



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health benefits of breastfeeding

MONDAY, 7 MAY 2007

CANBERRA

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING

Monday, 7 May 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 and Mr Somlyay

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.

WITNESSES

BELLIS-SMITH, Ms Nerida Davina, Professional Services Director, Dietitians Association of Australia.....	11
ELDRIDGE, Ms Sally, Private Capacity	30
ESCOTT, Ms Ros, Consultant, Australian College of Midwives and Committee Member, National Baby Friendly Health Committee	18
McKENZIE, Ms Ingrid, WEL Maternity Services and Breastfeeding Working Group, Women’s Electoral Lobby Australia	30
POLLOCK, Ms Natasha Ann, WEL Maternity Services and Breastfeeding Working Group, Women’s Electoral Lobby Australia	30
SMITH, Mrs Lorraine Winifred, Member Delegate, Pharmaceutical Society of Australia	2
VERNON, Dr Barbara, Executive Officer, Australian College of Midwives	18
VOLDERS, Ms Evelyn, Member, Dietitians Association of Australia.....	11

Committee met at 10.36 am

CHAIR (Mr Somlyay)—Good morning, everybody. I now declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing inquiry into the health benefits of breastfeeding. Today the committee is back in Canberra to hear from some of the national organisations which are based here. The Pharmaceutical Society represents members who are a key source of information for breastfeeding mothers, as does the Dietitians Association of Australia. We are also looking forward to hearing more about the Baby Friendly Health Initiative from the Australian College of Midwives, as well as the perspectives of Australian Rural Nurses and Midwives and the Women's Electoral Lobby. This hearing is open to the public, and the transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry transcripts, please ask any of the committee staff here at the hearing.

[10.37 am]

SMITH, Mrs Lorraine Winifred, Member Delegate, Pharmaceutical Society of Australia

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

Mrs Smith—I am from the Tasmanian branch of the national PSA. I was asked to represent PSA at this hearing on breastfeeding because I have had a long association with breastfeeding over the years, being both a mother and a health professional. In that capacity, I have been asked to represent PSA.

CHAIR—The committee does not require you to speak under oath, but you should remember that these hearings are formal proceedings of the parliament and giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I am required to read that out. I invite you now to make a brief introductory statement to the committee.

Mrs Smith—On behalf of PSA, all I would like to say is that pharmacists, being at the forefront of the health line with regard to mums with bubs coming in and asking for advice, are there to give them our full support in whatever way they decide they wish to feed their infants. Being health professionals, we would like to make sure that we get all the up-to-date information that we can. So, in supporting this in parliament, we would like to encourage government to initiate funding for education in the front line, particularly for pharmacists, from our point of view, to make sure that we will give those mums who are seeking our advice the correct advice.

CHAIR—Obviously you are a woman and a pharmacist—

Mrs Smith—Yes.

CHAIR—and you have a view on breastfeeding. Do you think the male pharmacists generally share that view? We have had evidence to suggest that it might be easier in a busy pharmacy to advise people to take some formula instead of advising on breastfeeding.

Mrs Smith—Yes—this is probably going to be taken as a little bit of a generational type statement, but I am finding that the younger members of the profession are becoming more responsive to breastfeeding, more responsive to mothers' needs and that sort of thing, so they are more willing to be out front with those mums. But, in the case of the older generation pharmacists, I usually think that they find they have a staff member who either has been a mum or has an interest in that area, and they will then hand that over to those assistants to do that. So, in supporting pharmacists, I think it is also important to support pharmacy assistants in this field.

Mr GEORGANAS—In terms of the retail space in a pharmacy that is taken up by formula for the displays and everything, is it a profitable return?

Mrs Smith—Not really, no. It is something that most pharmacies will stock as there is a need to do so, but, because of the bulk size that they need, they generally only carry just what they have to. Probably the pharmacies that carry the most in that line would be your brand-name

pharmacies like your Chemmarts and your Amcals—that type of thing—which then market their own brand of infant formula. But most pharmacies will only keep probably the highly specialised formulas and probably then will not keep them on hand most of the time; they will just get them in on an ad hoc basis as required.

Mr GEORGANAS—So, when there are displays—and I am sure we have all seen them—for formula, who sets up those displays?

Mrs Smith—Quite often the actual companies will set them up. They come around to the pharmacies and obviously barter and do deals et cetera. They are the ones that usually set up the displays. I think most pharmacists are well aware of the WHO code and try to stay on the right side of that.

Ms HALL—They ‘barter and do deals’? Could you explain that a little to us, please.

Mrs Smith—The companies will come out, and they will have package deals on, say, a whole range of baby products and that sort of thing. Sometimes those deals will include, ‘If we give you this at this price, we’d like you to keep this, this and this.’ Sometimes, some of those items may well be formulas.

Ms HALL—Sorry, Steve; I just needed that clarified.

CHAIR—Discounting, I suppose.

Mrs Smith—Basically I suppose they would call it that, yes.

Ms KING—Are there any programs or initiatives you can point to that pharmacists have done in relation to promoting breastfeeding? Are there any good examples?

Mrs Smith—A few years ago in Tasmania we had a workplace-friendly breastfeeding initiative where representatives went around and joined pharmacies up to encourage breastfeeding—for example, if they had a mum who came in and needed to feed her baby at that particular time, they could have an area of privacy to do that. Also, on the other side, it was to encourage their mums who were still breastfeeding and wished to come back to work. They would support them to do that, with approachable work hours and that sort of thing.

There was a project in Tassie prior to that called Mum’s the Word, but that was not really particularly pharmacy orientated. But I think a lot of pharmacists, particularly the female pharmacists, became involved in that and therefore spread the word of that program out to other members. We would really like to get out to the young mums in these days where the extended family is not as strong in the Western world as it is elsewhere, so those mums need support. We as pharmacists find that, if we are open to their needs, they will get that support then, and then they are more likely to gain confidence in you. They will come back to you and seek further help if needed.

Ms KING—Do you have any links to the Australian Breastfeeding Association or any partnership arrangements with them at all?

Mrs Smith—PSA do not as such, but we certainly do support their policies on breastfeeding and we certainly, as best we can, follow the 10 steps to successful breastfeeding where we need to have an input in that.

Ms HALL—Thank you for coming along today. My first question is about something that came up while we were in Queensland. When we were taking evidence from some midwives, they said that, if they apply—and some of them had applied—for positions in pharmacies, part of their being successful in that application was to be prepared to push, for want of a better word, the sale of formula. If a mother came in with a problem about breastfeeding, they were to suggest to that mother that she try this or that formula. Would you like to comment on that?

Mrs Smith—I probably cannot comment very much because I am unaware of that. I was working in Queensland less than two years ago and I certainly did not have that put on my plate. It may well be a ‘banner group policy’ type of thing or it may well be dollar driven, because there are a lot of online, phone-up pharmacy type set-ups where they sell products but do not give advice or anything like that. From my point of view, I was never exposed to that in Queensland. In fact, in the positions that I held in Queensland, I was encouraged to take whatever line I wanted to in that area. I said, ‘I’m very pro breastfeeding, so that’s the way I will go,’ and they were more than happy with that.

Ms HALL—You have referred a couple of times to the banner groups. Could you go into that in a little more detail? You said that Amcal and other groups were more likely to promote their own brand formula. Could you make us aware of what happens—

Mrs Smith—I did not actually say that they would promote their formula. What I said was that they would be more inclined to keep a bigger supply of formula because it is their banner group brand. When I was in a banner group—this is going back about 10 years—there was a requirement as part of your being in it to keep a certain percentage of the banner group’s lines, and it is a big percentage of their lines. They will generally have a product in most areas of pharmacy, and infant formula is one of them.

Ms HALL—What initiatives do you think your association, as a peak body, could take to promote breastfeeding more widely in the community and to assist breastfeeding mothers who are experiencing problems?

Mrs Smith—We can certainly do that by holding educational sessions with certain groups of mums—that sort of thing. Quite a number of pharmacists go along as guest speakers to child health groups and nursing mothers groups and so on. It is very difficult to promote breastfeeding as such when, in a pharmacy, the vast majority of the products that you sell are not actually pro breastfeeding—for example, teats, bottles et cetera. From my experience, a pharmacist will always take the line of breastfeeding first when giving advice to a mum. If there are any aids that will help that mum, we will certainly be supportive in that way. If a mum decides that she wants to go another way, we then support her in that decision. Ultimately, it is the mother’s decision.

Ms HALL—Given the lines that pharmacies stock and that, in effect, formulas compete with breastfeeding, do you think a conflict exists within pharmacies?

Mrs Smith—Not as such, because, if you look at pharmacy in a very big general sense, most of what we keep is for people who have things that go wrong with them. We encourage people across the board to endeavour to have as healthy a lifestyle as possible. When you look at it in that way, basically everything that a pharmacy has inside it is a conflict of interest. Pharmacists are people-type persons. We are there to support people in whatever they want to do. We would be there to support someone with their breastfeeding. If they were having issues, we would certainly be in a position to steer them towards people who could best help them. Obviously, most pharmacists are not experts in breastfeeding; but, if people are having particular issues, we have the resources to point them in the right direction. If we can help them, we will do that.

Ms HALL—You said in your submission and evidence that you inform pharmacies about MAIFA. Do you believe that it should be mandatory for MAIFA to be more in line with the WHO guidelines or the WHO requirements than it is at the moment?

