreadful about health professionals. For every one who is fairly uninformed about breastfeeding there are six or seven who are marvellously informed about breastfeeding. These were just gathered to demonstrate the inconsistency that exists out there. We on the helpline pick up the fallout from that. Here is another one:

I was told when my son was 10 months old by my GP when she was carrying out my annual breast check that my breasts were too soft so I must not have enough milk so I would need to start giving him formula. My son was with me and was sitting up looking as healthy as anything and he went on to feed till he was 3 years.

That's a goodie. Here is another one:

A mother was interested in weaning her one year old and was down to three feeds a day. Her paediatrician suggested that she go 'cold turkey'. 'Why delay the inevitable?' were his words. Just stop. The mother followed his advice and three days later called the Helpline sobbing into the phone, as her breast engorgement was so painful.

There is a paediatrician who clearly does not know much about breast management.

Mr GEORGANAS—I can see why you want to target health professionals when there are cases like that.

Ms Hamilton—Yes. I stress that I do not want to say anything dreadful about health professionals, but there is a great inconsistency out there and I think we could work on that. I think ABA's diploma course could be a good start to getting some standardised education. I believe that in the basic degree a medical student gets less than an hour's worth of training.

Mr GEORGANAS—Do think that is the core problem as to why there are so many inconsistencies with our GPs out there, or are there other issues?

Ms Hamilton—It is also a wider cultural issue. GPs are members of our culture and they are not immune from cultural influences about breastfeeding, and that is important to remember. A GP might have a good idea of the physiology of the breast and how breastfeeding works

mechanically, and so they should. But their own thoughts and feelings about breastfeeding, their cultural perceptions about breastfeeding and whether they feel breastfeeding is culturally valuable after one year or after six months or whatever, would differ from person to person, just as it does in the general community. Health professionals are not immune from cultural influences.

CHAIR—Is there a difference between women doctors and male doctors?

Ms Hamilton—Not necessarily. I am generalising, and I cannot use any facts and figures to back this up, but women might have slightly more interest in breastfeeding because it is something that can happen to them, or is something that has happened to them, so it is possible that they are a bit more informed and up to date, but maybe not.

Mr GEORGANAS—How can a government assist in informing health professionals?

Ms Hamilton—As a national association the ABA wrote a big submission to the inquiry. They recommended some things, such as an accredited, evidence based breastfeeding education program that the government could help to fund and develop—or help someone to fund and develop it—aimed at healthcare professionals, including GPs, emergency medicine specialists, practice nurses, midwives, pharmacists, pharmacy assistants and early childhood nurses. That would be great. The government could initiate a public health campaign to increase community awareness of the importance of breastfeeding and the role that everyone in the community plays in enabling mothers to breastfeed. That is the big cultural shift required, and that too affects doctors, nurses and everybody else. It could provide funding for the delivery of a national policy, including a detailed action plan and adequate resources to ensure its implementation. It could appoint an infant nutrition coordinator. These are some things government could do to get some standardisation and provide basic education in breastfeeding and breastfeeding management across Australia.

Breastfeeding education needs to start when children are babies and continue through primary school and high school. I agree with what was said before: a high school life-skills program would be a great place to have a unit about breastfeeding, what it means and how normal it is in society. The ABA does sometimes try to visit high schools and give talks. We are always open to any opportunity to talk about breastfeeding and to educate the community. That is one of the core reasons why we exist. All of our activities tend to be fairly ad hoc because we are just volunteers, and we do things as our families and time allow.

CHAIR—You have talked about your national submission and, obviously, there is overlap. Is there anything from the point of view of being in Queensland that this inquiry should know about? We have just heard from Dr Lee.

Ms Hamilton—We would like the new WHO growth charts to be adopted as soon as possible in Queensland. That would address some of the inconsistent advice that is given. I would like to talk about the effect that inconsistent advice can have on a mother who calls the helpline or on a mother who is out in the community. I believe the MAIF agreement has to be tightened up. It is too narrow in scope and so many things are not covered by it. It is a voluntary agreement, so if you are not voluntarily agreeing to it you can pretty much do what you like.

Here is something to show you. This printout is from such a fabulous website. It is beautifully designed and so inviting. It looks like a beautiful and innocuous parenting website. You can get to it on the net through any number of links from general parenting websites. It is just out there. It is called 'infanurture.' What is that? We do not quite know, but the website looks lovely and helpful and so a mother might access it. That is the first page and it poses a few questions. Under the heading 'infant nutrition' it says:

Apart from love, a growing baby needs essential nutrients.

Under 'common feeding problems' it says:

Find out what you can do about the more common problems.

If you go on to the next page it starts to detail common feeding problems according to this website: colic, constipation, diarrhoea, hunger and sleepless reflux. On the right side of the page it asks the question:

Is there something that can help with infant feeding problems?

The mother is thinking, 'I have some infant feeding problems. What are mine? Hunger and sleeplessness, so here we go.' The site talks a bit about hunger and sleepless babies and that, yes, those are problems. There is some empathetic language. On the next page is the disclaimer statement. When you get to this page, if you are a mother who has had a hungry and sleepless baby, are you going to say that you disagree with the disclaimer and not go on? No. You are just going to click on it because you want to see what is on the other side. It so beautifully lists all the possible things which might be going on for that mother and it is all in very reassuring language. On the next page, there it is—the answer.

Here is a scenario: a mother has a two-week-old baby and has had four hours of broken sleep a night for the last two weeks. She has had a bit of nipple trauma, so breastfeeding has been difficult, but she is sort of persevering. Her husband has just gone back to work, so she is feeling like now she has to go it alone. She has not particularly been out of the house, so she has not accessed much else that is out there. She is having enough trouble getting out of her pyjamas by 11 am. The baby is particularly fractious when she is visited in the late afternoon by her mother who is starting to drop some pretty heavy hints about the fact that the baby is very fractious and is asking why she does not do something about it. Her mother is ambivalent about breastfeeding and comes from the greatest bottle feeding generation of all time and is not up-to-date in what she knows about breastfeeding. She is providing support but in a negative way and has turned up at the time when the baby is at its most unsettled.

For that mother, a website like this would be so attractive. Her own mother is saying to her, 'The baby is hungry. What you doing? Just feed the baby.' So the mother is putting the baby onto the breast and is keeping on trying and the baby is pulling on and off and she cannot get the baby to settle and she is so anxious that she cannot let down anyway, so it is all just a complete disaster. That is exactly what this sort of website is playing to. When the website asks the question, 'Is there something that can help with infant feeding problems?' where does it list any of the support services that are out there? It is not suggesting that infant feeding problems might be solved in any way by getting support for breastfeeding or getting support for the women's

current situation and her lifestyle. It is just offering this as the great solution to everything. This kind of thing is not in support of mothers; it is just there to sell a product. It dresses it up as support for mothers in their circumstances but it is negative support.

Mr GEORGANAS—It is selling a product.

Ms Hamilton—It is just selling a product, beautifully dressed as if it is supporting the mother and her feelings. There is so much else out there in support of the mother.

Mr GEORGANAS—How would you like to see that changed? What changes would you suggest?

Ms Hamilton—I would like to see it not allowed to exist in that fashion. If you are going to ask the question, ‘Is there something that can help with infant feeding problems?’ you have to give the full picture—not just ‘This is our great product; come and use it.’

Mr GEORGANAS—It does say in small print, ‘Consult your healthcare professional’.

Ms Hamilton—Would a mother who is in that state read the small print? I would not. I have been that mother; I would not do that. I would just be clutching at straws by that stage. These are the calls we get on the helpline. So much helpline work is reassurance. Sometimes the mother knows what she wants to do and needs to do, and she just feels defeated and demoralised and does not have any confidence in her body’s ability to do the job it is built for. That is a cultural thing in Australia. We kind of expect that we are going to be able to have a baby, because we are women and we are built for it, but when it comes to breastfeeding we do not just expect to be able to do it. We hope for the best that we can. Why don’t we just expect? We had the baby. It is the same body, it is the same mother; we are built for it. It is a confidence thing as much as anything. If we do not believe we can do it, then we will not be able to do it. I think that is really important to change.

Ms HALL—Do you believe that is a breach of the MAIF agreement?

Ms Hamilton—I do not know. To me it looks like a breach of the MAIF agreement.

Ms HALL—Do you believe it should be highlighted on the website as an advertisement as opposed—

Ms Hamilton—What happens when the MAIF agreement is breached? The MAIF agreement is not legally enforceable. What happens to this company? I think they just get a letter saying, ‘You’ve been a very naughty company. Don’t do that again.’ That is what happens in Australia, I believe, isn’t it?

CHAIR—How does a mother who is having these problems get hold of that brochure?

Ms Hamilton—It is freely available. You can google it any time of the day.

CHAIR—Is there other information available that gives the opinion that you want to give?

Ms Hamilton—There is, but again, as volunteers with not many resources, this is our competition with their massive marketing budget. We cannot hope to compete with that unless we get help.

CHAIR—In other words, unless you get public funding.

Ms Hamilton—Yes. And from time to time we do get public funding, and we do social marketing of one kind or another. As volunteers we constantly do things like hospital visits, where we hand out free literature. In comparison, it is fairly piecemeal. We are not in every supermarket in Australia.

Here is another one. We do not need to continue to talk about this, but I did put in some other pictures as talking points. Here is something from the local chemist. This demonstrates that the MAIF does not cover bottles and teats, and here is one that purports to be ‘closer to nature’. What does that mean? It ‘makes it easier to combine breast and bottle feeding.’ What does that mean? It is saying that the teat is closer to a human nipple, ‘designed to mimic the natural flex, feel and movement of a mum’s breast’. I am sorry, but a teat is a teat and a breast is a breast, I think.

Mr GEORGANAS—These are current ads?

Ms Hamilton—Yes, that one was taken at a chemist up north a couple of weeks back. The MAIF agreement does not cover that at all, so that is interesting.

Ms KING—What would be wrong with expanding the MAIF agreement to cover those issues and keep it voluntary?

Ms Hamilton—Nothing would be wrong. I would be really happy if that happened.

Ms KING—But keeping it voluntary.

Ms Hamilton—Novalac is not a signatory, so they could keep doing what they are doing, with glee. If it is voluntary then you can just opt out of it. Here is another one, this one with the bear. ‘Breastfeeding is best.’ It has even appropriated all the language we use in promoting breastfeeding. But what comes next? See how that immediately dismantles the first statement by suggesting that breastfeeding is something you do temporarily.

It then goes on to talk about other things such as lack of iron. Iron is not an issue particularly for a baby who is breastfeeding. It is a false concern, as are a lot of these things on the other website. Constipation is noted as a common feeding problem—not in a breastfed baby. Diarrhoea is not a common feeding problem in a breastfed baby. ‘Hungry and sleepless’ sometimes happens in a breastfed baby. But, if you keep breastfeeding and you sleep with your baby, that is not necessarily an issue either. Reflux is a mechanical problem; it is not a breastfeeding problem. As to colic, every baby is a bit like that. Colic is a broad term. It can mean any number of things. They are false concerns, really. They are making the mother phone the helpline because she is feeling inadequate and she is feeling like she is not able to provide the answer herself. She is not feeling confident about her own ability. These products are

promoted as equivalent, so what she has ain't that special anyway. Again, that is a cultural thing in Australia.

Ms HALL—What sort of training do your volunteers have?

