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THE *Maternity Coalition* INC

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27 February 2007

Mr Alex Somlyay
Chairman
House of Representatives Standing Committee on Health and Ageing
Inquiry into Breastfeeding
Email: haa.reps@aph.gov.au

Dear Sir

Please find attached our submission to the parliamentary inquiry into breastfeeding.

Maternity Coalition is pleased to present this information and recommendations to the inquiry. We look forward to appearing before the inquiry in due course.

Yours sincerely

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National President

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SUBMISSION TO PARLIAMENTARY INQUIRY INTO BREASTFEEDING

CONTENTS

EXECUTIVE SUMMARY

Maternity Coalition's focus in this submission is on the care women and babies receive in acute maternity care and in the early postnatal period. Some of the concerns about establishing breastfeeding that have been expressed to us by women who have given birth recently include:

- The increasing medicalisation of birth, with babies being 'drugged' and unable to respond as a result of receiving opoids including pethidine, morphine and fentanyl;
- The increasing rates of Caesarean births, with subsequent separation of mother and baby, and the difficulty/pain experienced by the mother in handling the baby;
- Fragmentation of care – new mothers do not have a known primary carer, and do not know who they can trust;
- Conflicting advice, with poor coordination of the many professional caregivers who advise them on breastfeeding (midwives, nurses, doctors, and others); and
- Inadequate postnatal services and peer support in the community after discharge from hospital.

The first days and weeks of a new baby's life are extremely important in the establishment of breastfeeding. Any separation or interruption in mother-baby contact, or any artificial food or artificial sucking device given to the baby may interfere with the natural processes of suckling and lactation. Although breastfeeding is a natural process, and both mother and baby have instincts that support breastfeeding, there are many skills and adaptations that mothers and babies achieve in their early days together. Furthermore we know that many maternity hospital routines, including separation of mother and baby, supplementing the intake of breastfed babies, use of bottles and teats, and the medicalisation of birth have historically been a root cause of poor breastfeeding outcomes.

We strongly recommend a return to non-medicalised birth as the norm, with medical and surgical interventions when indicated (ie not for convenience or routine or to avoid potential litigation). We consider the under-utilisation of the midwifery workforce, as primary maternity care providers, to be a significant feature of maternity care that has lost sight of the natural processes in birth and breastfeeding. A culture of promoting, protecting and supporting the natural processes in both the mother and the baby will result in an improved acceptance of breastfeeding by both consumers and professionals.

In providing comment on the six questions posed by the Inquiry, we have offered recommendations that are consistent with our view.

AUTHOR

This submission was prepared by Joy Johnston with assistance and comment from other members of Maternity Coalition. Joy Johnston is a midwife and lactation consultant, and Editor of Maternity Coalition's quarterly journal Birth Matters. For further comment or information, please contact inquiries@maternitycoalition.org.au.

Recommendations

MCs recommends to the Inquiry:

Question 1

1 That the Government require all maternity care providers to implement guidelines that aim to reduce unnecessary medicalisation of childbirth, as part of their accreditation and funding agreements.

2 That rewards and incentives be provided to maternity service providers, including self employed midwives, who demonstrate acceptable rates of caesarean births for the population they service.

3 That monitoring of clinical indicators, such as rates of caesarean births for healthy women who reach Term, be linked to monitoring of breastfeeding rates in data that is collected by the State and Territory perinatal data collection agencies.

Question 2

4 That the sale of breastmilk substitutes, including so called 'Toddler formula' be restricted; requiring them to be sold in pharmacies or other regulated premises, and then must be kept 'behind the counter,' with no promotion or advertising

5 That funding be provided to improve the education of the public in the value of breastfeeding.

Question 3

6 That the promotion, protection and support of breastfeeding be valued as a priority in health promotion in all communities.

Question 4

7 That all hospitals providing maternity services be required to achieve BFHI accreditation, or demonstrate that they are working towards BFHI accreditation, as part of their funding agreements.

8 That funding be provided to support the work of organisations such as MC and ABA, in establishing community based peer support groups for mothers.

Question 5

9 That a multi-disciplinary review, with representatives of maternity consumer organisations, be established to investigate and advise the Government on the education and accountability of health care professionals who advise mothers on infant feeding.

Introduction

Who is Maternity Coalition?

Maternity Coalition (MC) is Australia's national maternity consumer advocacy organisation, and is made up of groups and individuals committed to improving maternity care for all Australian women.