Mrs Smith—Personally, I do. From an association point of view, I think we do as well. Obviously we need to take a path with all the things that exist to make them as consistent as we possibly can so that the outcome at the end of the day will be far more advantageous to everybody.

Ms HALL—What role do you think the federal government should have?

Mrs Smith—We always say ‘money’.

Ms HALL—We are not talking about money on this occasion.

Mrs Smith—I think there should be support for us to get out into the community and to educate, and there should also be support for us to make sure that we keep our knowledge up to date, because, as I said, not every pharmacist is an expert in breastfeeding. It is an area of our study that is not touched upon deeply at all, and so it is an area that most pharmacists would certainly benefit from continuing and further education. Unfortunately, all these things come at a cost.

CHAIR—As a first resort, people would not go to a pharmacist for advice on breastfeeding. They would go to their doctor, wouldn't they?

Ms HALL—It depends.

Mrs Smith—They might. It is a bit of one and a bit of the other. Once again this is probably a ‘genderised’ statement but I would think that, in a situation where you have a female pharmacist in your local area, you know that person and you know that she is a mum as well, you would probably be more inclined to go that way. It is probably fifty-fifty.

CHAIR—Or a female doctor.

Mrs Smith—Yes. I think it is probably fifty-fifty. Some mums would feel happier with their pharmacist and others would feel happier with their GP. If we can have consistent lines of referral, we would benefit at the end of the day.

CHAIR—You would refer people to the Breastfeeding Association if they were having problems?

Mrs Smith—Most definitely.

CHAIR—But there is no formal arrangement between them and the PSA?

Mrs Smith—No, not at all.

Mr GEORGANAS—Earlier we spoke about the displays and the negotiations that take place between the formula companies and the pharmacists. How robust are those negotiations? Do you find that the formula companies push them to their limits? I know that there is the agreement, but how far do they push?

Mrs Smith—They try to push it as far as they can.

Mr GEORGANAS—Are aggressive salesmen type tactics used, or are the companies pretty genuine in their—

Mrs Smith—They are sort of full-on, but I would not say that they are unusually aggressive. They know that they are not allowed to market infant formula so they will structure their package so that infant formula will be almost an integral part of that whole package. The pharmacist feels, ‘A lot of this I can’t do without, but in order to get that I have to take this.’

Mr GEORGANAS—Would you be able to explain briefly to us how they structure that package, if you can, in terms of the display? How would they fit the formula into that total package?

Mrs Smith—They know they are not allowed to market it as a big part in the pharmacy.

Mr GEORGANAS—How would they market it? Give us an example of how they would do that.

Mrs Smith—They would put it in a very obvious position, say, in the baby section of the pharmacy so that no-one entering the baby section would miss it—things like that. Some pharmacies still have little stacked displays, but not out in the open; they are still in the baby section. They try to shift the boundaries a bit, but I think a lot of it depends on how well the pharmacist knows where it is allowed to go and where it is not allowed to go. There probably are still some pharmacists who are a bit unfamiliar with the WHO code.

CHAIR—Would mothers who are not breastfeeding be inclined to go to a pharmacist or a supermarket for formula? They would not get much advice from the supermarket.

Mrs Smith—They would get no advice from the supermarket, but, once again, the power of marketing is in that you can get everything you need from the supermarket.

Mr GEORGANAS—And the same displays would be—

Mrs Smith—And the same displays in the same sorts of situations. Supermarkets would definitely carry a much bigger volume of infant formula than any pharmacy could hope to carry, even if they wanted to. I would definitely say that supermarket sales for infant formula far outweigh pharmacy sales.

CHAIR—We went to some remote communities in Queensland. We visited the local supermarket and they said that they turn over only about two tins a month. There is not a big trade in it, but there is a danger that, because infant formula is in the high price range of available foods, they might be substituting cheaper things like condensed milk et cetera.

Mrs Smith—I would have no doubts about that either—I am going back three or four generations.

CHAIR—Carnation milk.

Mrs Smith—Watered down Carnation milk was the way to go. These are some of the wives' tales that come through the generations and still exist. Education about all these things needs to be a high priority; otherwise it is detrimental to our children in the long run.

Ms KING—What is the relationship between the Pharmaceutical Society and the Pharmacy Guild?

Mrs Smith—We are both professional bodies of pharmacists.

Ms KING—Do you have the same membership but do different things?

Mrs Smith—The Pharmacy Guild probably more supports pharmacy owners. They are there to negotiate the national health Medicare arrangements and the government agreements they have. The PSA is probably more the professional education type body. That is not to say that members of the guild are not members of the PSA, but PSA members who do not own a pharmacy cannot be a member of the Pharmacy Guild.

Ms KING—Through your members, do you run any other programs about population health? I think there were coordinated care trials or something at one point. I think the primary care partnerships in Victoria, for example, were trying to include pharmacists within that whole referral network. Quite a bit of work was done then on some of the population health stuff.

Mrs Smith—There may well be, but I am not familiar with them. With regard to anything in this area that is vaguely linked, I think pharmacists from a professional education forefront type of setup should be involved. We are also there, particularly for mums who are breastfeeding and who require medication, to give the best advice we can.

Ms KING—I am assuming that for many of the mums who come in seeking advice it is crunch time—it is when breastfeeding is not working or something has happened; it might be late at night and they are at their wits' end—so there is some potential for pharmacists to provide a good link.

Mrs Smith—Most certainly.

CHAIR—Going back to Jill’s question, what can government do? As a committee, we are examining the broad issue of breastfeeding. Let us take the point of view of pharmacists. I know what we can do to promote breastfeeding, but how can government interact with the pharmacy industry to enhance the incidence of breastfeeding by promoting it?

Mrs Smith—I suppose if there were a way of tightening the reins that the drug companies have on getting their products into a pharmacy that might be an option, as would definitely having some form of regular education available for pharmacists. I would probably even mention working with universities and endeavouring to get some form of breastfeeding content into their courses. Take pharmacists’ assistants as well: give them education sessions. I would mention allowing pharmacists time to go out and educate members of the community and other members of the health profession.

Ms KING—The comments that you have made in your submission are that the PSA does inform pharmacists from time to time about the MAIF agreement. What does that actually mean?

Mrs Smith—We probably use it as a session every so often to reinforce.

Ms KING—What does ‘every so often’ mean?

Mrs Smith—You have got to consider that most pharmacists are fully working people; they work most days. To get education sessions and these sorts of informational sessions in, they always have to be after hours. Pharmacists have families and they have commitments outside so to get them along consistently to these sessions is a big deal when you consider that we like to have our education sessions covering most topics and that rotating them does take time in rolling around to the next one. I would say maybe once a year would probably be optimistic; probably once every two years would be it.

Ms KING—Do you have a newsletter or something that goes to members regularly?

Mrs Smith—Generally, the PSA has a newsletter that goes out three times a year.

Ms KING—Does it ever have articles reminding them about the MAIF agreement and to be aware of it in their pharmacies?

Mrs Smith—It probably does not. I think that could be something that might need to be included on a more regular basis, just to remind them. There is the same sort of thing from the guild. They receive guild newsletters that go out, and something like that could certainly be on the agenda for those.

CHAIR—Do you think there is adequate warning for women who are breastfeeding, when they go to a pharmacist to buy drugs over the counter or get prescription drugs, of the impact of those on breastfeeding given that those could be passed on to the child?

Mrs Smith—A lot of the time it is an oversight on behalf of all three parties, including mum. She will go along to the doctor and ask for something. She might say, ‘Oh, I’ve got this wrong with me.’ She probably will not remember to tell the doctor that she is breastfeeding. The doctor may well not then ask her. So sometimes we will actually get prescriptions into the pharmacies

and the pharmacist will say, 'Was the GP aware that you are breastfeeding?' Because they quite often do not say, and we do not necessarily read minds very well. It is something that I think needs to be in our frontline questions. Do not assume that mums either are or aren't. It is a question that we need to ask them.

CHAIR—Is there a role for government in that?

Mrs Smith—That could probably be brought into certain policy lines that a pharmacist and a GP must establish whether a mum is or is not breastfeeding and, as such, the line of treatment needs to be taken accordingly.

CHAIR—Normally would there be a list of contraindications in the medication that would cover that? I do not know. I do not look for breastfeeding when I buy—

Mrs Smith—Sometimes. Most of the drug companies with all their drug inserts or patient information sheets will always have it on there, but a lot of times too the drug company is actually erring on the side of caution just to save their bottoms from litigation. From my own point of view, I always err on the side of caution. If there is any possible doubt, I would say to this mum, 'If I had to make this decision, this is the reasoning that I would follow it up with.' There are some definite contraindications, and we will say so. If we get a prescription that comes under those definite contraindications, we will then immediately consult with a GP and say, 'Were you aware of this? Will that now change your thinking?' So we would work with both the mum and the GP on that.

CHAIR—Does it happen often that a mother might have a condition that does require certain medication which would be contraindicated for breastfeeding and they would go off breastfeeding because of that?