Ms Hamilton—Our breastfeeding counsellors undergo about 12 to 18 months part-time training in breastfeeding knowledge but also in counselling techniques. We use a model of counselling known as the Rogerian model. It is empathetic counselling. We are there to support, listen, really hear the mother—not just what she is saying but what she is not saying—and to be really present with her in the counselling call or face-to-face.

We have a fairly controlled vocabulary for counselling and some stock phrases which we use. They are designed to empower the mother and help the mother to own her own feeling about what is happening with her breastfeeding and her decision about what she does with it. For instance, if a mother phoned the helpline and said: 'I am just really low supply. I am just empty. I cannot satisfy the baby. I feel like I cannot go on with it. The child health nurse has told me that the baby is not gaining enough weight and I should start comp feeding.' The paediatrician has said to her, 'Look, you don't have a problem—just keep going; there is no problem.' So he is not hearing her. The GP has perhaps said: 'You're putting the baby on and off the breast all the time. You're doing it too much.' There is some typical conflicting advice.

The mother rings the helpline and says, 'What do I do?' We would say to her that we are not there to prescribe or particularly to suggest; we are there to offer information and ideas and just build her up so she can make her own decision about it. We might use a stock phrase like this: 'Some mothers find that, if they have shorter or smaller feeds more often during those difficult evening hours, that makes the baby feel a bit more settled. Feel free to offer top-up feeds.' It would be something like that. We are not saying, 'You should do this.' We are just saying, 'Some mothers find that that sort of thing can help them.' The mother might then think: 'I haven't tried that. I might try that and see what that does.'

We might ask her about what is happening in her day altogether and say: 'Some mothers find that, if they make the dinner really early in the day so that they just have to reheat it at night or just rearrange the day so that they can devote from seven to nine just to sitting on the couch feeding, that can really help. The baby can just suckle and you are not expected to be doing anything else.' Sometimes they just have not been able to steer their sleep-deprived brain towards taking a step back and thinking about how they could rearrange their day. Sometimes it is as simple as that. That is tremendously reassuring. Sometimes they just need only one thought to grab hold of to feel relief, and then they are okay—or they are okay until the next call.

Ms HALL—Does a person have to have some sort of accreditation before they can offer counselling and support?

Ms Hamilton—They do. We have been training in-house for 40 years. Until we needed to have this certificate IV accredited, training was internal and, in terms of the association, they came out as a qualified breastfeeding counsellor or a qualified community educator. As part of introducing this new course, we will get all our current counsellors RPL-ed so that they also will be accredited for what they know.

Ms HALL—So at this stage there is no formal level that counsellors have to reach.

Ms Hamilton—With this new course, there will be. It is brand new.

Ms HALL—I would be a very big supporter of RPL. I think RPL is useful.

Ms Hamilton—We have not quite rolled it out yet. The units are done and are up on the NTIO's website, but we are still working on the workbooks, which is all the educational material that accompanies each unit; that is still coming.

Ms HALL—Then all the counsellors will be certificate level IV accredited?

Ms Hamilton—They can be if they so choose; yes, that is right.

Ms HALL—If they choose not to?

Ms Hamilton—The units can be chunked. They will get a statement of attainment for each unit. They can probably operate as a breastfeeding counsellor within the association but not have the full certificate IV. Breastfeeding counselling techniques are only a component of the certificate IV, so they could do the counselling techniques and still work within the association.

Ms HALL—You stated earlier that definitely breastfeeding gives babies the best health outcomes but it has other greater outcomes. Would you like to expand on that a little?

Ms Hamilton—I will tell you what it means to me. I am the mother of three beautiful girls—aged nine, seven and four—the last of them fed like a trooper until she was almost 4½. For me, breastfeeding has been a very emotional experience. It is a very intimate experience. It is a very communicative experience. It is very empowering for a mother to be able to do that for her child. It can be a beautiful and loving experience. It is a very chemical experience. I do miss breastfeeding; I miss that oxytocin release, which is one of the hormones that give you a sense of wellbeing.

It can be a tremendously fulfilling experience for every reason—and I have not mentioned nutrition once. Nutritionally it is the optimal thing for a baby. Breastfeeding is something that is not to be missed in this life. Certainly, most of us who are counsellors know that; and many who have become members of the association joined because they knew that and wanted to share that experience with other mothers and help them to achieve it also.

Ms HALL—Earlier you touched on Indigenous communities. Has the ABA looked at putting in place strategies—and not for Indigenous and remote communities—to embrace women in, say, Brisbane's lower socioeconomic groups in order to help them become members of ABA, as opposed to your current membership, and to give them greater access to breastfeeding?

Ms Hamilton—Our resources are pretty limited. I think Indigenous health issues are fairly complex—

Ms HALL—I am not talking about Indigenous.

Ms Hamilton—Lower socioeconomic? Yes, we try to join with other health professionals. We are part of the South Brisbane breastfeeding coalition—and someone else who is here will be able to speak about that in more detail. We try to be part of or at least have a voice in Queensland health initiatives with other coalitions that are operating services or doing things in lower socioeconomic areas. Again, I guess we rely very heavily on our local groups in those areas to visit those hospitals and do all the things we already do. We would love some help in that area. I do not think we address it very well at all, partly because there is a geographic problem and partly because there is a volunteer problem.

Mr GEORGANAS—People can get conflicting advice. If someone has been to a health professional or to their GP to get advice, they may decide to check it out by calling the ABA and then find that the advice is different. Do you keep records to see how many do not take your advice on board?

Ms Hamilton—We have no mechanism to do that. We rely on the anecdotal evidence of mothers who contact us.

Mr GEORGANAS—I am just trying to work out whether people take the doctor's advice—it might not be the correct advice—because he is the health professional and what effect that has.

Ms Hamilton—Is your question whether we record it in some way?

Mr GEORGANAS—Not whether you record it but whether you have a feel for how many people are more likely to take the advice of the association. It is a big thing when a GP gives you advice and tells you what you should be doing. Being a professional, a lot of people would take that advice on board.

Ms Hamilton—Again, I think we just hear about it anecdotally. We do not follow up on counselling calls; we cannot. Sometimes we do, but, no, we do not have a mechanism to really find out what happened to that mother. Hopefully, she will come to a group meeting because we have advertised that one is on. Our subscribership is large and rising. We are certainly a large group out there. We are getting more resubscription, too, as a general trend. People perhaps write to us, but, no, there is no real mechanism.

Ms KING—What funding does ABA Queensland receive? Do you get any from the government?

Ms Hamilton—We do; it is Queensland Health funding.

Ms KING—How much do you get?

Ms Hamilton—We receive about \$15,000 to fund our state helpline, a diverter system. There are two counsellors on during the day and one during the night.

Ms KING—Is it a toll-free number that women can ring or is it a cost to them?

Ms Hamilton—It is a cost.

Ms KING—So that \$15,000 goes towards the administration?

Ms Hamilton—That is right. We receive a bit over \$50,000 to administer our office. Last year and again this year we received \$100,000 which dropped out of the sky, thanks very much to Queensland Health, to conduct a social marketing campaign to specifically look at duration of breastfeeding and to attract people to continue breastfeeding for longer. We, as local groups, as regions, as branches, also apply for funding here, there and everywhere. Occasionally we are lucky enough to get funding from other sources too.

Ms KING—Yes, so there could be things like federal volunteer and small equipment grants for your branches?

Ms Hamilton—Yes, that sort of thing—for example, the Gambling Community Benefit Fund. There is a gazillion of them out there.

CHAIR—I must confess that in 18 years as a MP I had no contact with the ABA—that I can recall—before this inquiry. I did a straw poll last week at my golf club. I asked about a dozen men, ‘Have you ever heard of the ABA?’ They said, ‘No.’ I asked the same of a dozen women, and they all had heard of the ABA.

Ms Hamilton—Good. That is a start, isn’t it?

Ms KING—I have stickers at my office saying that my office is a breastfeeding zone, so you should have one as well.

CHAIR—Could you send me some? Steve says he wants some too.

Ms Hamilton—We can send you a pack to distribute at your golf club if you like.

CHAIR—I will do that. Thank you, Robyn, for appearing before us.

Ms Hamilton—Thank you for the opportunity.

CHAIR—Keep an eye on our website and keep track of the evidence we receive from other witnesses in other states. If they inspire you to give us more information, we will welcome it.

[2.37 pm]

THORLEY, Ms Virginia Gwendolen, Private capacity

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Ms Thorley—I am appearing as an individual and also as an IBCLC certified lactation consultant.

CHAIR—You heard me say before that, although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement.

Ms Thorley—First of all, I would like to mention infant feeding statistics. Other speakers have already touched on that, and one of the problems is getting different bunches of statistics even from different areas in the same state or different years. There is no comparability across time and place because of differences in methodology. There are flaws and inconsistencies—for instance, infant ages are inconsistent. Discharge age in the last 50 or 60 years went down from two weeks old to typically two days for public clients and five to six days for privately insured women but about eight hours for birth centre deliveries. So comparing a baby who might have had one or two breastfeeds and been discharged early with a baby who has been there for two weeks is comparing chalk and cheese or apples and oranges.

A lot of the data in the next figure was taken at any time from four weeks to two months. Some surveys did not look at those age groups, and they differ quite markedly. The most consistent figures taken were at three months. Definitions have been faulty. Definitions of breastfeeding have been very woolly. ‘Fully breastfed’ sometimes meant that they did not have other milks, but it included babies who were topped up with everything else, as was very common for quite a number of years. ‘Partially breastfed’ could mean anything from a baby who was having a daily top-up through to a baby who was mainly artificially fed but still going to the breast. The definitions were not very good.

I believe we should use the 1990 World Health Organisation definitions, for consistency. There is some good work being done in arriving at better designed studies and better designed definitions. But once again we cannot say, ‘Have things improved?’ and look back at old figures and reliably say we are comparing the same things. So that makes comparisons across time difficult. In an unpublished study that I have completed, I have come to the conclusion that figures on exclusive artificial feeding at three months were the only really a reliable figures based on definitions. They were the ones that were the most reliable across time and place.

Regarding WHO code monitoring, which a number of submissions both online and here have mentioned, Australia, as you will know very well, is a signatory to the WHO code and also to the subsequent relevant World Health Assembly—WHA—resolutions. Bottles and teats and the retail sector were covered by the WHO code but, as other speakers have mentioned, were not in

the MAIF agreement. Bottles and teats and the retail sector have been mentioned specifically in some MAIF reports. The one I can remember most reliably would be the 1998 one, but it has been mentioned in other reports. So in the MAIF the panel has been aware that there is a weakness in advertising artificial feeding by the bottle and teat manufacturers. I looked very closely at adverts. My study cut off at 2000 and I do not think things have changed very much since. They basically advertise in a way that is contrary to the WHO code, but they are not covered by MAIF.

Breast pump distribution is also a backdoor means of selling bottles and targeting specifically breastfeeding women, who very often go into having a baby thinking they are going to need a breast pump irrespective of what their lifestyle choices are going to be. The marketing is: 'You are going to need a steam steriliser. You are going to need a breast pump.' Some ads actually said, 'If you are full-time breastfeeding you will need two bottles and if you are not you will need more.' Those are all issues that are not covered under MAIF. Submission No. 121—she was a dental surgeon—I notice also mentions bottle use and oral development.