MC was formed in 1991, and has branches and member groups in every state and territory. See Appendix A for a list of member groups.

Why is Maternity Coalition responding to the Inquiry?

MC's interest in breastfeeding is to promote the optimal nourishment and health of the baby, promote the optimal health for the mother, and encourage mother-baby bonding as integral parts of the pregnancy-birth-nurture continuum.

While MC respects women's decisions and choices within maternity care, we state unequivocally that professional service providers and levels of government must clearly promote and support practices that help and do not harm the recipient of the service. In the case of the newborn infant and young child in the first two years of life, the protection, promotion and support of breastfeeding is essential.

Why is breastfeeding important?

Our submission to this Inquiry is based on philosophical and scientific understandings that:

- Pregnancy and birth and breastfeeding are a natural process, not an illness. The events and experiences in pregnancy and birth have significant effects on the mother and baby in the postnatal period, and can impact on the ability of the mother and baby to establish breastfeeding.
- The mother and her baby must be the focus of any proposed changes in breast-feeding policy. For each woman social, cultural and psychological factors play important roles in her childbearing and child raising experiences. The attitude of the woman's partner and other family members towards breastfeeding influence the long term outcomes.
- Health promotion is a key activity in all maternity and children's services, enabling each woman to take control of her needs and those of her baby. Women have a right to informed decision-making about their care. This also implies taking responsibility for the health and wellbeing of the baby who is totally dependent upon that care.
- Women require access to primary care on a one-to-one basis from a known midwife throughout the episode of care. The principles of partnership between a woman and her known midwife are enshrined in the Definition of the Midwife (ICM 2005).
- Women and babies require access to seamless appropriate medical and other health services that respect the mother/baby unit as central in the care, when complications arise for either the mother or the baby. Such complications include physical illness, psychological or psychiatric conditions, disability or social problems.

First Inquiry Question:

1. The extent of the health benefits of breastfeeding

MC draws the Inquiry's attention to the peer-reviewed published work by Julie Smith and colleagues (2002), "Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory". The researchers "identified relative risks of infant and childhood morbidity associated with exposure to artificial feeding in the early months of life vs, breastfeeding. ... This study suggests that the attributable hospitalisation costs of early weaning in the ACT are about $1-2 million a year for the five illnesses [gastrointestinal, respiratory, otitis media, eczema, and necrotising enterocolitis]."

Significant research has demonstrated many health advantages to babies who breastfeed. We highlight the following:

- **Better infant general health.** Infants who are not breastfed have a larger number of medical conditions requiring some treatment including ear infections, upper respiratory tract infections, gastro-intestinal infections and disturbances, atopic conditions, allergy and intolerance of dairy products, allergy to latex or silicone, thrush, and oral malocclusion. Breastfed babies are, generally, more healthy than their non-breast-fed neighbours.
- **Better maternal health:** Mothers who do not breastfeed in the immediate postnatal period are at increased risk of haemorrhage and subsequent anaemia.
- **Reduced psychological disturbances for mother and baby:** Early uninterrupted skin-to-skin contact of a mother and her newborn baby, enables both mother and baby to establish lifelong strong psychological attachments or bonding, protects the breastfeeding relationship.
- **Improved child spacing:** Mothers who breastfeed their infants to the standard set by World Health Organisation (exclusive breastfeeding for six months, followed by gradual introduction of suitably prepared family foods while continuing to breastfeed to two years and beyond) are able to use natural family planning through the Lactational Amenorrhoea Method (LAM).

1.1 Social issues in breastfeeding

In discussing breastfeeding from a global reproductive health and rights issue, authors Menon and Amin (2005) present strong social and economic arguments, understanding breastfeeding as "a human right, a woman's right and a reproductive right. In order to realise these rights in full, some fundamental precursors include gender equity, the right to life and survival, the right to exercise choice which is free from commercial or political coercion, and the right to food." (Saira Shameem in the Foreword to Menon and Amin (2005). This publication is particularly relevant to the Inquiry's focus on disadvantaged, Indigenous and remote communities, and to migrant peoples who have come to Australia from developing countries.

Realities in women's lives during their childbearing in Australia, that have a significant impact on breastfeeding, include increasing rates of caesarean surgery for birth, access to appropriate maternity services, the need for paid work, job security and maternity leave, changing patterns of family and social support, contraception and family planning, and violence against women.