Mrs Smith—Yes, there are some instances of that. In that situation, I would recommend that they consult with a breastfeeding counsellor. If it is going to be a short treatment and that mum cannot feed for that particular time, she can just express her milk and discard it and then continue on with breastfeeding once the treatment has finished. There are some instances where it is probably best that we do not go there at all. In that situation, once again, if we had a bit of time on our hands, I would recommend they see a breastfeeding counsellor, because, with weaning, the slower the process, the better. We would work into it that way, so I would recommend that way. If it is something whereby the decision has to be made very quickly, I would then explain to the mum her best ways of coping with what is going to happen in the next few days as she starts treatment.

CHAIR—Do you see any evidence of women who are breastfeeding who are affected by drugs? I mean drugs other than prescription drugs, like amphetamines.

Mrs Smith—Yes, I do.

CHAIR—What happens in that instance?

Mrs Smith—We can only advise the mum as best we see. We cannot say to her that she has to stop using drugs. We can only say: 'This is not to the best advantage of your baby. If you are

going to do this, this might be the best way to work around it to try to minimise the amount of drug that the baby receives.’ It is probably not something that a pharmacist would be asked to advise on a lot. I am not convinced that the public are completely aware of the fact that we are bound by confidential ethics—that anything they say goes nowhere else. I am sure that that would be one of the reasons why in that situation we probably would not be asked for advice.

CHAIR—Thanks very much for appearing before us.

Mrs Smith—Thank you.

CHAIR—Please keep in touch with the evidence that we receive over the next few weeks. If there is anything further you want to add, please let us have it in writing.

Mrs Smith—Not a problem.

CHAIR—Thank you very much.

[11.10 am]

BELLIS-SMITH, Ms Nerida Davina, Professional Services Director, Dietitians Association of Australia

VOLDERS, Ms Evelyn, Member, Dietitians Association of Australia

CHAIR—I welcome representatives of the Dietitians Association of Australia. Although the committee does not require you to speak under oath, you should understand that this hearing is a formal proceeding of the Commonwealth parliament. Giving false and misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make a brief introductory statement.

Ms Bellis-Smith—DAA is the national association for the dietetic profession in Australia and has over 3,200 members. We thank the committee for the opportunity to present today. DAA has members who work in a diversity of sectors across health—in a clinical setting and in women’s and children’s hospitals—where we inform clients, teach health professionals and advocate breastfeeding-friendly policies and practices. Community based dietitians often service Indigenous and culturally and linguistically diverse communities. They can work one on one with clients to promote breastfeeding prenatally and to help encourage continued breastfeeding. Very importantly, they work with the early childhood sector and local employers, looking at breastfeeding policies in workplaces. Dietitians in public health nutrition and in rural and remote areas and their policymakers in urban centres advocate for breastfeeding promotion and protection to be incorporated into various programs. Our submission was developed by members across the continuum of these practice areas. The promotion of breastfeeding is of central concern to dietitians, as it is the No. 1 dietary guideline. DAA believes that all women need adequate knowledge and skills to breastfeed, along with an environment that supports and enables their decision. The DAA submission has eight key recommendations, which identify a comprehensive response to this issue.

Ms Volders—I will expand on a couple of those points. In order to target interventions and programs appropriately to increase both the rate and the duration of breastfeeding, a national system of monitoring breastfeeding practices should be adopted. An extensive document was prepared by Webb in 2001 that detailed methods to standardise monitoring. It was an enormous body of work and gave us percentages of children ever breastfed and the amounts of exclusive and full breastfeeding as well as the length of breastfeeding. We have been able to use those figures to target interventions to specific groups and time points to extend the duration of breastfeeding.

In terms of marketing, we have concerns about the MAIF agreement being a voluntary agreement and about it not covering all of the aspects of infant feeding such as teats, bottles and the more recent phenomena of the use of toddler formulas. The advertising of those, in particular, stretches the boundaries and implies health benefits that parents can easily extend to younger infants. Few sanctions are applied. I recently contacted MAIF about some advertising in a pregnancy magazine which blatantly contravened the WHO code. But, as the company was not

a signatory, nothing could be done. MAIF wrote them a letter encouraging them to become a signatory and that was all.

CHAIR—Could we have a copy of that?

Ms Volders—Yes, I will give that to you. We think that we need stronger legislation, we need the ability to penalise companies in breach of the agreement and there needs to be mandatory signing if people are going to sell formulas in Australia. In terms of strategies, we hope that they can be coordinated, easily understood, evidence based, from a variety of formats and targeting various groups, both pre and post natal: small health groups, community education and public health messages. There is an enormous variety of things that can be done.

The submission we gave you had lots of ideas for accessing groups, particularly the culturally and linguistically diverse groups, and providing information. Programs that have been shown to be effective overseas include antenatal classes, home support programs, peer support, WEL clinics and so on. The baby-friendly hospital initiative in particular has been shown to increase rates of breastfeeding significantly and could easily be extended in Australia if hospitals were offered some sort of incentive to adopt this award. As dietitians, we feel that we are well placed in community settings, women's and infants' health to promote the benefits of breastfeeding. We suggest that formal training in lactation should be extended in medical schools—it should be obligatory—and should also be extended to nursing and other allied health and should include health workers' responsibilities under the code of marketing. A lot of the time we talk about the health benefits of breastfeeding but we do not talk about our responsibilities as health workers.

CHAIR—Evidence given to the committee has universally said that there should be more formal training.

Ms HALL—One of the things that has come out in the evidence is that women make a decision on whether they are going to breastfeed before they have their baby. The earlier they are introduced to information and education about breastfeeding, the greater the chance that they will breastfeed. We have been given evidence that they should be introduced to education around the first trimester. I would like you to comment on that.

Ms Volders—I think it needs be earlier than that. I think we should be targeting to the entire public the health message that breastfeeding is the social norm and also the best way to feed infants. That should include secondary students so that the information is at the back of their minds. By the time they are pregnant, you could reinforce the message but it would not be the first time they were hearing it. I think that extended information is much more likely to be adopted if people have heard it a few times. The stages of change model about acting on health information means you need to have thought about it quite a lot before you act on it. Nerida and I were talking earlier about the antismoking message. Thirty years ago we did not hear much about that, but now my small children are able to—

Ms Bellis-Smith—We cannot wait until we think they are going to start smoking. We start the message when they are five or six and then we have a comprehensive message. I think the antismoking message is a very good example of a public health intervention. It has been comprehensive, it has had public health messages and it has had the legislative framework. It has

had all those things. But we are not waiting until someone might be tempted, when they are 14, to start those messages. It is very much the same with breastfeeding.

CHAIR—At what stage of pregnancy would someone see a dietitian for the first time?

Ms Bellis-Smith—Maybe never.

Ms Volders—If they are well and healthy, maybe never. A number of antenatal clinics have dietitians doing screening and things. We will often speak at antenatal classes about healthy eating during pregnancy. That is an opportunity to introduce the concept of breastfeeding as an optimal way to feed babies.

Ms HALL—I was going to ask you how involved dietitians are in antenatal classes.

Ms Volders—It depends on the setting.

Ms Bellis-Smith—Routinely, dietitians would be included as part of the mix that delivers those sessions, certainly in the public health sector. But it might just be coming in and doing a two-hour session within a six-week program, for example, on the basics. As you can imagine, there is often a lot to deliver in that time, but it is certainly an opportunity to promote the breastfeeding message.

Ms HALL—Going back to the breastfeeding message, we have been told about courses that run in high schools. I think these courses have a very beneficial role. Students are given babies to look after; the babies cry and they give them a bottle. But there are aspects of the course other than just giving them a bottle; it is about teaching them a caring role. Could that be adapted and modified in some way to get the breastfeeding message out as well? That would encode the message in young girls' brains.

Ms Volders—I am sure there would be strategies that you could adopt as part of that same infant care responsibility in a children's program. There would be ways of teaching girls about breastfeeding. You might even set them up into different groups, some breastfeeding and some bottle feeding, and ask: 'How long does it take to sterilise the bottles to make the formula? How much does it cost?' You could say this one is simulating breastfeeding. You could do all sorts of things. I think there would be lots of innovative programs that you could introduce into a scheme like that.

Ms HALL—Within the education systems of each state are dietitians brought into schools to talk to young girls?

Ms Volders—Not on a regular basis. A lot of high schools will access community dietitians to come in and do health talks. We will often be invited to speak to parent groups or at out-of-hours things. Quite often local schools will access dietitians just to come in and do a one-off presentation, but it would be good to work with the education sector and have a curriculum based on that.

Ms HALL—Yes, because there is a role for you not only when it comes to breastfeeding but when it comes to looking at obesity and other things.

Ms Bellis-Smith—Yes. Folate is another really good example. We are battling with the whole folate fortification issue. Certainly getting messages in there about good nutrition is vital for prevention.

Ms HALL—Yes, and there are eating disorders.

Ms Bellis-Smith—And it is about getting clever messages. I think that is a challenge. I think with the obesity issue there is a challenge around how to present that in an appropriate way, as opposed to other things, and with eating disorder issues as well. There is certainly a cluster of nutrition issues that could very much be addressed.

Ms HALL—My final questions relate to the MAIF agreement and the very good example that you have brought along for us demonstrating how the MAIF agreement has not actually been breached but, rather, is inadequate. What would your recommendations be for the MAIF agreement?