I know you are going to be talking tomorrow to somebody from a milk bank that is starting up at the Gold Coast. I would like to offer my support for the value of milk banks, particularly to improve the health outcomes of premature and sick infants. I do not want to go into detail because I know that you are going to be able to observe and ask lots of questions tomorrow, but I notice several submissions have mentioned milk banks specifically, including submissions 105, 122 and 125—and I think I missed some other ones.

Workplace issues are often raised as a barrier. I think that for individual mothers there will be different barriers, but these issues often come up as a barrier because of the need to return to work for a whole lot of reasons. I certainly agree with the previous speaker, from the Queensland health group, and with submission 129 by Helen Perris on workplace flexibility being important. Some of the older ILO resolutions—or agreements, I am not sure—such as the 1990 and, I think, the 1952 ones emphasise things like lactation breaks. The more recent one has been a little bit more contentious. I do not have the details of that in front of me. I believe it is important to think again about issues such as on-site or workplace creches which might serve as cluster creches for several buildings, with perhaps some tax breaks for those.

Let us look at affordability. I have noticed, in looking at a number of submissions on the web site—and I am trying not to be critical—that there is a slightly 'gimme' attitude in thinking about the ideal world in which there would be a big bucket of money and lots of things could be possible. Unfortunately, we live in the real world, and I have tried to make my recommendations more affordable. I believe that there is a submission by a Dr Smith of Canberra, who is an economist and better able to address these points than I am, so I would prefer not to go into the economics, which is not my area. However, besides cost savings there are also issues of lives saved. There has been a study in recent years in a comparable country, the USA, by Rogan and Chen about the lives saved by breastfeeding and about the higher death rate in a developed country for children who were not breastfed or were weaned early.

One of my recommendations was to fund the Baby Friendly Hospital Initiative office in Canberra for at least the next three years at a more realistic level with more hours for its manager. That would enable more hospitals to be accredited, leading to better care for mothers and babies and less conflicting advice. There has also been work done—and this is on the

Cochrane database which I have referenced in my submission—by Michael Kramer and others. It includes a study in Belarus. Longer breastfeeding meant that there were better health outcomes and that there was less need for rehospitalisation with particular illnesses. Mothers breastfed for longer in hospitals that had been accredited as baby friendly. This was based on studies in a comparable industrialised country. So funding the baby friendly office and improving our baby friendly initiative take-up should at least theoretically balance things out and perhaps have health savings.

Preparing for baby friendly assessment has been raised from time to time as a very expensive undertaking for hospitals. I believe that tomorrow you will be hearing about how the Logan hospital, a public hospital in Queensland, did it on a shoestring budget. I was at a symposium at Logan about a week and a half ago, and they were telling us about how they did this very affordably, so it does not necessarily mean breaking the bank in order to achieve this.

Another issue that I raised—and this is in my supplementary submission—is reimbursement or rebates; I think the Americans call it ‘reimbursement’ while we tend to say ‘rebates’. These are rebates from health funds and Medicare for the services of international board certified lactation consultants. This issue has been raised in a number of submissions. Some health funds do give rebates but, where they do, it is very ad hoc. Sometimes it is the smaller funds. Often they require a person to be an RN rather than requiring the salient point of why that person is qualified—that is, under the IBCLC certification. IBCLCs reach the same standard. They have to have the same training and capacity to pass the exam across the exam blueprint, irrespective of their background. Originally, the bulk of successful exam candidates were people from breastfeeding counselling backgrounds, whether it was La Leche League in the United States or ABA in Australia. Now the predominant affiliation is with some form of nursing background, but people come from a number of backgrounds, whether it is research, breastfeeding counselling or nutrition. There are nutritionists, GPs and paediatricians. I have some friends who are paediatricians who are also IBCLCs. There are dieticians, occupational therapists and others. Irrespective of background, the salient point that makes us able to provide advanced-level breastfeeding help is the IBCLC certification. Health funds, when planning rebates, really need to look at that as the qualification.

As I said in the supplementary material that was sent to you, for other health professionals breastfeeding is only part of their studies—to a varying degree, depending on the profession—and training and expertise as breastfeeding facilitators has often had to be acquired through personal interest and individual effort; for instance, when the health professional becomes a mother or the health professional’s wife has a baby. The ranks of both lactation consultants and lay breastfeeding counsellors are swelled by persons from the traditional health professions who have seen these as worthy avenues for improving their training and skills in supporting breastfeeding. IBCLCs are required to recertify five-yearly. If we do not pass the exam or certify in the intervening year by continuing education, we are out on our ear and can no longer be certified.

I did not go into the cost-effectiveness of that—sorry about that. What I was thinking about was from the mother’s point of view. If there are reimbursements, mothers are more likely to go for that specialised help rather than put it off, let a small problem become a bigger problem and perhaps wean ahead of when they had planned. If more mothers could afford this, they would have that help. The ABA telephone helpline could perhaps be provided with some funding for a

national number at a local call level. It is an existing service, so it would not cost anything to set it up; it already exists. It is 24/7, which not every other service is. Regarding hospitals where mothers can go back to a breastfeeding clinic, although they can be excellent they are not 24/7 and some are not staffed on weekends. It is cost-effective; it uses volunteers. None of those people draws a wage for being on the helpline, and that includes the email counselling service as well as the telephone helpline. Also, as the previous speaker from ABA just mentioned, there is quality training. It has been quality training all along but now it has been raised so that it is much more formal.

Peer counsellors are about as rare as hen's teeth in Australia. A colleague of mine in Cairns, Ros Gabriel, had a Churchill scholarship to study it overseas and she is doing some great work with the Indigenous community. But I would like to talk about the following facts. It is cost-effective; these people are usually volunteers. It reaches the priority groups. Those priority groups, depending on the peer counselling program, can be Indigenous communities. Remember that Indigenous communities are very different—they can be middle class, in remote areas or in low-income suburbs. It is not an amorphous group; it is a very wide group. Teen parents have special needs that do not always relate to those of people in other age groups. So peer counsellors have a role with teen parenting.

Non-English-speaking-background mothers is, once again, a heck of a wide area. I have other qualifications in teaching English to speakers of other languages and have worked in an educational capacity with over 60 ethnicities and nationalities, from Indigenous Australians and indigenous Pacific islanders to many people from all continents except Antarctica. I am not saying we need a peer counselling set-up for people from non-English-speaking backgrounds. There are going to be different needs. Some people who come here have much greater needs and lower literacy than others. Of course, there are also people from low socioeconomic backgrounds in mainstream groups such as Anglo-Celtic and European Australians. People from low socioeconomic and low educational groups often do not have the skills to reach out that middle-class people from the mainstream do. They are all areas which would benefit from peer counselling.

I know that in the Republic of South Africa they have peer counsellors trained by La Leche League of South Africa. I have met some of these people, and they include male peer counsellors. The male peer counsellors arose by accident. One of the female peer counsellors did not drive. Her husband, on a cold night in, I think, the Khayelitsha township in Western Cape outside Cape Town, was sitting in the car and he felt cold, so he went round the back to the kitchen and hung out with the father. The father said to him, 'What's all this stuff about breastfeeding?' and asked him other questions. He thought, 'I don't want to contradict my wife; I'd better get some training,' so he asked if he could have the same peer counsellor training to talk man to man.

In that culture and in some of the cultures in Australia—even in Anglo-Celtic cultures in country towns—it is the man at one end and the woman at the other end. So talking man to man is not something that a breastfeeding counsellor or a peer counsellor who is female can do. It was found that there was a need for men to speak man to man and to give advice or suggestions that were not contradictory to what the female peer counsellor who was in the front room talking to the wife was saying. They have peer counsellors in some states in the United States with the

WIC Program. I know the Texas department of health is big on peer counselling, although I do not have a lot of details there.

My last point is on social marketing. While I was in South Africa in 1996 to do some speaking, at one of the sessions I went to people presented on a social marketing program which was integrated. Some social marketing is very isolated, short term and not integrated, so it falls flat on its face. *Soul City* was a soapie and it was integrated with a little magazine. It was on the radio in the morning at about breakfast time and it had a TV segment, and it had eight health messages. One of them was on breastfeeding, but there were seven other health messages that were believed to be important to women of a particular group, aged, I think, 18 to 35. They had done their market research and they integrated that. Now I am happy to take questions.

CHAIR—Thank you. I should have introduced the members of this committee—Catherine is from Ballarat, Jill is from Newcastle, Steve is from Adelaide; I am from the Sunshine Coast in Queensland and Ross is the local member here.

Mr VASTA—Welcome, everyone, to Bonner.

CHAIR—This is why we have this beautiful venue.

Mr VASTA—I was very impressed with your submission, Ms Thorley.

Ms Thorley—Thank you.

Mr VASTA—Thank you very much. You are a very well-spoken, lovely lady and you definitely know your subject matter. You referred to the Republic of South Africa and how you have been able to help with the South Africans.

Ms Thorley—I did not help very much; I merely spoke there, but I learnt a lot.

Mr VASTA—I think you are just being modest. For a national agenda, what are your plans that we could take back to the minister so that we have a succinct recommendation? Where would you see this committee making progress on this vitally important matter?

Ms Thorley—With the number of submissions that you have had and the number of points that have been raised, I know some people have been nice and succinct and had two or three points and then people like me have had lots. I have gone through and colour-coded some of the common threads, basically looking at consistency of advice and what happens post discharge. Anything to support the Baby Friendly Hospital Initiative will help make advice in hospitals less confusing to mothers. They will not get something different with every shift. That is going to help them with their continuing breastfeeding.

I forgot to mention the 10th step. It is the community outreach—mothers having support when they leave hospital. Most statistics in Australia, South Africa, Romania, Russia, the United States and no doubt other places show that, irrespective of what the breastfeeding rate on discharge is—and remember that figures with definitions are sometimes not very reliable—there is a great plummeting in the few weeks after. Anecdotally, a lot of that is in the first two weeks, even though it is not picked up until perhaps the age of one month or later. So for hospitals are not

accredited 'baby friendly' if they turf mothers out the door and say, 'Bye-bye; you are on your own.' They have to be able to provide them with contact details where they can have follow-up. It is supposed to be 24/7 so, if the hospital does not have a follow-up service—whether it is midwives going out into the community or a clinic that they can come into—or if they cannot get an appointment with child health hospitals in Australia, 24/7 they can get the ABA helpline. So step 10 is very strong in Australia with baby friendly hospitals.

As well as that, Australia has a large uptake, the third-largest number, of lactation consultants. USA and Australia are ahead. Ours might be the best per capita, but I am not sure. The hospitals give those contact details about the ABA helpline, child health and anything that the hospital is able to provide. Also in Queensland there is a brochure for lactation consultants in private practice, which means we do not need to have on an answering machine, 'If I'm not here, ring so-and-so,' because the mothers leave with the brochure and they just go through the list until they find someone.

Mr VASTA—Excellent. Thank you very, very much for that.

CHAIR—I must say Ross is a single member of the committee.

Ms HALL—Let Ross keep going.

Mr VASTA—I also want to say for the record, maybe for the lovely ladies behind you, that my sister is still breastfeeding her firstborn. He is 2½ and he is fit and healthy. I am a great advocate of making sure that more children get breastfed for a longer period of time.

CHAIR—Are there any apparent differences in rates of breastfeeding in ethnic communities? We have not talked much about the ethnic communities, as distinct from Indigenous and remote ones.