The following brief case studies, first person accounts by mothers of their experiences, are presented to illustrate some of the complex interactions of a woman's social issues, maternity care, and breastfeeding.

1.1.1 Case Study 1: Increasing rates of caesarean surgery for birth are well documented in all Australian communities. A consequence of birth [a natural, physiological process] becoming more and more a surgical, medically managed process, is the separation of mother and baby, and delayed commencement of breastfeeding. Sallyanne Naylor's first person account of two caesarean births (for publication in Birth Matters Vol 11.1, March 2007) illustrates this point:

... As I lay in the operating theatre, I waited what felt like a lifetime for my daughter to come to me after she had been lifted out of my belly and carried out of view to the other side of the room, with me allowed a brief touch as she passed over my head. Finally, a tightly wrapped newborn baby was handed to me. I tried to stroke her face and the top of her head – the only part of her body I could see or touch, but was too restricted by the pulse cord which left no free hand.

In recovery, the binding of my baby wasn't our only barrier as I struggled to get down the hospital gown in a feeble attempt to try and breastfeed. No assistance was offered and when I asked for help it was all too hard. ... Even this contact was short-lived however, as the drugs they fed into my system began to take effect and I could no longer stay awake to hold her.

The following day, and some 20 hours later in the fog of pethidine they had continued to pump into my body after the collapse of the epidural, it suddenly dawned on me that beyond her face and the top of her head, I still hadn't seen my baby's body.

32 hours after her birth, Stephanie finally attached and was able to suck.

19 months later with my second child's birth, I again ended up with an emergency caesarean, but this time I was prepared and no longer quite so naïve. During this pregnancy, I approached different hospitals with a list of 'must haves' for labour and birth, whether caesarean or vaginal. One hospital met all my criteria and when our baby was born, he was given the minimal medical attention by the pediatrician, all done within my view. I was able to hold him unwrapped and look at his sex and count his fingers and toes and hold onto his naked body. In recovery, the first thing they did was help me get down my gown so I could breastfeed. While still experiencing the emotions that came with not being able to birth vaginally, it didn't come with the utter despair and emptiness that my first birth had been. There were many positives to take away and treasure, not least of which was that early contact - something Jack and I will have for the rest of our lives, even if he doesn't consciously remember it.

... Dr Heather Rowe-Murray and Associate Professor Jane Fisher [2002] at University of Melbourne undertook a survey of 203 women in four Melbourne hospitals were interviewed at two days postpartum and the researchers found that "mother-baby pairs were being routinely denied (skin-to-skin) contact after birth by the practice of caesarean section"(1). In addition, their study 'of women eight to nine months after childbirth found one of the factors associated with significantly increased chances of depression was the mother's inability to hold the baby after the birth' (2).

Rowe-Murray and Fisher write: "Knowledge of the emotional components of first stage labour is being harnessed in the service of better outcomes for women and babies ..." "early mother-infant contact may be a psychosocial casualty of medically managed delivery". They contend, however, that "optimal care can also be approached when there is operative intervention in delivery" (2).

In examining the effect of delayed mother-infant contact on the initiation of breastfeeding (1), Rowe-Murray and Fisher make recommendations on practices that support early initiation of breastfeeding. "Practices that support early initiation of breastfeeding after caesarean section include, first, the elimination of routine observation of the well newborn in a special care nursery, a practice that may be economically rather than clinically indicated. Second, a delay in routine neonatal procedures could be instituted, to enable mother and baby to remain in close early proximity. Third, it is possible to staff the postoperative recovery area with a midwife or other appropriately qualified individual, whose responsibility is to care for the baby, while the mother remains in the care of the delivery nurse." The authors refer to a previous study which found "temperature regulation in the first hour after birth can be achieved by skin-to-skin contact with the mother."

"Fourth, mother-baby contact is fostered by flexible policies that allow the pair to be transported together from the recovery area to the postnatal ward. All policies that rely on the provision of sufficient numbers of appropriate staff should be in place regardless of the time of day or night. Fifth, couples should be informed prenatally that discussion with their in-hospital caregivers about postoperative hospital protocols may be advisable to avoid potential delay in mother-infant contact after caesarean delivery."

The increasing levels of caesarean births, make such practices "a matter of public health concern".