Ms Volders—We really need to have mandatory signing. If companies want to sell infant formulas in Australia, I think they need to be somehow forced to sign or agree to the MAIF agreement. I would really like to see it extended to toddler formulas. I work in a children's hospital. I know people cannot distinguish between toddler formulas and infant formulas. With the extension of health benefits we have recently had television advertisements with paediatricians saying, 'I have used these for my children.' I think the whole thing has just gone too far. When the MAIF agreement was formulated, there were no toddler formulas. It has not been extended to address the change in products that are available now.

Ms HALL—And baby foods and teats?

Ms Volders—Teats and bottles should be incorporated as well. When they are advertised there is an implicit message that if this is the best teat then maybe I should not be using myself; I should be feeding the baby using a bottle.

Mr GEORGANAS—I have two questions. The first one is this. Earlier, in your opening remarks, you told us about the particular case of the MAIF agreement not being adhered to. Do you want to give us the details of that? You do not have to name anyone. Just tell us how they did it.

Ms Volders—They are named in the letter.

CHAIR—Do you have any objection to us tabling the letter?

Ms Volders—No, Chair; you may table that. I do not have a copy of the advertisement with me. It was a full-colour, A4 page in a magazine called *Pregnancy*, which is available in antenatal clinics and doctors' surgeries for women to pick up. It had photographs of households with lights on and off and crying babies. It said if your baby does this at night then you need to use this formula, if it does this then you need to use this formula and if it does this you need to use this formula. It was blatant.

Mr GEORGANAS—Yes, we have heard about that one before. When we were in Brisbane someone spoke to us about it. The other question I have is this. What are your views on breastmilk banking? We were lucky enough to visit a breastmilk bank recently.

Ms Volders—We think it is a fantastic idea.

Mr GEORGANAS—Do we do enough of it?

Ms Volders—We do not do enough of it. When I first graduated, we actually had a number of breastmilk banks but with the HIV scare they all closed. There are policies and procedures around them. There is enough evidence from other centres around the world—in the United States, Scandinavia and the UK—where they do have breastmilk banks that that would be an opportunity to provide breastmilk to babies whose mothers are unable to breastfeed or babies who are unwell. As it seems we have the technology to do all sorts of amazing things in medicine, to provide human milk to human babies would be a quite simple solution.

Ms KING—The federal government has put together a national breastfeeding strategy. Is it working or not working?

Ms Volders—I do not think enough people know about it. I do not think it has been fully supported. The sorts of things that we have seen are that there are lots of little bits and pieces happening in isolation and there is not a big coordinated policy.

Ms KING—There is a big national strategy but it is obviously falling down somewhere.

Ms Bellis-Smith—Certainly the monitoring and surveillance issue is really important as well, because a strategy with some direction but without some monitoring to see whether what you have implemented is having any impact, I think, is deficient. The two need to come together.

Ms KING—To change the MAIF agreement to a mandatory code is quite a big thing to do for industry. There is a large cost of compliance for them to do that. You have provided us with one piece of evidence as to where the voluntary code is not working. Are you aware of any other breaches or areas where it is not being enforced? We seem to be getting a lot of anecdotal evidence about it but not necessarily anything as solid as what you have provided today.

Ms Volders—They do provide their annual report every year—I did not bring a copy of that with me. It documents all the breaches and things. Even with the parent help lines, the websites and things, although they are very careful to state things like, ‘Breastfeeding is the best way of feeding your baby,’ after that there is that sort of implicit: ‘You cannot get information anywhere else, so why don’t you go to the parent help line of Nutricia,’ or whichever other company provides those things. I think those again stretch the boundaries of the agreements.

Ms KING—And you couldn’t imagine a scenario where strengthening the voluntary code in some way—

Ms Volders—I just wonder what a company would do when they get a letter saying, ‘Really you shouldn’t have done that.’ They would just go: ‘Ha! We’re a multinational company from all

over the world. So what! We've got a letter from this group in Australia. What are we going to do about it? Nothing.' We need to have some sorts of sanctions.

Ms KING—It needs to have some teeth with it.

Ms Volders—Yes, it needs to have some teeth. Absolutely.

Ms HALL—I just remembered a question I wanted to ask you, and I will probably ask the midwives the same question. Recently there was a report released in which one of the claims made was that breastfeeding leads to better health outcomes in relation to obesity throughout life. And recently there has been another report released which says that, factoring in socioeconomic factors and the education of the mother, actually breastfeeding does not have any long-term impact on obesity; rather, it is linked more to the mother's education and socioeconomic grouping et cetera. Would you like to comment on that?

Ms Volders—It is always really difficult in nutrition research to be able to pull out all of the strands of arguments like that. There is quite a big body of evidence and a lot of European studies. There was a particular Czech one where the economic backgrounds of the groups were very standardised because of the communist regime. They looked at breastfeeding rates and obesity rates and they found that the children that were breastfed for longer had much less obesity. That was a very big study and it took out all of those confounders. So the body of evidence suggests that breastfeeding does play a part in reducing obesity. Nobody quite knows why—whether it changes hormonal imprinting and things like that, fat cell size and so on, or the number of fat cells. One of the issues has been about satiety. Breastfed babies know when they have had enough and they come off the breast, whereas, with bottle-fed babies, the mothers go: 'Fifty mils; you had better have a bit more,' or 'Oh, he's only had 60.' They override that satiety and they never learn when they are full. So, there is still a lot of work to be done.

Ms HALL—Do you know anything about that study?

Ms Volders—Which one is that?

Ms HALL—The study that was released—I think it was last week.

Ms Volders—I do remember seeing it very briefly but I have not read the fine detail of it, unfortunately. I would like to know who funded it and where it came from and all of those things.

Ms HALL—That is part of the reason I am asking this question and I am hoping that we may get some answers on that today.

Ms Volders—Yes, there is a lot of evidence around about people being overweight.

CHAIR—Thanks very much for appearing before us. Is there anything you want to say in conclusion?

Ms Volders—Thank you for having us.

CHAIR—If you keep an eye on the conduct of the inquiry and if there is anything else you want to add, or give the committee, please send it to us.

[11.30 am]

ESCOTT, Ms Ros, Consultant, Australian College of Midwives and Committee Member, National Baby Friendly Health Committee

VERNON, Dr Barbara, Executive Officer, Australian College of Midwives

CHAIR—These are formal proceedings of the parliament and the giving of false or misleading evidence is a serious matter which may be regarded as a contempt of parliament. I invite you now to make a brief introductory statement before we proceed to questions.

Dr Vernon—The College of Midwives is a peak professional body for midwives in Australia. There are about 3,500 members across the country. Breastfeeding is obviously an integral part of midwifery care. Since the mid- to late 1990s one of the programs that the college has participated in to help support breastfeeding in the Australian community has been the baby friendly health initiative. Ros has in-depth expertise in that initiative, and has provided advice to the college since the mid-1990s. But the college also has interests broader than the baby friendly committee. So we are very happy to provide you with information and advice on that initiative but also on the broader aspects of the role of midwives in supporting and sustaining breastfeeding.

Ms Escott—To give you a bit of information on my background, I am here today representing the baby friendly aspects. I am an educator and an assessor. I have been very active in baby friendly at a national and an international level. I have visited hospitals all over the world, including in Africa, Asia and Europe—

Dr Vernon—China.

Ms Escott—Yes, China—as well as being involved in baby friendly locally. I am an international, board certified lactation consultant. I work for the organisation that certifies lactation consultants and have done since 1999. I have been an Australian Breastfeeding Association counsellor for 20 years. You might be interested to know that I served on the APMAIF panel from 1992 to 1997 as the first community representative and was on the body that wrote the MAIF agreement. Having listened to the evidence this morning, I have a few comments I would like to make on that.

CHAIR—Why don't we start with that?

Ms Escott—Okay. Going back to when we wrote that agreement, our brief was to go through the international code and pull out the parts that were applicable to formula companies, because it was to be an agreement with the formula companies. We could not ask them to agree to do anything to do with bottles and teats or anything to do with health professionals' responsibility or anything to do with pharmacists in their pharmacies. The concept from the beginning was that there would be an MAIF agreement. We would then go on to have a similar agreement with the bottle and teat companies. We would then go on to have guidelines for health professionals in relation to the international code and guidelines for retailers. Those other three bits never

happened. It disturbs me that, in the guidelines for health professionals where there is a section in relation to the code, they have gone through the MAIF agreement and pulled out health professionals' responsibilities. When we wrote the MAIF agreement we left them out. So there are things in the international code that got left out.

The other thing we left out that I feel dreadfully sorry about, because I did not appreciate its relevance, was the preamble to the international code, which is really the whole explanation about why it matters. It is the most wonderful piece of that document. I thoroughly recommend you to read it, because it really says why this is important and why it is important in both developed and developing countries. We should have had a preamble to the MAIF agreement, because it sets the whole spirit for what the rest of it is about. I did not appreciate that then.

At a later date I was invited to represent this region—I cannot remember what we are called; we are Pacific something—at a WHO code implementation training program in Geneva, which I went to. I subsequently did a project for the World Health Organisation on revising the *Common review evaluation framework*, which is a booklet for countries to use to evaluate the implementation of the code. Once again I would recommend that to you. It is a project that I worked on. The booklet has incorporated in it a whole lot of work that the Australian government did way back early on when they were looking at implementing the MAIF agreement. There were a lot of questionnaires and stuff that was done. That was incorporated into it, because it was excellent work. It is in there and used. It has been translated into numerous languages and is used all over the world.