Ms Thorley—That is an interesting question. Once again, as you would be very well aware, ethnic communities are a very broad continuum. In the study that I have been working on the cut-off point was 2000, but some of the studies from the seventies and the eighties—and I would say it is probably still true—indicate that people, when they come to Australia, have noticed when people are out they are bottle feeding, so they think that that is what people do here. Also, some people have to work straight away so their breastfeeding rates may be lower. But I do not have recent figures.

However, for Indigenous Australians I notice that the figures vary from state to state. I believe that in Western Australia they are very high in the remote communities, but in the inner city it depends on the Indigenous mother's social class. If she is middle class it will be comparable; if she is in an underprivileged area—a low-income earner and so on—it will be comparable to that particular group. But I believe, from what was said before, that Queensland figures are lower. I believe that the breastfeeding rates in mothers from some places in Queensland are lower, but I do not have the figures in front of me. I like to be able to give accurate information instead of saying, 'Hey, I think I remember.'

Ms HALL—Can you get that information and make it available to the committee?

Ms Thorley—I think Queensland Health might be better placed to use the perinatal collection data so you could make a note to ask them, because if I got it I would have to get it off them, and it is probably better to go directly.

Ms KING—You have talked about extending the scope of the MAIF agreement and setting up a new agreement. Can I get your views on voluntary versus mandatory agreement.

Ms Thorley—I think originally it was made voluntary in order to get people to sign. At this stage, because it has been running a long time, I think it would be a good idea to have it mandatory. But you are the politicians; you would have a better idea of the fallout and so on.

Ms KING—And what is doable and what is not, to some extent.

Ms Thorley—Yes, and what is doable. I did not mean party political; I simply meant in relation to business. There are many levels of politics, and some of them have got nothing to do with Canberra or George Street. Basically, getting things through. The title of the MAIF agreement specifically says that it is artificial baby milks—they say formula—so that particular agreement is not set up to include the bottle and teat sector or the retail sector, although the retail sector is got at by various backdoor ways. The MAIF committee apparently contacts the manufacturer, who then speaks to the retail person. But it is a very roundabout way of dealing with it.

It would be good either to have a separate agreement for the other sectors—bottles, teats and retail—or to revamp the thing now. I do not know how doable that is. I think the logistics would be extremely difficult, to make them one agreement. Also, it does not go all the way of the WHO code, which was originally—from all that I have read, and I have been looking into the documentation in great detail in the last five years—meant as a minimum. But when countries implement it in part they treat it as a maximum. That often happens; once something has been codified people think of it as a maximum when it was intended as a minimum.

Supplementary World Health Assembly, WHA, resolutions have taken up things such as free and low-cost supplies being left at hospitals by companies. Australia ended that in the 1990s. I cannot give you the year exactly. It might have been 1994, give or take a year. I should have done my homework on that. It still happens. Anecdotally, I know of instances where representatives have not seen the purchasing officer but have left free supplies, which have been found in cupboards or on bench tops. That is covered in at least one and possibly more of the WHA resolutions that Australia is a signatory to.

Ms KING—I want to also thank you for your submission. You have provided in both your submission and opening statement lots of evidence about practical things that are working in other countries and here. It seems to me that there is lots of information and evidence around what programs might work and possibly a little bit about what programs might work in different communities with different socioeconomic groups. Why are we not implementing many of those in Australia at the moment?

Ms Thorley—I welcome that question because—and with the realities of funding that all of you will know very well—there is a basket of money and very often when something is funded it is funded for either a three-year period, which is fairly common, or for other lengths of time, and

because there are other calls, decisions are made and things are not continued past that. Written into some recent funding of breastfeeding coalitions have been things such as developing self-sustainability rather than being dependent on that. But sometimes three-year funding does not extend quite long enough to get people into the self-sustainability curve, and sometimes it is difficult to continue that.

It is not just a problem with Australia. At one of the informal sessions we had at the 1979 international conference on self-help and mutual aid in Dubrovnik, we discussed across five different welfare states around the world how sustaining funding is a problem because you cannot fund everybody. Somebody else might get the funding at another time, so sometimes things fall flat when the funding runs out. Perhaps the people who have worked hard on it move on and they have been so busy running a program that they—

Ms HALL—On the funding issue, do you think the state-Commonwealth crossover—

Ms Thorley—COAG?

Ms HALL—Yes. Do you think that and the silo mentality between the states and the Commonwealth impacts on this as well?

Ms Thorley—As one of the previous speakers from Queensland Health mentioned, we often hear about the times it does not work well and we forget the times that it does work well. As I was saying, Indigenous people and various other groups are not the same across the country. On particular projects people work together well at the state and federal level and with other things they do not, perhaps because of the people who are on the ground or because of people not forming a bond. There are a whole lot of issues that are very complex. Sometimes it works well; sometimes it does not.

Ms HALL—Framing the question a little bit differently, do you think that the process would work better if there was a more cooperative approach between the state and the Commonwealth as opposed to the state running a state program and the Commonwealth running a Commonwealth program in parallel?

Ms Thorley—I think it comes down, first of all, to the ‘c’ word, which is one of my favourite words: communication. Another favourite word of mine in a whole lot of situations in life is respect. So it comes down to communication and respect, working from that and then finding out where people are not perhaps overlapping. It is in all systems, not just in Australia. You often get things that two instrumentalities are doing and other things where you get a gap, where nobody is doing it but everybody could be. It is a very complex thing, but I think communication and respect—sitting down and talking—help. It is difficult. It is one of those ongoing things that there is no easy solution to.

Ms KING—Just to unite that with the Baby Friendly Hospital Initiative, you have recommended that the Commonwealth provide a more realistic level of funding for it. What is the current level of commitment from the Commonwealth to that program?

Ms Thorley—I was not able to find out before coming here today.

Ms KING—No-one else has been able to tell us that yet either.

Ms Thorley—I am even less able to because I am not in the office.

Ms KING—I thought you may have an insight.

Ms Thorley—Previous funding for a three-year period will have obviously not kept up with inflation and rising costs. They need to be able to pay somebody full time instead of part time. I know that she gives a lot of free hours. Educators and assessors do a lot. We give up time when we could be better paid in order to do things for Baby Friendly because we believe in it.

Ms KING—With your wealth of expertise and experience in this area, how do we as a community strike a balance that encourages breastfeeding while still supporting mothers who, for whatever reason, are unable to breastfeed?

Ms Thorley—The best place in which mothers can give birth is in a baby friendly hospital. Instead of mothers having either a video showing them what to do or a group talk about it, which is the way that things have been done for a long time in hospitals, in a baby friendly hospital they are shown one-on-one what to do. So a breastfeeding mother will be given one-on-one help. A mother who is in a baby friendly hospital and who has made an informed choice, not a commercially influenced choice, in her particular circumstance not to breastfeed will be given one-on-one help with the measuring and mixing-up of the artificial milk, with the cleaning and sterilising of bottles—many people are not aware of the hygiene needs there—and with anything else concerned with the whole procedure. Instead of going home and feeling as though she is floundering, she will have been shown one-on-one how to do it. It is not a case of, ‘What did they demonstrate in the group talk?’

The number of people who are physically unable to breastfeed is extremely tiny but it does occur in certain hormonal situations and in a few other situations. Also, there are some mothers who perhaps have a very strong emotional barrier to breastfeeding. However, over 80 per cent—and in some states it is much higher—of mothers start breastfeeding. So it shows that the majority of mothers assume that they are going to breastfeed but then down the track a heck of a lot of them are not. So they are not meeting their goals.

Mr GEORGANAS—One of the points that you brought up earlier was that we have the third highest number of lactation consultants in the world, after the US and, I think, Canada.

Ms Thorley—Yes.

Mr GEORGANAS—We have had other submissions and we have been looking at reports from around the world that say that the period of breastfeeding in Australia falls way behind most other nations in the OECD. We are completely outdone by European nations such as Sweden and Norway where the breastfeeding period is quadruple what we seem to be doing here. Why is that? Is it the message that we are getting out or is it the way that we are funding that message to get out?

Ms Thorley—It is to do with it being normal. In the last couple of days I have been talking online with someone from Norway, and in Norway and Sweden breastfeeding is considered

normal. It is just assumed that people will breastfeed. Nobody thinks of it as a big deal, gee whiz, or anything like that; it is just something you do. That has a lot to do with it. Their maternity leave provisions—although I am not sure of the specifics of them—and their parental leave, which has some kind of provision for dads, are a good deal better than ours. The thing is that it is a society-wide assumption. It was not always that way; it changed.

Could I say about information about breastfeeding across the curriculum that I do not believe it should be only in human relations courses. There is room for it in maths, in statistics—there are a heck of a lot of stats and small surveys that students can do. It can certainly be in biology. I know that when my eldest child was at school her biology teacher said, ‘You’ve all got to read this book by Virginia Phillips’—which was my former name. My daughter said, ‘That’s my mum.’ There are a number of areas across the curriculum. One of the South American countries was at one stage developing breastfeeding across the curriculum; I think it was P to 12. So besides being in health professionals courses it can be all the way through so that students do not think of it as something gee whiz, shocking, horrifying or anything like that but just a part of life.

It is a learning process, just like walking. We do not say to babies: ‘Maybe you can’t do that, you’d better not. We’ll pick you up because you can’t walk.’ But we say to mothers: ‘Maybe you can’t. Maybe your breasts are too small,’ or ‘Maybe you won’t be able to do it.’ It is a learning process. Kids do not get up and walk the first day, and we do not expect them to. We don’t say, ‘You’re a failure because you didn’t do it first up.’ They often take a while and a lot of tumbles, and so do mums.

CHAIR—Thank you. One of the main recommendations in the report we tabled last year was that the Commonwealth and states should adopt a national health agenda so that everyone knows the direction in which they are working, and the Commonwealth should fund the states that have achieved this national agenda. Breastfeeding should be, for my part, a very important part of that agenda. Thank you very much for appearing today.

Ms Thorley—Thank you for the invitation.

Proceedings suspended from 3.21 pm to 3.31 pm

HEGNEY, Professor Desley Gail, Private capacity**O'BRIEN, Ms Maxine Lesley, Private capacity**

CHAIR—Welcome. I apologise that we are running so far behind time.

Prof. Hegney—I am here wearing several hats. One is that I am the supervisor of two PhD students, Dr Wendy Brodribb, who put in a submission, and Maxine, who is next to me. I am currently a professor and director of a research centre at the University of Queensland in Brisbane but, twelve months ago, I was the director of the Centre for Rural and Remote Area Health in Toowoomba.

Ms O'Brien—I am appearing as an individual in my capacity as a PhD student and breastfeeding researcher.

CHAIR—Although the committee does not require you to speak under oath, you should understand these hearings are a formal proceeding of the Commonwealth parliament and the giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I will ask you to make an introductory statement to the committee.

Ms O'Brien—I have a summary of the work that we have done and the issues as we see them. Research conducted over several decades has confirmed the natural superiority of breastfeeding as a species-specific method of feeding human infants. Breastfeeding has an important role in protecting infants and their mothers against numerous health threats as well as providing significant economic and environmental benefits. I am confident that the committee will be provided with ample evidence of these things during the inquiry.