References
1. Rowe-Murray H and Fisher J R W, 2002. 'Baby friendly hospital practices: Cesarean section is a persistent barrier to early initiation of breastfeeding', Birth 29:2 June, pp 124-131.
2. Rowe-Murray H and Fisher J R W 2001. 'Operative intervention in delivery is associated with compromised early mother-infant interaction', British Journal of Obstetrics and Gynaecology, vol. 108, pp 1068-1075.

1.1.2 Case Study 2: Breastfeeding after spontaneous unmedicated birth, with a known midwife (From Emma's Birth, by Kylie Wise. Published in Birth Matters, Vol 10.4, December 2006)

... Leaning forward over the pool felt like the right position and ... Emma's body seemed to come out quickly and the next thing I remember [midwife] was handing Emma to me and it was all over!

I hopped up out of the pool with everyone's help and moved over to the couch. The placenta came about 15 minutes after Emma was born and it came out easily. The midwife showed us the placenta and Emma started to have her first breastfeed while we were sitting on the couch. After an hour or so, our midwife weighed Emma and I was quite shocked to see that she was 4.5kg – she still seemed so tiny to me.

1.1.3 Case Study 3: Breastfeeding after a spontaneous unmedicated birth, with a known midwife, when complications arose postnatally (From *Partnership: the importance of the one to one relationship with my midwife*, by Nicole Tricarico, published in Birth Matters, Vol 10.2, June 2006)

... I was very happy with the birth and all was good for a while, I had held my boy, showered, tried to get him to feed and we weighed him, then after a few attempts at getting the placenta to come out, I fainted and started to haemorrhage. My midwife tried again but I could feel it was stuck and wasn't coming out ...

When I was still in surgery having the placenta removed, our midwife (as well as my husband), was there to ensure my wishes were carried out. When the hospital midwives wanted to give Reuben formula as he was hungry, my midwife came into recovery and expressed some colostrum so Reuben could be fed. It was great to know that if a situation like this did arise I had total faith that my midwife would see that everything was handled.

My frustration in hospital was huge, while some midwives were great, they all told you something different regarding breastfeeding. The lack of continuity was appalling and I can certainly see why very few women breastfeed long term. Once I did get home, Andrea spent a lot of time helping me get breastfeeding established, and after the first couple of weeks I was confident and it continues to go well seven months down the track.

Having a midwife who instils confidence in your ability to give birth and breastfeed is priceless. I know that they give you contacts for help with breastfeeding etc in hospital, but I would be much less likely to seek this out, than to ask someone I know and trust well to help or offer advice. Because you spend so much time during the ante-natal visits getting to know and trust your midwife, when it comes to the birth, I think that you just know and agree when intervention is required, and afterwards, there is just no doubt that breastfeeding will happen.

I feel that it's vital that this type of care is offered and promoted to women, as it will make a huge difference to women's birth experiences and also their ability to breastfeed long term. ... I would never choose another system of care if I have more children, or another midwife for that matter as the partnership is that important to me. Partnership to me is working together supporting each other to achieve your goals, which is my case was achieved despite and also because of my complications.

1.3 Contemporary research

Further concern about potentially serious effects of medical intervention into birth is highlighted in Research Roundup, prepared by David Vernon, and for publication in Birth Matters Vol 11.1, March 2007.

Epidurals can make breast-feeding a struggle

International Breastfeeding Journal 1:24 11 Dec 2006 (Available online)

If you have an epidural, be prepared for a longer than normal settling in period while you and your baby are learning to breastfeed.

1280 women who gave birth to a single live baby in the ACT were studied. In the first week after the birth, 93% of women were either fully or partially breastfeeding their babies. This fell to 60% after 24 weeks. It appears that women who had epidurals were less likely to fully breastfeed their babies in the first few days and were also more likely to stop feeding within the first 24 weeks.

The effect was quite marked with women who have had epidurals being twice as likely to have stopped, even after taking into account other issues such as education and the age of the mother.

It appears that the culprit may be the opiate-derived drug fentanyl which passes easily into the bloodstream and thus quickly crosses the placenta and into the unborn baby. The baby appears to react to the fentanyl and lose its ability to instinctively feed. The same effect has been noticed by midwives in babies whose mother has had an intra-muscular injection of pethidine, shortly before delivery.

See also: Article in The Australian by David King, 11 Dec 2006 (Available online).