Ms HALL—Would a recommendation to this committee be that those other three areas be covered to make it effective?

Ms Escott—Absolutely. I would love to see that recommendation. It was the original intention and I think it does need to be there.

Ms HALL—And also that the preamble should be included?

Ms Escott—Yes. I think the MAIF agreement needs revising, and I would like to see a preamble included in that. It needs strengthening. It is quite correct that toddler formulas and things were not on the market. They have come on since. At the time we wrote the MAIF agreement, follow-on formulas were around. We actually included follow-on formulas, which a lot of other countries did not do at that time. We took the definition of an 'infant' as the official definition of up to 12 months, which automatically covered follow-on formulas. A lot of the toddler formulas I think are about brand name—about getting your name out there. You can market them as much as you like. It is a loophole and it needs closing.

Ms HALL—How does the MAIF agreement need to be changed so that you do not have this sort of thing happening where a company—

Ms Escott—Yes, I am aware of that. I was hearing that before.

Ms HALL—that is not a signatory to the MAIF agreement does it? How do you get around that with it being voluntary as opposed to mandatory?

Ms Escott—I will go out on a limb here. I differ in this opinion to a lot of people: I personally think that voluntary agreements can work, with some provisos. I would have concerns if you put it into a legal format. For the countries that have implemented the code as law, because it has to go through all frameworks of the law and courts and everything else, nothing ever happens—the companies never seem to get into trouble. A voluntary agreement could work if all companies—and I do not know whether this is possible—which market infant formula had to sign on to the MAIF agreement as a condition of putting a product on the market, and if there were teeth added to it as well.

Dr Vernon—If they have to sign on to it, it is not voluntary, is it?

Ms Escott—Yes, maybe it is not so voluntary, but it is short of putting it actually into legislation—if it were possible for them to do that.

CHAIR—You certainly have to assess whether the MAIF agreement is working.

Ms Escott—I think it is clearly not working. That company was clearly breaching the MAIF agreement, but they said, ‘Oh, we’re not a signatory,’ so it ceases to be an issue. Every pharmacy catalogue you pick up has tins of formula. They are meant to only do price promotion, but in fact the tins themselves have become promotional. There are cute little animals feeding their babies and all sorts of things on them. The whole spirit of the agreement is just not being honoured anywhere.

There is this question of how much it is an influence on women. Women do not make one decision to breastfeed; they make a decision almost every day to continue, particularly when they are having trouble. Most women in Australia are initiating breastfeeding. It is how long they keep going. They are making those myriad decisions in an environment where formula is just the norm. On every piece of junk mail that comes into the letterbox there is a tin of formula at such and such a price. It is normalised in so many ways. That normalisation of infant formula is the essential problem, and the promotional activities of companies are a big part of that.

Ms HALL—Thank you.

Ms Escott—That is not what I am specifically invited for.

Ms HALL—It is very helpful; that’s excellent.

Ms Escott—I have given you a couple of documents. One contains some recommendations in relation to ‘baby friendly’. The other, which I want to talk about briefly, looks at what is happening across the Tasman in New Zealand, because I think that is a very nice model in a culture that is very similar to ours. Would you like to start there?

Ms KING—Yes, I think that would be helpful.

Ms Escott—New Zealand were very slow getting ‘baby friendly’ off to a start, but in 1999 the New Zealand Breastfeeding Authority was contracted by the Minister of Health to develop BFHI documents for New Zealand and to train assessors. I went over and did the initial training program for them. In 2001 the Ministry of Health had a contract with the NZBA to conduct the

BFHI audit of maternity facilities. This, I think, is a really excellent idea. They assessed exclusive breastfeeding and pre-implementation compliance with each of the 10 steps, and they did it in 30-something hospitals—and also compliance with the code. That gave them baseline data. Then they contracted with the New Zealand Breastfeeding Authority to implement ‘baby friendly’. First of all, the government said that maternity contracts required facilities to be working towards becoming accredited, but in 2005 the Minister of Health said that all maternity facilities were required to become accredited.

I would like to put this to the Commonwealth government. I know we are in a different situation because we have Commonwealth and state but, in trying to do something similar to that and in getting agreement with all the states, it seems that, once again, the only thing that works is to basically tell them to do it. I am from Tasmania and our minister for health some years ago agreed to contact all the public hospitals and tell them that they should become accredited. There were committees and various people trying to get their hospitals to become baby friendly but getting nowhere. Suddenly they got called in by the administration, which said: ‘What do you know about “baby friendly”? We’re going to be doing this because we’ve been asked to do it.’ It is when it comes from above that the energy comes in. I think the New South Wales policy on breastfeeding is asking for more facilities. That would be something we would like if there is a requirement to do it. It is basically requiring hospitals to have best practice, and I can talk about what the implications would be.

So they are still working towards it. They are a bit slower than they had hoped in New Zealand, but the Ministry of health has had ongoing contracts with NZBA because they are very impressed with the results they are receiving. There has been quite a noticeable impact on exclusive breastfeeding data, and I have summarised it up the top, but I have given you the data down below. In New Zealand, as in Australia, breastfeeding rates have virtually plateaued. What they have found is that since the hospitals started working towards ‘baby friendly’—and I think they still have not seen anywhere near the impact they are going to see—at six weeks they had a six-percentage point increase in exclusive breastfeeding rates, at three months they still maintained that six-percentage point increase and at six months they had a three-percentage point increase on the exclusive breastfeeding rates. Six-monthly figures are a bit hard to get because if somebody introduces solids at 5½ months then suddenly they are not exclusively breastfeeding. But, if you get good figures at three months, that is the trend.

Exclusive breastfeeding is associated with a longer overall duration of breastfeeding and better outcomes on a number of important health issues. If you can increase your exclusive breastfeeding rates—if mothers are having no comps in hospital and no comps in the early period—you get the beginning of a change in the cultural norm. It is a sign that people value breastfeeding and see it as important. It is important to completely breastfeed and not just think, ‘Well, I’ll give them a bottle here and there,’ or whatever.

Dr Vernon—I will bring that back to the Australian context. We have about 58 hospitals at the moment that are accredited in Australia. The initiative has been running here for 10 years. It has a large proportion of volunteer input. We have had multidisciplinary committees at the various state levels making contact with hospitals, providing education to them and encouraging them to apply for accreditation. The college has then been managing the assessment process. We have a certification or accreditation for people that undertake assessments—and Ros is one of those people—and we provide a team of assessors to each facility that follow a fairly regimented

process for identifying whether the hospital meets the UNICEF Ten Steps to Successful Breastfeeding.

Our efforts to expand the baby-friendly initiative in Australia have been mainly limited by the political factors that Ros was talking about. If there is support from a state health minister for the initiative then it is certainly a lot easier. South Australia, Tasmania and New South Wales are the states where that political support has been provided through to health facility managers. It has also very much come down to a resourcing issue in that the college is contributing substantial in kind resources. It is a modest sized organisation. We did have some Commonwealth funding for two years to support the expansion of the initiative. We had substantial growth: we doubled the number of hospitals that were accredited in those two years. But that funding has not continued so we are in a position where we need to cost recover as much as possible. We do not quite manage to cost recover, so the fees that we set for the hospitals to participate are pegged to the size of the hospital.

Ms KING—What sorts of costs are involved?

Dr Vernon—For a small hospital, which would be a hospital with fewer than 100 women having babies each year, the cost is \$3,000. The accreditation lasts for three years and then the hospital needs to seek re-accreditation. For a large tertiary hospital the cost is \$5,800. Those costs purely go into paying a modest honorarium for the assessors, travel—which is often required because we make sure the assessors do not have any association with the hospital, have not worked there or do not know any of the staff et cetera—and some of the labour costs for the administration of the process.

CHAIR—The Commonwealth is negotiating right now the next round of health care agreements. Should we put this in the health care agreements? Should this be written in?

Dr Vernon—If baby-friendly accreditation was seen as an expectation in terms of providing quality health care for units providing maternity services then I think the rest would flow. I will speak about community facilities in a moment, but we have only been accrediting hospitals and they have had competing priorities. Health dollars are scarce. In terms of spending money on accreditation, it is not only the actual assessment that they have to prepare for but also the investment they have to make, particularly in educating their staff. Ros would be able to fill you in on the details of that if you want to know more about it. Some hospitals have to make quite a lot of changes to what they have been doing to meet the standards; other hospitals are pretty close to meeting those standards before they apply so they do not need to do quite as many hours of staff training. But the hospital needs to arrange a trainer. More importantly, the difficulty and the cost for them is in actually backfilling the work that those staff would otherwise do if they were not at the training course. If it was in the health care agreement as part of an expectation that that resourced the institutions to access the accreditation, I think it would be viable for us to expand the initiative quite quickly. We certainly do not spend anything on marketing baby-friendly accreditation to hospitals. We have a website and that is it. We do not have any dollars to spend on letting people know about it.

Ms Escott—For example, I convened the committee that has been revising the documents—because the original documents were from 1991—and it has all been done by volunteers. I think we are the only country in the world where we have to have volunteers do this. We have done

some fabulous work. We submitted our work to the group revising the global documents for WHO and UNICEF, and I know that paragraphs I wrote are word for word in the global documents. So the work we have done has been really respected but it has been so slow because we have not had any funding. We were just not resourced to be able to do it. We are all in different states. We cannot get together and have meetings on a regular basis and get the work done because there are just not the resources.