Our research and that conducted by other Australian researchers suggests that most Australian women want to breastfeed and that the large majority initiate breastfeeding with the intention to breastfeed for six months or more. Yet the majority of Australian women wean their babies or introduce regular formula long before the full complement of benefits from breastfeeding can be conferred. This was particularly clear in a study that we conducted in 2001 in which almost 93 per cent women initiated breastfeeding but only seven per cent were exclusively breastfeeding when their babies were six-months of age. These breastfeeding initiation rates did exceed Australia's target of 90 per cent of women breastfeeding on discharge from hospital but the rates at six months fell well short of the targeted 50 per cent of women exclusively breastfeeding at this time.

One way to increase the duration of breastfeeding is to identify the factors which contribute to early weaning and find a way to modify those factors or remove any negative effect. This sounds relatively simple until we look at the list of factors that are currently known to place breastfeeding at risk. Unfortunately, most of these are difficult or impossible to modify. They are things like woman's age, years of education or early return to paid employment. Research which focuses on identifying and exploring modifiable factors is therefore increasingly important. Much valuable research of this type has already been done. I have been privileged to be part of a multidisciplinary team including nurses, psychologists and medical doctors who have completed

three funded studies into breastfeeding in addition to the three studies that form the basis of my own honours and PhD work.

I note that the committee is considering initiatives to encourage breastfeeding. I would like to share with you some of the insights that we have gained through the work we have done. Firstly, Dr Brodribb has put in a submission to you outlining her work for her PhD. This work follows on from our finding that the GP is amongst the most commonly utilised sources of breastfeeding support to Australian women and is also rated amongst the least helpful. We discussed that earlier in the submissions today. This is the first Australian study of its kind to be done, so it is probably quite timely.

The major focus of Dr Brodribb's work is to ascertain what gaps are with regard to GP breastfeeding knowledge and to design a training program that can overcome those gaps, thus ensuring that GPs can provide an effective service even if that means knowing when to refer the woman to someone with more skills and knowledge. Dr Brodribb's work to date has shown that medical students in their final year have probably no better knowledge about breastfeeding than the general well-educated person in the community. It also appears that male GPs see breastfeeding as women's business and therefore something that a woman should see a female GP about. However, female GPs, unless they have breastfed their own child, have no greater knowledge about breastfeeding than their male GP counterparts. Professor Hegney can give you some more information about those results if you would like to ask questions later.

Another factor that has arisen as important in our research is the time at which the woman makes the decision to breastfeed her baby. Women who do not make the decision to breastfeed until after they become pregnant are around three times more likely to wean prematurely than women who decide before they become pregnant. This suggests that women should be exposed to information about breastfeeding which may help them to make this choice earlier, perhaps in high school or in primary school, as some of the other speakers have suggested. Trialling and evaluating a project like that might take several years and it will not be easily funded, but the research does clearly indicate that deciding to breastfeed before you become pregnant might be very important to breastfeeding duration.

Also, the research results and the discussions that we had during the course of the research with participants and staff highlighted the importance of the women's psychological make-up as an influence on breastfeeding duration. Given my professional background as a psychologist, my own PhD research has focused on identifying and exploring the psychological characteristics of women which might influence how long they continue to breastfeed for. This research has revealed that measures of the psychological characteristics of individual women such as the time at which she makes her decision, her faith in breastmilk, her breastfeeding expectations and plans, her self-efficacy or confidence, her optimism and her anxiety can predict how long she will breastfeed for. This is particularly exciting because many of these factors are thought to be amenable to change.

This research has also revealed an alarmingly high incidence of symptoms of anxiety, depression and stress in new mothers in Australia. More than 44 per cent of the 375 women in our mixed public and private hospital sample were suffering from some form of postnatal distress in the first two weeks following the birth. That is almost one in every two women. Anxiety was the most common form of postnatal distress, with almost 34 per cent of the

sample—that is, one in three—showing higher than normal levels of anxiety, and 7.5 per cent of women were rated as extremely severe. Anxiety was also significantly related to breastfeeding duration such that the more severe or frequent the symptoms of anxiety, the more likely the woman was to wean from the breast.

There is still much work to be done before we can achieve a comprehensive understanding of the psychological forces which influence breastfeeding duration and how they can be modified to empower women to reach longer breastfeeding goals. However, I do see two major opportunities associated with continuing this work. Firstly, the research showed that measures of the women's psychological characteristics significantly improved our ability to predict which women would wean early. This is important if limited health services resources are to be directed at those who need them most. The analysis showed that, even after controlling for the effect of a long list of sociodemographic factors, some psychological factors were able to predict early weaning on their own. This information could be used to construct a tool capable of identifying women at risk of early weaning for additional support or interventions. Secondly, the research can progress into the construction of an antenatal program designed to modify high risk variables and reduce psychological stress in new mothers, thereby improving breastfeeding duration while often at the same time enhancing a woman's general mental health.

Finally—and I know this is a problem you probably do not want to hear about too much today—one recurring theme that was in all of our studies was guilt. The women repeatedly told us about the pressure that they felt to breastfeed, both from health professionals and from the general community. Many told us that their switch to artificial feeding left them feeling inadequate. Many women felt that they had failed and let the baby and themselves down and they carried guilt about their breastfeeding performance, sometimes for long periods of time. I am uneasy in the knowledge that a large number of Australian women currently find themselves in this position. Empowering women to reach their breastfeeding goals may be part of the answer to this problem in the long term but I believe that the provision of appropriate support to women who wean early should also be considered now.

Prof. Hegney—There are only a couple of things I would like to point out. A lot of the research into breastfeeding in Australia has only looked at women who access the public system. The work that we have been doing in Toowoomba and the surrounding rural area looks at private system women as well, and they are two quite different cohorts of people. In some of the work we have done they had quite different needs. I have brought some research reports along—light reading for you. In the study that was funded by the department of health and aging we set up a service we called the Infant Feeding Support Service in Toowoomba. That allowed women to ring in. A lactation consultant would ring the woman once a week on a set appointment time. We found that was very positive for the women in the private sector. It increased the duration of breastfeeding but it did not for the women in the public sector. Interestingly, the public sector hospital Toowoomba Health Service has continued with that health service after we finished the study, which I thought was excellent, but the private system did not, because they did not have any funding to put on the lactation consultant.

Ms O'Brien—One important thing about that was that, although the breastfeeding rate or duration rate was only increased in the private sector, and not the public sector, it was very clear that the women really appreciated and loved that service. We had very positive feedback from women. It meant that they could have the advice and support that they needed in their own

homes. A lot of our women do live in rural and remote areas. They come into Toowoomba to give birth and then go out sometimes to remote areas and so having a service that can be accessed by telephone was really helpful. It has to be very flexible. The women who delivered the service were all lactation consultants and very well qualified, but they were also very flexible. If the woman was not ready to receive the telephone call at that time because the baby was crying or for whatever reason, she would just ring her back at a time that was more convenient. There are problems with that, funding wise, but I think that is the way it needs to be.

CHAIR—I don't recall seeing submissions where anybody is saying that they were psychologically affected by not breastfeeding.

Ms O'Brien—That may well be. I didn't do a written submission. I was just invited to come and give verbal evidence.

CHAIR—I know of cases where there is definitely a problem, but I don't think we have had any submissions from that side of the argument.

Ms O'Brien—This is a very new area of research, but there are little pieces of research out there by people who have looked at individual psychological characteristics in women. Things like breastfeeding self-efficacy or the woman's confidence in her ability to breastfeed have been known to be very important for a number of years now. Studies have been done around things like self-esteem and depression, postnatal depression, which we know has an effect on breastfeeding duration. But no-one to date that I can find has actually said, 'Okay, what are these things? What is the list? Let us test them and see which ones are making a difference.'

CHAIR—Do you think that needs to be done?

Ms O'Brien—That is what my PhD is about. It is, as yet, unpublished but it is—

CHAIR—What can government do to encourage that to be done?

Ms O'Brien—Once the research is published, or if more funding is available, this important information in terms of constructing a tool may help us to work out where to send the limited resources that the health service has at its disposal. We can see who is most at risk. Mental health is an enormous problem in our country at the moment, so if we can design a program that will enhance women's general mental health while at the same time increasing the duration of breastfeeding that is exciting.

Ms HALL—Could I put that question to you in a different way: do you think there should be more funding for research into that aspect?

Ms O'Brien—Funding for research is needed in a lot of areas. Dr Brodribb's work is also worthy of consideration. I think Julie Smith will be talking to you about the economics of breastfeeding or she already has. She is very skilled in that area, but my understanding is that it can be quite cost-effective.

Ms HALL—Just the psychological factors and needing extra funding to look at research in that area.

Ms O'Brien—I would certainly welcome it.

Prof. Hegney—One of the things I think is important about Maxine's study is the high level of anxiety in these women, and no-one has ever reported that before. The focus has been on depression, and the scale that has been used is the Edinburgh Post Natal Depression Scale. The scale that Maxine has used measures depression and anxiety, and I think her findings are very exciting. She might be being modest but I will not be: We need to fund Maxine to continue and expand her work out of Toowoomba. It would be fantastic if something like that was available.

Ms O'Brien—The last point I made is also relevant: it is not just the effect that women's psychology has on their breastfeeding duration but also the effect that breastfeeding duration has on women's psychology. I have not been able to carry on and do any research on that side of it at this point in time, but research has been done that suggests that women who wean before they had planned have significant drops in self-esteem. That has big implications for women in lots of areas.

CHAIR—Is that different for first, second and third children?

Ms O'Brien—Women tend to do the same thing with their subsequent children as they have done with their first. I have not seen any research that has specifically looked at child number parity.

Prof. Hegney—Except for one of the studies we did, which looked at women who had extraordinary breastfeeding difficulties. We looked at women who continue to breastfeed and those who did not. We are trying to get a paper published at the moment on that. From memory, it did not show any differences between parity. In that study the overwhelming finding was that women who had extraordinary difficulties and weaned were overwhelmed with guilt, whereas women who had the same difficulties—and we did a case controlled study where we matched women for continuing and non-continuing—and did not wean had pride, which I thought was a very interesting finding.

Ms O'Brien—It does not just impact on their breastfeeding per se; we find with a lot of women that their feelings about breastfeeding and their performance as a breastfeeder 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.

Ms KING—On this theme, I do not know if you are aware that you said it but you said, 'Finally, and I know you don't want to hear this' and went into how people commonly feel guilt, et cetera. Why did you say 'I know you don't want to hear this'?

Ms O'Brien—Because it makes it a very difficult area, and I am very aware of that. How do we promote breastfeeding at the same time—

Ms KING—How does it make it difficult?

Ms O'Brien—If you are promoting breastfeeding, I think the reason that it has not been done as strongly in the past is because a lot of people are very hesitant to make women feel guilty and they are frightened about making them feel guilty about their infant feeding choices.

Ms HALL—That was shown in the paper that was presented on doctors' attitudes, wasn't it?

Ms O'Brien—Yes.

CHAIR—Every journalist who rings me about this inquiry puts that question to me.

Ms O'Brien—That is right, and it is something that we need to talk about. Women who wean early for one reason or another deserve to have some counselling around that if that is what they need. There are going to be some people who feel bad, and we need to accept that, be open about it and give them what help we can.

Mr VASTA—And do they feel worse the earlier it is? After three months is it at a certain level, and then after six months they feel a little bit better?