MCs recommends to the Inquiry:

1 That the government require all maternity care providers to implement guidelines that aim to reduce unnecessary medicalisation of childbirth, as part of their accreditation and funding agreements.

2 That rewards and incentives be provided to maternity service providers, including self employed midwives, who demonstrate acceptable rates of caesarean births in their client population.

3 That monitoring of clinical indicators, such as rates of caesarean births for healthy women who reach Term, be linked to monitoring of breastfeeding rates in data that is collected by the State and Territory perinatal data collection agencies.

Second Inquiry Question:

2 Evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;

2.1 General marketing:

The marketing and promotion of breast milk substitutes in any community leads to the widely held assumption that there is a clear 'choice' in the matter. For example, a mother who entered 'My Pharmacist' store at Box Hill Central (Victoria) on Wednesday 7th February 2007, was confronted by the following infant formula 'on special'. The tins where stacked in the entrance and the main counter.
"S-26 Toddler Gold 'Save $3' now only $12.99"
"Nan Gold 2 with Bifidus 'Save $2' $17.99".

A pharmacy is the place where people are often directed by their doctor to obtain medicines and other treatments, in a highly regulated market. At times people speak to the Pharmacist about conditions they are experiencing, and the Pharmacist may advise them about management and over-the-counter treatments. It's an environment in which a professional exercises a duty of care to advise the customer correctly. The promotion and marketing of breast milk substitutes in this environment of professional trust can be, at best, confusing. A well-informed mother might not pay any attention to the 'specials' being promoted in the pharmacy. But a woman from a socially disadvantaged background, or a woman who has migrated to Australia from a developing nation, may respond to this marketing in the way that the manufacturers intended, and purchase the product, believing that items promoted in a Pharmacy must be good for her baby.

One significant feature of breastfeeding, and breast milk production, is that once lost or devalued, breastfeeding is not easily retrieved. The natural process in the human body is that suppression of lactation is, to the woman's body, the equivalent of loss of the baby. The woman's body's processes revert quickly to the non-lactating state. This physiological reversion can happen in a brief period, such as the first week of the baby's life, or more gradually over a period of weeks. Furthermore the supplementation of a breastfed baby's intake with artificial feeds reduces the mother's milk production through a supply and demand mechanism. These facts are addressed in the WHO-UNICEF global criteria for the Baby Friendly Hospital Initiative, in seeking to minimise barriers or obstacles to breastfeeding in the first week of the baby's life.

2.2 Marketing via the Internet:

Changes in communications since the wide accessibility to the Internet has the potential for historically unparalleled and unregulated marketing and promotion of breast milk substitutes. A few examples of current web-based promotion are included in Appendix B.

2.3 Choice of mode of feeding:

James Akre in his recent book 'The Problem with Breastfeeding: A Personal Reflection' (2006) writes "We often talk about the role choice plays in our lives, which is understandable since we are fond of describing our behaviour in terms of rational decision-making. But where child-feeding mode is concerned – to breastfeed or not – my sense is that it's roughly equivalent to the role that choice plays in deciding whether to hold a small child's hand as we

cross a busy street together, which is to say not at all. ... that doing otherwise is irredeemably irresponsible, dangerous, culpable and downright stupid.

"So, do we then "choose" not to breastfeed based on carefully worked out criteria? In the main, I think not. We respond in the way we have learned to respond, which is why I insist that if we want to change a society's predominant artificial-feeding mode we need to change society in all its structural complexity." Akre considers that the widespread acceptance of artificial feeding of babies is deeply rooted ignorance.

This ignorance permeates all levels of society, and has long-term historical connections with the medical profession's paediatric branch. Professions that claim to promote evidence based practice, including Pharmacy, Medicine, and Nursing, have been slow at best and negligent at worst to take notice of the evidence for the value of species-specific natural feeding of the human infant. The example above of the promotion of breast milk substitutes in a local pharmacy illustrates this fact. The people who are most likely to suffer the consequences of this promotion are those who have not been educated to research an issue or to think critically about commercial pressures they experience through the marketing of products.