Ms HALL—In effect, that impacts on the number of women who are breastfeeding long term, so it has an enormous impact.

Dr Vernon—One of things we are very keen to do is accredit facilities that are providing care in the community. We made a submission and were short-listed for some funding to assist a couple of years ago, but it did not end up happening. There is strong interest from the facilities that are providing care in the community to become accredited. Ros has been involved in a committee that has been developing the criteria—there are two other countries, I understand, that have also developed criteria—for accreditation if you are not providing birthing care but you are actually providing care to women in the post-natal period. For example, there are some of the family centres where women might live-in for five days and have assistance with their breastfeeding et cetera.

Ms Escott—The maternal and child health clinics.

Dr Vernon—We have had strong demand from those sorts of facilities saying, ‘We would like to become accredited,’ and we have not actually had a mechanism to accredit them. So we have now done all the work to develop it, but we just do not have the resources and the workforce of assessors to be out there accrediting those facilities as yet. The costs to us of just getting two people to each facility are pretty well the same whether it is a hospital or a community facility, yet they do not have \$3,000 to pay for those costs. We are trying to identify possible ways in which we might be able to resource that extension.

CHAIR—Why can’t it become part of the normal hospital accreditation?

Dr Vernon—We have certainly had conversations with the Australian Council on Healthcare Standards with exactly that idea in mind. I know that the commission on safety and quality is looking at accreditation systems at the moment. We have contributed to their hearings and we will see what recommendations they make. One of the risks to that approach, as I understand it, is that there is a great deal of specific expertise and particularly voluntary contribution being made at the moment to the baby friendly initiative by people like Ros and 70 or so others who are accredited assessors around the country. They are donating their time and expertise to that initiative. There is some anxiety that, if it moved over to ACHS, which the College of Midwives would have no problem with—our ambition is to see that the initiative exists and expands—some of that content-specific work that the workforce does with the individual institutions might not be continued. Part of that arises from the fact that, as well as being the assessors, we have a workforce of accredited educators—if someone is involved in education of a facility they will not be on the assessment panel—who provide a lot of the actual content-specific education to the institution that is looking at accreditation. I am not sure that ACHS has a component at the moment where they are doing that kind of on-site education to support applications for accreditation.

Ms KING—I want to go to the issue around community care. Obviously parents are engaged with the hospital system for a fairly brief period of time.

Dr Vernon—That is right.

Ms KING—What are some of the things that are barriers for women continuing breastfeeding? Can you talk a little bit more about how far the baby friendly initiative could actually go? You have mentioned maternal and child health centres. We have heard from pharmacists this morning. How far do you think it could go?

Ms Escott—I think you need to go back, first of all, to the hospital part. There is a lot of evidence that suggests—and it is the reason the baby friendly hospital initiative came in—that many women were leaving hospital already doomed to fail because of hospital practices. That is what baby friendly has been all about, and that is why that is the cornerstone: that you get them to initiate breastfeeding, which Australian women are pretty good at doing, and that you do not have them coming out of hospital, even two days later, doomed to fail. Step 10 of the baby friendly hospital initiative is to actually make links with the community and to encourage community support. That has recently been in the new documentation. It is making sure that women have contact quite soon after they go home and another follow-up two weeks later. There has often been quite a gap between leaving hospital and picking up community care—in some states more than others. The baby friendly community facility would then pick up and take off where step 10 leaves off. There is a lot of interest from maternal and child health centres. Once again, the issue is getting consistent education so that they are giving consistent information.

There has been study after study. There was a very big one in Victoria, where I think something like every woman who gave birth over a two-week period was given a questionnaire. The thing that came out strongest of all was conflicting advice about breastfeeding. In a baby friendly hospital they get consistent advice. Part of the interview process is that you actually talk to mothers. It is not just the hospital saying, 'We do this.' We say to the mothers, 'What was your experience?' They say, 'It's so different from when I had my last baby.' Then they need to get the same sort of consistent and good quality advice in the community about breastfeeding. That could include pharmacies or anywhere that women are seeking help.

The New Zealanders are actually taking a different approach. Instead of accrediting facilities in the community, they are looking at accrediting communities. A number of different organisations group together and they have one person pulling that together. They actually have funding at the moment to do some trials in two or three areas.

Dr Vernon—Another aspect of this is not to do with baby friendly accreditation but to do with picking women up from when they leave hospital—it can be even the same day that they have their baby—and following them through. The postnatal services in Australia are very patchy. The majority of women have no access to support from a health professional when they go home. That is something that we could do in a very cost-effective way that would make a vast difference to women's adjustment to parenting in terms of not just their breastfeeding but also other indicators, like mental health.

The college has put together a submission that we have put forward to a number of political parties in order to provide some of the evidence about the efficacy in other countries of

midwives following the women out of the hospital into the home. There are some medical services around Australia where that happens, but, with very many of them, there might only be one visit. South Australia has a policy, I understand, of having a single visit from a midwife. But that is often not the person who was involved in the woman's care previously—it is a newcomer. There is just one visit, and you cannot do a lot with one visit.

In fact, one of the consumers I was talking to the other day said to me that many of the consumers or the women that she knew in Melbourne regarded the visit by the maternal and child health nurse as a test rather than as a support mechanism. You had to have the house organised, you had to be dressed and have your hair washed and have the baby in a clean nappy when the maternal nurse came, because, if they found that you were in total disarray and really not coping with being a parent, they might take your baby away. I thought, 'Goodness—I am sure that the people trying to provide that support and care would be alarmed if they thought that was how women anticipated it.'

We should provide more effective ongoing visits. International best practice is visits by a midwife up to six weeks and ideally that midwife has been involved in that woman's pregnancy, labour and birth. There are randomised controlled trials showing the efficacy of that for supporting the transition to motherhood as well as supporting establishment and maintenance of breastfeeding.

Mr GEORGANAS—You were talking about the midwife coming every six weeks and so on. I think there was another time period—you mentioned that two weeks would be the ideal thing after the mums come out of hospital.

Ms Escott—One visit within I think 48 hours of discharge and then a second visit into the second week as an absolute minimum—but somebody seeing her in relation to breastfeeding.

Mr GEORGANAS—Is there an opportunity to make contact via the phone in that period?

Ms Escott—There should be.

Mr GEORGANAS—What happens is that you come out of hospital and everything is new to you. The baby is crying. It might be very easy to just go down to the chemist and get the formula. But if you have someone to talk to—

Ms Escott—One of the things that we would be assessing in a baby friendly hospital is whether they are providing follow-up support so that the mothers can actually phone the hospital. They are often the midwives that they know and who have cared for them, so they can at least phone the people that they know. They are also made aware of the Australian Breastfeeding Association as a contact point. But some women will use that service and some women will not, unfortunately. They are made aware of that. A lot of the child health clinics are providing new mothers groups. They are made aware of the range of facilities. There also needs to be cultural sensitivity in there so that women from different cultures are aware of possible support within their own culture or someone that they can see.

CHAIR—Mr Georganas, can you move that this submission be accepted as an exhibit?

Mr GEORGANAS—So moved.

Ms HALL—Also, maybe we should move that the letter that—

CHAIR—We did.

Ms HALL—There are two areas I want to ask you about, one of which was commented on earlier. Firstly, do we need to develop definite guidelines for midwives in pharmacies? Secondly, it has been reported to this committee that one of the criterion for the employment of midwives in some pharmacies is that they have to be prepared to recommend formulas. Would you like to comment on that?

Ms Escott—Yes, I have some comments, and they go back to my APMAIF days, when we occasionally got complaints about information that was given to mothers by the breastfeeding person—there is often a health professional employed. One of my concerns is that there is no regulation of the system. An increasing number of pharmacies are now employing a health professional for one day a week, five days a week or whatever it is. Many mothers use that service instead of going to maternal and child health—they will often weigh the baby, take photos and do other things—and get their breastfeeding advice. There is zero regulation. She could be a mothercraft nurse who has one year or six months of training, she could be a regular nurse, she could be a nurse midwife or she could be a lactation consultant. I think there needs to be some minimum standard. I heard of a mother who went to a pharmacy and was told by the mothercraft nurse—I do not want to bag mothercraft nurses—‘This is the formula. If the baby is unsettled put an extra scoop in.’ That is appalling advice which a colleague of mine overheard someone saying to a mother.

I think there does need to be some regulation. There is a very good service in Victoria, and I think another one in Queensland, which provides professionals to work in pharmacies so that if, for example, the one who comes on Tuesday is not available they will provide someone else. The nice thing about that is that they have standards for who they will employ and they provide them with ongoing, in-service education, so they are getting education about breastfeeding. That sort of a service is to some degree regulated and it is giving them some education. That is a really good quality service. I do not think any of those people have problems with pushing formula or whatever.

Dr Vernon—In consultation with the profession, the Australian Nursing and Midwifery Council has been developing a national code of ethics and a code of conduct for midwives. The council is the peak body for the regulatory boards that maintain the register for midwives. One of the requirements of the code is that it is not possible for a midwife to agree *carte blanche* to make a recommendation about a woman feeding with formula and they must abide by the code, which is part of their ongoing registration as a health professional. As a midwife, and also in the published competency standards for midwives, their responsibility is to provide support and advice to help the woman make informed decisions about all aspects of her care and then, once she has made a decision, to support her, knowing what she knows, to do that well. So, if a woman decides she wishes to feed with formula, the midwife would still be providing her with support and advice. But a midwife would not be in a position where, complying with the codes that are attached to her registration, she would ethically be able to sign something that says she will always recommend that women feed with formula. That would be a breach.