Ms O'Brien—Absolutely. The reality is, as you are probably very aware now, that women generally tend to breastfeed for fairly short durations in Australia anyway. If you get to breastfeed your baby for three months it is very easy to say, 'I've had enough,' and people will not necessarily say anything negative to you. A minority of people may. But generally it is the women who wean in the early weeks that feel really bad.

Mr VASTA—Is there a pain barrier as well? A person that I know said that she could not do it anymore because it was just 'ripping her apart'—those were her words.

Ms O'Brien—Absolutely. I think we need be very aware and up front about this: for some women, breastfeeding is an absolute nightmare, for lots of reasons. I am not saying that it needs to be like that; I am saying that it is like that. Perhaps that is around this psychological stuff that I am talking about and working with at the moment. There are some women who feel very confronted by that intimacy and there are some women who really struggle with the embodied reality of breastfeeding a baby. What do we do with those women? Do we make them breastfeed? I do not think so. We need to find a way to get around that and work with the woman before the baby is born so that she has some realistic expectations about what this is going to be like and real deep knowledge of the benefits of this for her and for her baby so that she has some reason to keep going.

Mr GEORGANAS—I think earlier you mentioned the differences between private and public. Were the differences in the services available or in the numbers of people breastfeeding? Can you elaborate on that and talk about both the services available and the numbers of people breastfeeding.

Prof. Hegney—I am just talking about what was going on in Toowoomba. At that stage the private system had a better system. They had a very good lactation clinic at the private hospital that had a maternity unit. There were very good services. Fifty per cent of the women in the private hospital and 50 per cent of the women in the public hospital come from rural areas to give birth. That is the only private hospital in that area outside Brisbane where women can go to give birth. They are different cohorts of women. The women who go to the private hospital are usually better educated and more likely to be—

Ms HALL—Socioeconomic factors—that is what I was thinking.

Prof. Hegney—All of those sociodemographics then impact upon their initiation and duration of breastfeeding. You do not see the high-risk mums that you see in the public sector. We lost contact with a lot of people in the public sector arm of our study—because people moved house, they were at high risk and they did not come into the study. Young mums, for example, are more likely to come into the public sector than the private sector. They are quite different groups of women. The work that has been done about duration of breastfeeding et cetera has mostly been done in the public sector. I think our study was one of the few, when we first started, that looked at private sector women and brought them into it—because it easier to study people in the public sector than the private sector, I think.

Mr GEORGANAS—You mentioned that advice by lactation consultants was far greater in the private—

Prof. Hegney—It was to start with, yes.

Mr GEORGANAS—Can you tell us about the difference between the programs that were available in the public hospital and the programs that were available in the private hospital.

Prof. Hegney—The public hospital had an early discharge program, and the supporting midwives service after early discharge was very limited, mostly because it had been cut back. They only really visited high-risk women, so women who were discharged from hospital had very little support. They used to sometimes ring the maternity unit in the public system or they would turn up in the emergency department. It is not unusual for them to turn up in the emergency department of the public system with a breastfeeding problem. The private women were referred to a very good lactation clinic postnatally, when they were discharged. They stayed in hospital longer anyway. The lactation clinic that was there was free—it was provided by the private hospital for nothing—and it was very supportive and very good. There was a change in management of the private hospital, and the lactation clinic was closed down. The public women used to go to the lactation clinic.

The only other system that was available and is still available is at the shopping centre in Toowoomba—Toowoomba Grand Central. Some midwife lactation consultants are paid two or three days a week to work out of one of the parenting rooms in the centre. That service was provided by the private sector, not the public sector. That was very extensively used by women from both the public and the private sector, and was very highly thought of—I know that. But once that lactation clinic closed down there was very little in the way of lactation services available for women in Toowoomba, let alone for women from rural areas who give birth in Toowoomba and then have to go back out to a rural area. There is very little support for them.

When we were doing our studies—though things might have changed now—the telephone number for the after-hours service used to ring out. Women said that they could not access support. The important thing to come forward out of our study—and this is why Dr Wendy Brodribb is doing her PhD in this area; she is a general practitioner—was that women would go to their GP for support had an extremely low level of satisfaction with the support they got from their GP. Wendy wanted to find out about the level of knowledge of GPs. We have looked at the knowledge of medical students and trainee GP registrars in their final year to get an idea of their grounding in this area. Wendy wants to design an education program that can be used by GPs that is accessible and quick—it has to be that. She is a GP so she can design it; she

understands their needs really well. So that was something that came out. To me, that also applies to the private system. If you think of the private system and what support services are available, you have to think past acute hospitals and think about GPs because they are, whether we want them to be or not, a major source of breastfeeding advice for women. Wendy's study shows that they do not know very much about it.

Ms HALL—Can I bring into play the urban divisions of GPs and the training programs that they run, given that you are looking at introducing this idea into medical training per se. There are a lot of doctors now that could use that information. Have you thought of linking in with the urban divisions of GPs and providing that funding?

Prof. Hegney—One of Wendy's other supervisors is Professor Claire Jackson. Claire is professor of general practice at the University of Queensland and is very involved with the divisions of general practice. We have approached them for funding and have not been able to get any funding from them for that.

Ms O'Brien—I think one of our long-term visions would be to create some sort of computer based tool with a decision tree, so that a mother with, say, sore nipples can click buttons to answer questions such as, 'Are they red?' and 'Are they hot?' They can carry on through a decision tree that will take them to a diagnosis and where they need to go for treatment.

Ms HALL—I am sure I read some research that indicated that doctors need the physical exposure. If women are tapping a computer to get all their advice, they are not going to have any physical contact. Wouldn't that be counterproductive?

Ms O'Brien—You are absolutely right. I suppose it would be nice to have both so that if we miss them on one turn we might get them on the next one.

Prof. Hegney—I think you have to realise what GPs are like with regard to accessing continuing professional education. The stories of the medical students and the trainee GP registrars are telling. We sent the Australian family physician paper that Wendy has just published of some of her early findings. Time is very important to them. If you can give them something that will support their decision then some of them will be really interested and want to learn more about breastfeeding. But it seems like the women are the ones who will do that and not the men. There should at least be something in the surgery for them and at the moment quite often there is nothing.

CHAIR—We were up in Kowanyama and Pormpuraaw last week. Women from the cape who are pregnant go to Cairns four weeks before their babies are due. How long before the birth of their babies do women who live in rural areas come to Toowoomba?

Ms O'Brien—Not a long time. It is not like birthing on the homelands up north. In the private sector, most of these women come in for caesarean sections, unfortunately, so they know when they are coming in to have their babies. In the public system, which fortunately does not have the caesarean section rate that the private system has, quite often women may be in labour when they are sent to Toowoomba.

CHAIR—So they are not far away?

Ms O'Brien—No. You do not have to go to Toowoomba weeks beforehand, although some women who are high-risk do tend to move. Toowoomba is an area where there are a lot of rural people who have moved off properties into Toowoomba, so a lot of people have contacts. People from out west can have contacts in Toowoomba and they quite often go there to stay with family.

CHAIR—Do you have any Indigenous babies being delivered in Toowoomba?

Ms O'Brien—Yes, of course. It was a very small subsection of our sample, so we did not really have big enough numbers to section them out and look at their individual needs, unfortunately. It is also difficult to attract Indigenous women and women from lower socioeconomic backgrounds into studies. It is very difficult to get them to enrol in research. That is one of our problems.

Mr VASTA—I am not sure whether your research has shown that bottles have an adverse effect on the development of a child's mouth and jaw.

Mrs Noble—That is something our research has not touched on at this point, but the papers I have read suggest that it makes a large difference to the way the baby's muscles develop in their mouth and jaw.

Mr VASTA—I saw when I was growing up different bottle tops that imitated the teat. They have changed dramatically over the years.

Ms O'Brien—They have, but I am not convinced that they are getting any better. I think they are just getting different.

Mr VASTA—It is just a new design and a new shape?

Ms O'Brien—Yes, absolutely.

CHAIR—Thank you for appearing before us. My wife's people come from Malara, so I have a bit of knowledge of the area you are talking about. We appreciate the effort and time that you have put into your submission to this committee.

Ms O'Brien—Thank you very much. I welcome the opportunity.

Prof. Hegney—Thank you.

[4.03 pm]

NOBLE, Mrs Robyn Ruth, Director, Bayside Breastfeeding Clinic

CHAIR—I now call our final witness for today, Robyn Noble from the Bayside Breastfeeding Clinic, to give evidence.

Mrs Noble—My business is a sole operator business called the Bayside Breastfeeding Clinic. It is in Manly in Queensland.

CHAIR—This committee is part of the proceedings of the parliament and the evidence that you give, if it is misleading or false, can be a serious matter and regarded as contempt of parliament. Would you like to address the committee with an opening statement?

Mrs Noble—Yes, thank you. I have absolutely no government funding for my activities. I have never had any staff. I look forward deliriously to that prospect one day. I have no commercial affiliations with anybody. What I have been doing for the last 30 years of my life was almost a celestial accident. I always planned to go back into medical science, which is what I was trained to do in the first place. It was my first love. Then life took three left-hand turns on me, which were my three children, and I learned the extent of the problem that we have in Australia with helping women to breastfeed their children. I learned a lot about what follows on from that in personal terms, in family terms, in health issues and in political issues. I have certainly found that it is a very political issue.

The clients whom I see and whom I have been working with for the last 17 years encompass every imaginable group of people, almost without exception. Probably the biggest exception is mothers who have an Indigenous background. Rarely do I see one of those, but I have certainly seen a lot of women through my practice who come from every ethnic background you can imagine. In the *Koran*, for instance, women are instructed to breastfeed their children for two years. There is a similar instruction for Jewish women. This has been almost traditional for a lot of cultures over a very long period.

The groundswell of interest in breastfeeding in Australia has come from women themselves. This would have to account for the fact that, per head of population, the Australian Breastfeeding Association is the world's largest breastfeeding association. The other figure I could lay alongside that is that per head of population Australia has the world's largest number of lactation consultants. We have a huge groundswell of pressure from the grassroots of the nation asking for more sensitive community environment in which they can breastfeed their children. It is much more than nutritional—this is the beginning of relationship within a family and it tends to set the foundations for many different things.

Ross, you mentioned the business of teat design. That happens to be one of my research areas. I have worked extensively over many years with a friend of mine who is a paediatric speech pathologist. Our contention is that commerce has been driving the designs of those teats purely for dollar reasons; it has nothing to do with the developmental or other interests of the children of the nation.

Mr VASTA—They are purely aesthetic?

Mrs Noble—I am afraid so. None of the current teat options available in the retail market relate in any way to physiological suck in our children. Therapists are now treating an epidemic of children with a peculiar form of modern learning difficulty called auditory processing problems. My friend, who has been in her field now for 30 years, says that if she had talked amongst the group of her colleagues 20 plus years ago and if one of them had a case of that amongst their case load then they would all have wanted to know about it because it was so unusual. Now they have clinics bursting with it. Every teacher I see as a client through my clinic I ask out of interest, ‘How many children in your last class had auditory processing problems?’ Generally they are saying things to me like, ‘About 40 per cent of the class.’ This has much greater implications than many people are aware of. I must not digress too much.

My personal assessment of the MAIF agreement is that it is a toothless tiger. From my perspective I see commerce doing precisely what it wishes to do in all spheres that influence infant feeding in Australia. That situation has steadily been getting more of a problem over the years because, as we get more savvy in Western countries and people are generally more highly educated, the people who wish to sell us things also have to become more clever in their efforts to sell us their products and expand their profit margins.

I want to get back to a couple of things that have come up already. Regarding research into the cost of not breastfeeding, there has been at least one really good article published in *Breastfeeding Review* in past issues. Those papers can be accessed through the Lactation Resource Centre, which is part of the Australian Breastfeeding Association.

Regarding the role of fathers in breastfeeding, I love that issue, Alex. It warms my heart. When clients come into my clinic I say to them that I really love it when they bring a support person. Generally, that should be the father. He is usually the person who is closest in influence to the mother of that child. I love educating them in that category. I love sending them off and then seeing what they end up being able to do. It is not just women who are breastfeeding with their children. Women need to have the support of the rest of the community in order to breastfeed. The closest person who usually will have the biggest influence on that is the father of that child. The sorts of discussions that fathers have at work amongst their colleagues are as important as those amongst groups of women in mother’s rooms. We are all in this together. I challenged the principal of my local high school some years back when my children were going there because my daughter was being subjected, but the boys were not, to an education program about mothering and raising children. I asked the principal whether he thought that it would only be the girls, not the boys, who would become parents. That was sufficient comment to change the situation.

Getting back to inconsistent advice, one of the biggest pieces of difficult advice that I hear about is prescriptions that the mothers get when they go to see a GP. The most consistent problems would be about prescriptions of amoxicillin for breast infections, when we have known for decades that that is not an appropriate drug to prescribe and generally tends to increase the chances that some of those women will develop breast abscesses. The other problem is that there are doctors who are still prescribing bromocriptine, which is a drug which the FDA in America has for decades decreed to be an unsuitable drug to prescribe for women, who, for various reasons, wish to dry up their milk. It is a bit like using a blowtorch, when all you need is a

match. It creates a mass of other problems and the known side effects have included strokes and heart attacks. In decades past, when this was a fairly common drug prescribed for the last generation before mine and my generation—30 to 35 years ago—who were producing children, the nursing staff said that they always knew which women were on it because they were the ones they had to pick up off the floor in the ward. It knocks the bottom out of blood pressure.

CHAIR—What is that drug prescribed for?

Mrs Noble—For drying up mothers' milk. It has quite an intense impact on pituitary function. Its other use is to treat pituitary tumours.

CHAIR—Does the antibiotic amoxicillin have an impact on the baby through the—

Mrs Noble—All antibiotics have an impact on the baby because they will, through the breastmilk, tend to clean out the normal non-pathogenic flora that should be in that infant's bowel. So it will tend to predispose those children to thrush problems. Oral thrush is one of the problems that can certainly ruin a breastfeeding relationship because, to start with, it will change the mechanics of the baby's suck. Often, that will then mean that the mother will have painful nipples as a result of it. I find health professionals are often reluctant to call it thrush until it looks like the pictures in their textbooks, which are always of the worst case scenario. One paediatrician, whom I had asked to treat one of my client's babies for oral thrush, recently said to that client, 'That wasn't thrush in the baby's mouth; it was just normal mouth organisms.' I am afraid I cracked up laughing, and said, 'Yes, but there's too many of them.'

Just getting back to a comment that Jill made before about the impact that she would like to see ABA making on women in the lower socioeconomic groups of the community: in my past involvement with the association—I was a counsellor for 15 years—certainly there were women in a lot of the groups who came from that part of the community. Breastfeeding is as much a dear part of their experience with their children as it is for any of the rest of us but there is one singular barrier, and that is money. What we used to say to women back in those days was that Nursing Mothers, as it was then called, is like water—it is free but it costs to bring it to you. Women who wished to be part of the ongoing group activities were then encouraged to become members.

I have to say that over the years there has always been a lot of resistance within the association to increasing the cost of membership. Back in my day I think it was about \$35 a year and now it is only \$50. It has not increased all that much over quite a long time frame, but it does mean that it could be quite a challenge for a woman who is living on the supporting parents benefit, for instance, to find \$50 to join a breastfeeding association. That is one of the natural barriers for women who are in that fairly difficult—

Ms HALL—How much is a week's formula, though?

Mrs Noble—You cannot reach them with that argument, unfortunately, although one way of doing that has been tried in a couple of hospitals in Australia. It especially targets young women who anticipate they will bottle-feed from the start, because we know from all of the studies that adolescent mothers, very young mothers, are not nearly as likely to breastfeed their children. That has a lot to do with body image issues. For instance, one of the hospitals in Tasmania has

had a policy for about a decade or so that women who do not plan to breastfeed have to bring all of their own feeding gear with them into the hospital. That does acquaint them, before they have their baby, of what the costs might be. That really is one of the problem areas.

We are up against a lot in the general community. We have now had several generations of supposedly successful artificial feeding. Typically, a lot of the people who have been artificially fed look as though there is nothing wrong with them. I look as though there is nothing wrong with me, but I can tell you that I have an immune system that says otherwise. That goes back to the experiences that my mother had as a breastfeeding woman. Her belief, which was fed at the time by the advice she was given, was that she would lose her milk at a certain point in her lactation. I guess my contention is, having heard so many other women say these things over the years, that by now there has to be a lake of the stuff somewhere in Central Australia, because that is about how much has been lost over the years.

I noticed on the front page of our paper last week, Ross, there was an article about a child who was confined to home because of her major food allergy issues. I have to say—and this, again, has been a bit of an accident with me—that probably half of my practice involves helping women to deal with the mechanical aspects of breastfeeding; the other half of it has come to be helping mothers to manage children who have these sorts of problems. This was not something which ever really came to the surface of anybody's consciousness in our country several generations ago. This is one of the things that we can view as fallout from several generations of supposedly successful artificial feeding. It compromises us because we are not getting the optimal food designed for our species.

CHAIR—I do not want to show my ignorance, but how do people pay for your services?

Mrs Noble—Directly.

CHAIR—Do they get any assistance from Medicare?

Mrs Noble—By that, do you mean the private health insurance system or the Medicare system?

CHAIR—Both.

Mrs Noble—The Medicare system, in general, is primarily designed to support doctors and certainly not people like me. That actually means that I have an advantage over a lot of other health professionals. It means that most people who see me know that they will be paying my fee—which, incidentally, is \$90. I see them for about three hours. I do not expect to see the vast majority of them again after that, but I do ask them to stay in phone contact with me and I do not charge extra for that. That allows me to monitor my success rates. It also gives me plenty of room for learning, on an ongoing basis, from my clients. I have learned more from mothers and babies than I have ever learned from textbooks—although I am fascinated with the contents of them as well. Sorry, I might have diverted slightly.

CHAIR—Is enough support being given to young mothers who need support like yours?

Mrs Noble—No.

CHAIR—Should these things be covered by Medicare?

Mrs Noble—I believe so, yes. If we are really serious about showing the general community in Australia that this is a meaningful thing and that we want to achieve this target, then money definitely comes into it. The power hierarchy in the entire health system is a pyramid, with all the money concentrated at the top levels, and very little filters through to the bottom levels. The bottom levels are where our primary health issues lie.

If you look back at UNICEF figures from 20 years ago—I can go back through the history, and I will supply you with overheads; if I had had an overhead projector I would have shown you—history can teach us many things, and the history of what we are recounting today is, I can tell you, a recurring theme. It is very difficult to achieve significant changes in primary health care. It is much easier to pour money into the top levels, and that is precisely what tends to happen in Western countries. That situation really needs to be changed and adjusted so that more of the funding filters through to the lower levels. At the moment we have a ‘crash and burn’ mentality about how we spend our health dollars. A lot of the women that I see quite are at the ‘crash and burn’ stage themselves, and that is another reason why I need to spend three hours intensively with them on a one-on-one basis. I can tell you that the result of that reflects the sorts of findings that our friends from Toowoomba were explaining before, about how much value women put on that ongoing ability to access an appropriate service that gives them the information and the support that they need at a crucial moment—not something that would be delayed.

I speak to women now who tell me that it is impossible for them to access their local child health nurse for, say, three weeks. They have to make an appointment. Thirty to 35 years ago, when I had my children, I could walk into any child health centre, anywhere I happened to live in Australia—and we did access a few in different states. You could do that any time and expect that you would not have to wait much longer than half an hour at the most. Our community services have actually shrunk over 30 years, and women are now not getting anything like the same amount of baseline support to do what they need to do. In this brochure which my professional body publishes—this is the current one—there are, I think, 33 of us who are crazy enough to be in private practice as lactation consultants. It does take a certain form of mental craziness, I have to say.

There is very little financial inducement to do this. On top of that, many of us are working in the field now with no professional indemnity, because we cannot cover it from what we earn. The health funds are not, on the whole, supporting what we do. Medicare does not make any effort to ensure that women go to see a lactation consultant. It really does come down to the individual insistence and passion that a particular woman has about having her own experience with her baby continue for the length of time that she envisaged. That is the sort of determination that I work with, with the clients who come to me. That means we can accomplish miracles between us. I see about a 95 per cent full resolution rate.

CHAIR—What impact has the baby bonus had on women having babies?

Mrs Noble—That is a bit hard for me to answer, because it has only recently been increased by that much.

CHAIR—It is \$5,000 as at 1 July.

Mrs Noble—Yes. A few of the women I have seen have said to me that it meant they were a bit less concerned about coming to see me because of the cost of it. But only a couple have commented on it.

Mr VASTA—We were speaking before about the trials and tribulations of trying to register your name. Could you let the committee know about that little part of history.

Mrs Noble—Again, history is interesting. When the Nursing Mothers Association of Australia began more than 40 years ago they were not permitted to put that nasty word ‘breastfeeding’ in the phone book; that was why they had to be called the ‘Nursing Mothers Association of Australia’. When I began my business venture with my friend 15 years ago, I was quite determined that that word would appear in my business name. That then raised the next problem: how were we going to have this listed in the yellow pages, because there was no appropriate listing at the time? It took two years, two written submissions and many phone calls to achieve that. We now have a national listing in the yellow pages under ‘Breastfeeding support services’. That is one thing I am quite proud of.

CHAIR—Thank you very much for appearing before us today with, obviously, a lifetime of knowledge. Thank you for imparting it to us. Please keep an eye on the outcome of the inquiry. If you see anything in the evidence as it comes up during the course of the inquiry that you want to comment on, please do so.

Mrs Noble—Thank you very much. I do truly wish you all the best in your endeavours with this. I understand quite well the scale of the problem you are about to tackle.

CHAIR—We are learning quickly. Thank you very much.

[4.30 pm]

CHAIR—We have planned a community forum—we did this in Cairns. People have been listening to this since one o'clock and we want to give you the opportunity, if you want to, of telling the committee what you want to tell it—any experience you have had that we might benefit from. I invite anyone who wants to make a statement to get up.

Jody—Firstly, I thank the committee for coming here today and for being patient with us mums with kids. We really wanted to come today but did not want to leave our kids behind, so thank you for being very patient with the noise from the back of the room. I come today wearing many hats. Firstly, I am the mother of an almost three-year-old child, who, as you have probably noticed, is still breastfed. I also come wearing the hat of the Home Midwifery Association and of the Maternity Coalition here in Queensland. I am the editor of the *Down to Birth* magazine, which is a grassroots natural parenting and birthing magazine. I also come as the friend of women who have both breastfed and bottle-fed their babies. I presented a written submission to the inquiry about six weeks ago. I apologise that the Home Midwifery Association has not yet had a chance to do so, but we have had a bit of a community organisational meltdown, as anyone who has ever belonged to a volunteer organisation knows happens from time to time. We will in the near future endeavour to present a written submission.