Ms HALL—Do you believe that should be a recommendation we make about the minimum accreditation?

Ms Escott—Yes, I think that would address some of the problems in pharmacies. If they had midwives, who are already covered by the code of ethics, that would address that issue.

Ms HALL—Earlier I alluded to the obesity study. Would you like to comment on that?

Ms Escott—I have briefly read it—quickly read it—

Ms HALL—Good.

Ms Escott—because it jumps out at you when you look at these things.

Ms HALL—Yes, it did.

Ms Escott—With many studies, particularly the ones where we in the breastfeeding world think, ‘That’s a surprisingly result because it goes against everything that we know,’ the first thing we look at is their definition of breastfeeding. That was a nurses’ study and they were looking at them as adults, meaning they were breastfed way back then. I can tell you now that they had solids introduced probably at six weeks, certainly at three months, and they probably had supplements of infant formula, cow’s milk or something else added into their diet very early. If you did a study of children who were properly breastfed, especially if they were exclusively breastfed, you would get very different results. That is what they find with almost every criteria that they look at, particularly where they are looking at those retrospective studies—some of that was prospective, but their infant-feeding data was retrospective—it will be because there was very early introduction of solids and probably early introduction of other milks.

Ms HALL—Do you think there is a need for a longitudinal study on this issue and other issues relating to breastfeeding, starting from birth and tracking that baby through—

Ms Escott—Some studies have been done. I think they already have some good data in Western Australia. Wendy Oddy has been doing a lot of allergy research. I think she gave evidence to the committee at some stage.

Ms HALL—A submission.

Ms Escott—She has done a lot of allergy research, where her definition of breastfeeding at the beginning was excellent, because it was a prospective study. A SIDS study was originally done through the Menzies Centre, but they have this cohort in Tasmania from about 12 years ago, where they did get prospective data and they are now studying that group. For example, they did a study on the bone density of a subgroup of them, children at the age of about eight to 10 and discovered that the only thing that correlated with better bone density was whether they were breastfed for six months. It was not to do with how much vitamin D they received or how much calcium was in their diet; breastfeeding seemed to be the strongest factor. They are suggesting that if that tracks through to the mid-20s—calcium builds up in your bones until about the mid-20s and then it starts to decline—and if you could reach a higher peak of bone

density in your mid-20s, you are protecting against osteoporosis, or it will occur much later in life. It started with six months of breastfeeding.

CHAIR—There was an issue raised with us in Brisbane: by being aggressive in advising people that they should breastfeed, it is causing a certain guilt among women for not breastfeeding. Do you have a comment on that?

Ms Escott—The answer is the same as with respect to smoking. It is actually more complicated than that. ‘We can’t make women feel guilty,’ has been around for a long time. I think this is such an important health measure that we are actually negligent if we do not give women full information about it. Women feel bad if they did not breastfeed and then later discover how important it is and think, ‘Perhaps I should have bothered, but nobody told me at the time.’ As a lactation consultant I travel on aeroplanes quite a lot. People sit next to me and they say, ‘What do you do for a job?’ I say, ‘I’m a lactation consultant.’ I have had middle-aged women, and older women, in tears saying, ‘I wish you had been around when I had my babies. They just told me to put the baby on the bottle or whatever.’ Women still get appalling advice. This is too important to say, ‘We mustn’t make them feel uncomfortable.’ This is really important stuff. When you go through the health implications of breastfeeding alone—apart from IQ issues or anything else—they are massive and they last for the rest of your life.

Dr Vernon—I think it also comes back a little bit to the marketing picture. We have written a letter to MAIF, because one of my staff picked up a magazine at a supermarket last week, and it was absolutely littered with promotions for infant formula. If we had as many pictures of a woman breastfeeding her baby showing how happy, healthy and thriving that baby is, alongside pictures for the formula, then at least it would be something that people are seeing and thinking about. We as a society spend a lot of time and energy and we have a lot of money invested in promoting alternatives to breastfeeding. We need to find some way of turning that around.

Mr GEORGANAS—It is a cultural thing, too. We have to change people’s attitudes, the way that we think.

Ms Escott—A huge cultural change is required.

Mr GEORGANAS—That should start in very early childhood.

Ms Escott—Certainly working in the schools.

Mr GEORGANAS—Breastfeeding should be seen as a very natural part of life, a normal thing.

Dr Vernon—We should start in the schools and work our way forward.

Ms Escott—Jim Akre, who was with the World Health Organisation for many years and responsible for the WHO code, often said that infant formula should be seen as a life saver, only to be used in emergencies, not just part of normal life. It is important that we have it for the babies who cannot be breastfed; they must be fed on infant formula. But it should not be normalised or seen as you just pick it up off your supermarket shelf.

CHAIR—The rural nurses have agreed to come and see us in a fortnight's time. Thank you very much.

[12.11 pm]

McKENZIE, Ms Ingrid, WEL Maternity Services and Breastfeeding Working Group, Women's Electoral Lobby Australia

POLLOCK, Ms Natasha Ann, WEL Maternity Services and Breastfeeding Working Group, Women's Electoral Lobby Australia

ELDRIDGE, Ms Sally, Private Capacity

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

Ms McKenzie—The Women's Electoral Lobby has been around for quite a while, as I am sure you are all aware, but I thought I would run through a bit of what the Women's Electoral Lobby is about, just in case you have all forgotten. WEL Australia is a national independent political organisation, established in 1972, dedicated to creating a society where women's participation and potential are unrestricted, acknowledged and respected, and where women and men share equally in society's responsibilities and rewards. We would like to express support for the recognition of the importance of breastfeeding in promoting the health and wellbeing of Australians, whom members of this parliamentary inquiry represent, as well as our hope that this inquiry will lead to real action on the ground as soon as possible to improve the life outcomes of thousands of individual Australian children and their mothers as well as benefit the nation as a whole.

It needs to be recognised that the overwhelming majority of Australian mothers want to breastfeed, and figures from the 2004 longitudinal study of Australian children show that over 90 per cent of women initiate breastfeeding while in hospital. I am sure you have heard that many times already. You have also heard that it falls away dramatically once they are discharged from hospital. It is often said that women choose to breastfeed or not, but we question what kind of choice that is, and whether women have real choice. Our society does not do enough to support breastfeeding, leaving women with the only choice or option of giving their babies artificial milks. It is this lack of real choice that hurts the health and wellbeing of current and future mothers as well as their babies. We will not run through the submission, because it is all there; we just wanted to highlight a few key areas that we thought were important.

Internationally, numerous treaties and conventions recognise the social function and nutritional benefits, as well as the economic and environmental gains, attributed to breastfeeding. They also recognise the important role governments play through legislative and funding programs in the protection, promotion and support of breastfeeding. Social and economic trends have meant that breastfeeding rates and duration, and the corresponding lack of shared experience, which I am sure you have heard about, and understanding about breastfeeding have diminished. Breastfeeding, although widely recognised as the best mode of

feeding our babies—and more recently we have been talking about it being the safest mode—is not the norm, as you have just been saying. Our point is that governments have a crucial role in reversing the trend—one which has not really been taken up very much.

The submission had a number of recommendations in it, but we would like to add a couple of other things. We recommend that the government appoint a national breastfeeding coordinator, an appropriate authority to oversee an integrated, whole-of-government national breastfeeding strategy—and that has been lacking in this country. Without this kind of strategy, the breastfeeding targets that have been set—specifically the National Health and Medical Research Council targets—have certainly not been met. We have only to look at the statistics about the decrease of exclusive breastfeeding and the plateauing of any breastfeeding over the last 15 years.

The current resourcing by the Commonwealth government is, to put it mildly, minimal. We find that particularly surprising in light of the current budgetary position when it is such an important public health initiative. You have heard and seen in the Australian College of Midwives baby-friendly submission about how the baby-friendly hospital initiative improves the exclusive rate of breastfeeding. We are most interested in improving that exclusive rate. The Women's Electoral Lobby supports them in their submission and finds it surprising that, as Barb said, the government did fund the baby-friendly initiative for a couple of years. As you know, it is an internationally recognised and supported, evidence based and fairly simple preventive public health initiative, and it had its fairly meagre funding discontinued a couple of years ago. We support what Ros was talking about: a top-down requirement for hospitals to become accredited. They have covered all that.

The next thing we want to mention is statistics and data collection. I am not sure whether people have mentioned that already. It was certainly part of a number of the submissions I looked at. There is currently no comprehensive national monitoring and surveillance system in place to monitor and report breastfeeding patterns. We need that data, and the government needs that data, to inform policy. My personal experience here in the ACT is that governments just do not place adequate importance on the asking of the questions and the collection of the data, so everyone says, 'Prove that,' and there is no data to prove it.

We recommend that the national perinatal data collection survey includes the data collection questions that hospitals are required to collect for their baby-friendly accreditation purposes. A lot of hospitals find it difficult to bring all that together but, again, if it is required and if it is part of the wallpaper, that is another step that makes it easier.

Ms HALL—That could be standardised, couldn't it?

Ms McKenzie—Yes.

Ms HALL—It does not have to go to each individual hospital to do that.

Ms McKenzie—No. If it is part of the national data collection, it means that everyone has to do it. It is not a drama. They do not have to say, 'We can't collect that data; it's too complex.' You just do it; it is one of those requirements.

CHAIR—Including the private system.

Ms McKenzie—Yes.

Ms HALL—Standardise it.

Ms McKenzie—That is right. Of course, that covers data up until discharge from hospitals; it does not cover the later breastfeeding data, which is well known as being difficult to collect. For that reason, we think Commonwealth leadership is really important in setting up some methods of standardisation for the later collection of data.

Ms Pollock—The Women's Electoral Lobby also wanted to raise the issues of paid maternity leave and breastfeeding friendly workplaces. For women to initiate breastfeeding successfully and also to continue to breastfeed they need some form of universal paid maternity leave and access to breastfeeding friendly workplaces. Paid maternity leave assists women to continue to breastfeed for longer and also to initiate breastfeeding, because it provides women with a continuous source of income and employment security following the birth of their baby. There are many work related reasons for early weaning and also for women not initiating breastfeeding. Early return to full-time work has been identified as one reason why some women do not even initiate breastfeeding. Mothers working outside the home and full-time work are more of a problem than part-time work in that respect.

Other issues are: lack of support and knowledge about breastfeeding management while employed; a non-supportive work environment, including a lack of lactation breaks for women to feed their babies; problems with pumping breastmilk—some women do not know what to do or what to use et cetera; healthcare professionals' lack of knowledge around expressing and returning to work; a perception that infants at work impede mothers' work and job performance—in those instances where it might be best for the baby to be brought in to the mother—and it is not considered within the scope of the business; a lack of privacy for breastfeeding or for expressing milk; an inability to find childcare centres at or near the workplace; and the high cost of child care and long waiting periods.

There is a strong business case for employers to support breastfeeding women and to support the introduction of breastfeeding friendly workplaces. It is a low-cost intervention which supports a family friendly work culture. It improves female retention, with some studies showing over 90 per cent of females returning to the same workplace. There is an earlier return to work in some cases, as well as reduced absenteeism and staff turnover—reduced absenteeism because breastfed babies are sicker less often and for shorter periods of time than bottle-fed babies. It can also be an easier work transition, and it acknowledges the needs of employees and so improves the relationship between the employer and the employee, which can boost morale and lead to greater loyalty. It can improve employee productivity, and some studies have shown a cost saving of \$3 for every \$1 invested in breastfeeding support. There was a US program that supported breastfeeding women in their return to work, and it had significantly improved results compared to the normal US breastfeeding initiation and duration levels.

We are also concerned about the continuity of care. Breastfeeding rates have also been shown to be improved by provision of a continuity care model of maternity care. This model sees maternity care provided to a woman by one midwife throughout her pregnancy, birth and post-

birth periods, because breastfeeding is not separate from the birthing experience and it needs to be considered in that context.

In summary and in conclusion, WEL urges the committee to make recommendations which take into account the special needs and concerns of all women, including Aboriginal and Torres Strait Islander women, women from non-English-speaking backgrounds, adoptive parents, young mothers, single mothers and same-sex couples, especially when talking about paid maternity leave and breastfeeding friendly workplaces. The vast majority of women want to breastfeed but do not receive the support and accurate information that they need to do so. Women need to make the choices that best suit their needs and their family situations, and they have a right to make an informed and supported decision about how they will feed their babies. Many women are currently not in a position to make such an informed and supported choice, which we think needs to be rectified.

Ms HALL—Thank you very much, Natasha. I understand that you have some material with you that would give us some insight into the effectiveness of the MAIF agreement. Would you like to share that with the committee? Maybe we could copy it, or whatever we need to do, to demonstrate it. Could you say what it is for the record?

Ms McKenzie—Okay. I am showing you a bag. It says on it, ‘Mammal—follow-up formula—six months onwards.’ It has lovely little pictures of toys and happy bears on it. At the bottom it says, ‘GMX—we know how champions grow.’ Do you!

Ms HALL—How was the bag supplied to the person who owns it?

Ms McKenzie—You will have to refer that question to our colleague Ms Eldridge.

Ms HALL—Is the manufacturer of that bag and that formula a signatory to the MAIF agreement?

Ms Eldridge—That bag was actually rescued from an op shop and taken out of circulation. It was brought into the country from Singapore, to the best of my knowledge. I have tried to research where it came from because it was of great concern to me that I found it in Australia. I think it has come from Singapore, but it has made its way back into the system. To me it represented probably what used to be done in Australia—there was that close link between formula companies and hospitals—and what could happen again if the MAIF is not tightened or strengthened. Inside the bag are a whole lot of examples of the advertising material that hangs out in my letterbox, my community and my supermarket that mothers are exposed to.

Ms Pollock—Lots of mothers are exposed to it through, for example, things like *Canberra’s Child*, *Sydney’s Child*, *Melbourne’s Child* and *Brisbane’s Child*. These newspapers are very widely read by mothers. It is very widely read and looked at.

Mr GEORGANAS—What is in that newspaper?

Ms Pollock—There are pharmacies advertising in this as well. In this newspaper there is a toddler health special—‘Organic first foods and toddler snacks’. That is a follow-on formula. It frequently has full-page ads in it.

Ms Eldridge—Those adverts in the parenting magazines come in under a health issue and an education issue. Some of the adverts are ones that convey that your child will be more intelligent if they take this stuff.

Ms Pollock—This is from *Canberra's Child*.

Mr GEORGANAS—How long ago was this published?

Ms McKenzie—June 2006.

Mr GEORGANAS—So only last year.

Ms Pollock—You will see them in every edition.

Ms Eldridge—They are in every edition across the country because they are replicated across the country.

Mr GEORGANAS—I can see the formula at the bottom.

Ms Pollock—Yes—it says, 'Getting your toddler enough nutrients can be a challenge.'

Ms HALL—This is really emphasising the need to include toddler formulas, isn't it?

Ms McKenzie—Yes.

Ms Eldridge—Here is another toddler one: 'Sarah won't eat these things, but she will drink them.' There is a little toddler cup there.

CHAIR—I think we have made the point on that.

Ms KING—We have heard from lots of groups about issues to do with health and in-hospital care et cetera, but you are one of the groups that specifically focused on workplaces. Thank you for your comprehensive submission in that area. Is there anything more that you want to add about that area given that you are one of the few groups that is in fact submitting on the whole of the system—the whole of women's experiences, both in the community and at work—and how that affects their breastfeeding?

CHAIR—Can I add to that. Can you give us some examples of good workplaces that are breastfeeding friendly?

Ms Pollock—There are some workplaces, like Westpac. They have paid maternity leave and paid paternity leave, and they also have introduced the ABA's breastfeeding-friendly workplace accreditation. They feel that has been a huge success; 66 per cent of their workforce are women, and a thousand women are accessing paid parental leave each year. Unfortunately there is not much research in Australia on the correlation between—

Ms KING—Westpac have childcare centres as well, don't they?

Ms Pollock—Yes, they do.

Ms KING—For their staff.

Ms Pollock—Yes; they have been voted the Equal Opportunity Commission's family friendly workplace for five or six years in a row or something, or even longer. There is not much research in Australia about the effectiveness of breastfeeding-friendly workplaces, on the initiation and upkeep of—

Ms HALL—So that is an area we need to look at, for research?

Ms Pollock—Yes, we do. The study I mentioned in the US was over 4.5 years. There were 462 women in that study.

Ms KING—Have you got a reference for that that you could provide us, unless the secretariat has already got it? If we could get a reference for that it would be helpful.

Ms Pollock—Five companies took part in that, from very different work environments. It was an employer-sponsored lactation program, and in it were breastfeeding-friendly workplaces as well as lactation support from a lactation consultant. So it was bigger than a breastfeeding-friendly workplace as we would know it here. There was a 97.5 per cent initiation of breastfeeding, compared to 69.5 per cent in other studies in the US. There was 57.8 per cent breastfeeding for at least six months, compared to 10 to 25 per cent. These are huge numbers for the US especially. Of the 462 participants, 94 per cent returned to the same job, 79 per cent attempted to express at work and 98 per cent succeeded. So, if women are given the right information, the right equipment, the space to do it in and the privacy, they can successfully do this if they are supported to do it. And 90 per cent returned to work before their babies were five months old, so they were returning to work quite early. But because they were supported they could continue to breastfeed. The mean age when pumping discontinued at work was at 9.1 months, and the mean number of months that they expressed for was 6.3 months. The maximum was up to 21 months. That shows what a success it can be if it is implemented properly.

At the moment there is no onus on employers to make a workplace breastfeeding friendly, and women do not know what their rights are with respect to that. There needs to be education for the women, for the employers and for the other employees as well, because women need the support of their fellow employees.

CHAIR—Thank you very much for appearing before us today. Before I close the meeting I call upon Jill to move that the committee authorise the publication of the evidence given before it today at the public hearing, including publication on the parliamentary electronic database of the proof of transcript.

Ms HALL—I so move.

CHAIR—There being no objection, it is so resolved. I declare this meeting closed.

Committee adjourned at 12.33 pm