When I sat down to think about what I would like to say today, I realised that I was just rehashing what I had written in my submission and that you would not want to hear that again. So I thought I would come and speak today about how you can achieve a successful long-term, full-term breastfeeding relationship. I came up with six key points. From listening to what I have heard here today—especially from our colleagues in Toowoomba, who quoted that 44 per cent of women are experiencing postpartum trauma as they endeavour to embark on a breastfeeding relationship—I think my first point is really important. A positive and empowering birth experience which utilises the continuity of care model, the one-to-one midwifery model, is so essential.

I was lucky enough, in 2004, to birth my son at home with a private midwife. We did it out of pocket—it cost us almost \$3,000—and, as you can see, I am still breastfeeding at almost three years. My midwife was there to support me in the antenatal period, during my birth and in the postpartum period. My antenatal care consisted of a lot of breastfeeding information. I belong to a support group, at which I saw women breastfeeding babies, toddlers and older children. Sitting in that support group was so important because, to me, it was just normal. So many women no longer see babies being breastfed, and they certainly very rarely see older infants or toddlers being breastfed. It is important for women to have that positive birth experience.

I felt like an Amazon woman after I had birthed my son. I felt like there was no challenge that I could not surmount. That is the frame of mind you need to be in when you embark on breastfeeding, because it is tough. I had nipple trauma. I had a son who did not want to feed. But we got through it, and it was great. My midwife was there for me on the telephone. She was there in my home for the first week, and I know that if I needed her, I could ring her today. So you need to have that positive birth experience; you cannot be traumatised when you are trying to breastfeed for the first time.

You also need social support. You need the support of your family, your friends and your community. I was very lucky that I had and still have a supportive family. I have supportive friends and I belong to a community that is incredibly supportive. I would say that the wider community is not supportive of breastfeeding. We do not see positive breastfeeding images in the media—on television—and I am still appalled sometimes when I see babies being bottle-fed on *Play School*. That social support is so important, and the social support that I had in the early period got me through it and has kept me going through it.

In respect of health benefits, you were talking earlier about the cost of not breastfeeding. I can tell you that my son has never been sick. He has never seen a doctor in three years. We have not spent a single cent on formula or prepackaged food. In a single income family that makes a huge difference. The health benefit for me is that I have been on a natural high for three years, and it cannot get any better than that, especially when, as a mother, you are going through a period in which you are losing your identity as a woman and are reforming a new identity. When you are vulnerable, that oxytocin kick really counts.

I was also lucky in that I have not had to return to work. I have not had to try and juggle when I go back or how I go back. I have not had to worry about expressing, and I think that plays an important part. I know friends who have struggled financially to remain at home so that they can breastfeed their children, and they do it. Another thing that has kept my breastfeeding relationship going is the wonderful relationship I have with my son. There is nothing that can beat that.

Lastly, it is about one's attitude. Breast is best as far as I am concerned. It has always been that way for me. That attitude has got me through the nay-saying and the disapproving looks that I have got when I have breastfed publicly. That 'can do' attitude has kept me going on this path. I call on the federal government, in what is both an election year and year in which we have a record surplus budget, to put its money where its mouth is. I am asking for publicly funded one-to-one midwifery care to ensure that women get the positive birth experience that they so deserve. Women do not deserve to be traumatised in birth. Birth is supposed to be a life-affirming and life-changing time, not a life-destroying one. I call for publicly funded lactation consultants so that women do not have to find the money, waiting until it is an extreme situation before accessing a lactation consultant.

I am asking the federal government to find funding to help volunteer organisations such as the ABA, which I take my hat off to. These guys are so seriously underfunded yet the work they do is just amazing. Also, take organisations such as HMA that promote and support breastfeeding. We do it all and have done it for the past 24 years with no government support whatsoever. I ask that the government publicly fund a campaign to raise awareness that best is breast and that breastfeeding is normal. I thank you for my chance to speak today.

CHAIR—Thank you very much. I guess you are telling us that the government should put its money where the baby's mouth is. We hear you loud and clear.

Elizabeth—my name is Elizabeth. I am a counsellor with the Australian Breastfeeding Association. I am also on its board of directors. As I have been a counsellor for 20 years, I can tell you that the stories that I hear when I do helpline work have changed very little from those that I heard 20 years ago. The major difference now would probably be that there are more

queries from women who are returning to work and want information on expressing and storing. I have very little to add to everything that has been said today, except that we have a concession membership for women who are on a supporting parent benefit or other pension. It is \$35 a year.

I saw Robyn Noble struggling hard while trying not to be critical of health professionals—and I am not saying that she was—when she was presenting her case studies. That is because a great part of our training understands our code of ethics or our code of conduct. One of the clauses is that we do not criticise health professionals; we work collaboratively with them. I believe that has been one of the big strengths of the association over the years and the reason why we have been so able to work with other bodies, which has become more and more common in the past few years. We do not criticise. We may think it privately, but we do not criticise. If a mother starts to talk about how awful her doctor was or things like that, we tend to deflect the conversation in a group. If it is a counselling situation and we realise that the information that the mother has been given is contradictory to our policies, we use clauses like ‘some mothers find’ and ‘have you thought of trying’. That is all the time of yours that I want to take except to say thank you very much to the committee for coming to Brisbane. I wish you all the best with your endeavours.

Kate—my name is Kate. I am a mother of three. My first child was born 18 years ago in Charters Towers. There was a lot of misinformation given at that time. I had a breast abscess surgically drained at six weeks. There was a lot of misinformation from the hospital and the doctor. I then got in touch with nursing mums, as it was called then. After my second birth I moved to Gympie, which had a really supportive nursing mums group. I stayed in hospital one night. I was full of confidence. I went on to train as well. There was another baby with no problems at all. It is about being with other people, seeing it being done.

Since then I have trained as a personal trainer. I know I do not look like it now since I am expecting in the next couple of months, but my area of interest is definitely in nutrition, having worked as a teacher’s aide as well and therefore having seen the allergies and with my husband being in behaviour management. Apart from all the benefits of breastfeeding, nutrition is a huge part of it as far as I am concerned. My niece just gave birth in Noosa a month ago and she was talking to me two nights ago on the phone. She did not realise how low the statistics are and she was amazed that, out of her little group of people in the antenatal, she is the only one out of the seven who is breastfeeding. This is at three weeks. She was amazed and I said, ‘That is what it is like.’ I am going to give her an Australian Breastfeeding Association membership because already she is passionate about it. She can see the benefits and she did not realise that people sometimes just choose not to breastfeed. I heard Robyn Noble talk and I have heard Virginia talk before too and also Wendy Brodribb, who has been mentioned. They are all amazing speakers and very inspirational. Thank you.

Alice—I will be speaking as the mother of a 13-month-old, who might finally be asleep after all this time! I had a really difficult time in the first four months of being a mum with breastfeeding and just being a mum in general, and I can imagine how many women would have stopped breastfeeding in the circumstances I went through. I consider myself very lucky that I was in contact with the Australian Breastfeeding Association. It made all the difference. So did consulting two private lactation consultants who, by coincidence, were Robyn and Virginia! I do not know if they remember me but I consulted both of them. It was not easy. My husband is a student, so we are virtually a no-income family and it was a big thing for us. That is why I agree

that lactation consultations need to be rebated and that there needs to be more funding for the Australian Breastfeeding Association. From my personal experience, that is what made all the difference. As I said, it was such a difficult time and I can see how other women would have not made it through. I am just reinforcing what everyone else has already said. Thank you.

Emily—I am a volunteer breastfeeding counsellor with the Australian Breastfeeding Association. I want to go back to the community perception that breastmilk and artificial baby milk are equal alternatives and that it is just the mother's choice. That perception is pervasive in our society now and it starts right at the beginning in children's books, or perhaps it comes from the community into children's books. If you look at books which are talking to young children about their new baby brother or sister, they all show that babies are fed with either breastmilk or a bottle. They are put in the books as equal alternatives. When you have a look at sex education books, they either do not mention breastfeeding at all as a normal way to feed a baby or, again, they present it to the young children or teenagers—whoever is reading the book—that you can feed a baby with breastmilk or with artificial baby milk. They say, 'It is your choice; it is the same.' That is the perception that needs to change if there is to be more community support for breastfeeding and more encouragement for mothers to keep going if they are experiencing difficulties. If the community is not with you and supporting you when you are having difficulties and is just saying, 'What is the problem? Just give them a bottle—what is the difference?' then you need to be a very strong person and very well-informed to go against the feeling all around you that there is no difference, when there is a difference. The perception that artificial baby milk and breastmilk are equal alternatives is a message that is promoted by the manufacturers and retailers of the product. They profit from that perception and breastfeeding suffers and people suffer.

So breastfeeding needs to be seen as the normal way to feed young babies and young children, and the general community needs to recognise that there are risks to early weaning. That information is not on the containers of artificial baby milk that you buy. Sure, you get told breast is best, but you do not get told of the risks that you are exposing your child to: that they are going to be more susceptible to gastrointestinal upsets, to ear infections, to illnesses which may end up with the baby in hospital because they suffer more severely from those illnesses. Surely carers need to be warned of these risks. Say a breastfed child falls ill with a tummy upset and that child is playing with a baby who is artificially fed. Both mothers may see the breastfed child recover fairly quickly. The mother who is artificially feeding may not realise that this illness could be far more serious for her baby because her baby does not have the protection that breastmilk is providing to the other baby. She has a right to be made aware that she has to take extra care. She needs to be made aware of those risks.

Underlying the community perception that artificial baby milk is an equal alternative to breastmilk is the marketing that is allowed. It should not be allowed. Artificial baby milk should be marketed like a generic medicine. You do not need advertising campaigns for that; you expect that that generic medicine is going to have the substance that you need to get you well. Artificial baby milk should have the status of an emergency substitute when breastmilk is not available for a child. There should not be any need for companies to be able to promote that their formula has this or that substance in it—the bifidus bacteria or the omega-3 whatever. If those are substances that children need for optimum nutrition, then all children should be getting them; they should be in all formulas; they should not be there as something which can help to sell one formula at a

more expensive cost than another if the mother can afford it. If it makes a difference to the children, then all children should have access to that substance.

CHAIR—Thank you very much. Virginia, you can wind up the day for us.

Virginia—I have two points. As you will know, pharmaceuticals that are available on prescription are not allowed to be advertised, so marketing restrictions on the advertising of products within the terms of the WHO code—they are not the only things on which there are restrictions. The other point is: in my 40 years in the breastfeeding field, first as a breastfeeding counsellor and subsequently as lactation consultant, one consistent thing has been mother blaming. Mothers, of course, are great blamers of themselves, whatever they do, but so also are the community, particularly other women. Back when I had my first child I was a bad mother because I wanted to persist with breastfeeding instead of being like a reasonable person and not doing that. It swings. Mothers are blamed if they work; they are blamed if they do not work. They are blamed for a whole lot of different things, but the consistent thing is that there will always be mother blaming and it does not really matter what they do; there will be that element. 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.

CHAIR—We thank everybody for participating today.

Resolved (on motion by **Mr Georganas**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 4.50 pm