2.4 Breastfeeding and human rights

While there are various international human rights declarations that call for adequate food for all people, including babies, it was not until the World Declaration on Nutrition (1992) that a clear statement was made "that access to nutritionally adequate and safe food is a right of each individual"; and the subsequent Plan of Action for Nutrition led governments to pledge to "make all efforts to eliminate ... social and other impediments to optimal breastfeeding. (Akre 2006, p32) The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (1990) "set the stage for breast-feeding programming approaches that were used throughout the 1990s and were reaffirmed in the Global Strategy for Infant and Young Child Feeding that was endorsed in 2002 by World Health Assembly and the UNICEF Executive Board. The Declaration inspired the establishment of the Baby-Friendly Hospital Initiative (BFHI). It called on all countries to implement the International Code of Marketing of Breast-Milk Substitutes and to follow the Ten Steps to improve maternity practices and ensure full support for mothers intending to breastfeed.

The human rights approach adopted in the Innocenti Declaration gained wide recognition as one of the best examples of the concept of shared responsibilities in support of individual and community-level efforts to promote the realisation of the child's right to the highest attainable standard of health. Soon after, the Convention on the Rights of the Child (1990) further recognized the importance of the protection, promotion and support of breastfeeding. ... (excerpts from the Executive Summary, '1990-2005 Celebrating the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding' http://www.unicef-icdc.org/publications/

This report concludes that "In spite of the vital role of appropriate infant feeding practices in reducing child mortality, investment in interventions to improve infant and young child feeding has apparently decreased, and few countries are implementing comprehensive, large-scale programmes to improve breastfeeding and complementary feeding practices, as well as maternal nutrition.

"The challenge is to learn from experience and use this knowledge to work for a global environment in which all children can thrive and achieve their full potential."

In asserting a human rights position, that human babies have a natural right to human milk, a problem arises in relation to the implied duty of mothers to provide milk for their babies. Akre states (p33) "Even sympathetic human rights proponents are quick to caution breastfeeding advocates that a child's right to be breastfed is not explicitly recognised under international human rights law. After all, a right for one automatically implies a duty for the other, doesn't it? ...

"Michael Latham describes as "strange, even aberrant" that the right to breastfeed is even discussed; he calls it a challenge to nature, to natural law and natural practice, and to our ecology and environment, and concludes that huge numbers of human infants not being breastfed and mothers being influenced not to breastfeed their babies is a distortion of nature. He also refers to mothers, who are not breastfeeding because of obstacles, as having suffered the loss of a right; he argues that, since "almost all mothers living under optimally baby-friendly conditions would make the choice to breastfeed, what is needed is action to remove obstacles to breastfeeding." (quoted from Latham 1997)

MCs recommends to the Inquiry:

4 that the sale of breastmilk substitutes, including so called 'Toddler formula' be restricted; requiring them to be sold in pharmacies or other regulated premises, and then must be kept 'behind the counter,' with no promotion or advertising

5 that funding be provided to improve the education of the public in the value of breastfeeding.

Third Inquiry Question

3 The potential short and long term impact on the health of Australians of increasing the rate of breastfeeding

In the chapter titled 'The Commercial Pressures against Baby Friendliness' (Murray 1996), Patti Randall discusses the expansion of the artificial baby food market, and the efforts of critics to limit marketing of such items. Of particular note is Dr Cecily Williams, "a paediatrician well known for her work with kwashiorkor. As early as 1939 she condemned publicly the spread of artificial feeding and the promotion tactics used by the companies. In a lecture to the Singapore Rotary Club entitled 'Milk and Murder' she stated (Williams, 1939) "... if your lives were as embittered as mine is, by seeing day after day this massacre of the innocents by unsuitable feeding, then I believe you would feel as I do that misguided propaganda on infant feeding should be punished as the most criminal form of sedition, and that these deaths should be regarded as murder." "(Murray 1996, p62)

3.1 Remote Indigenous communities

The potential impact of improved breastfeeding practices and rates amongst Australia's remote Indigenous peoples must be understood in the same way as that in developing nations, where breastfeeding is the only practical way of feeding milk to the infant and young child. Furthermore, breastfeeding is as part of the life continuum, understood through millennia in human populations. Not breastfeeding requires a complex set of rules for cleaning, preparation, and storage, as well as financial resources and access to the artificial product throughout the child's infancy.

There are many complex health problems in Australia's Indigenous peoples, and health outcomes are frequently poor. The protection of breastfeeding is one health promotion activity that has potential for immediate and long term improvements in health. In reporting on Birthing Services for Aboriginal Women from Remote Top End Communities (Kildea, 1999), the researcher Sue Kildea emphasises respecting the wishes of individual women and communities in the provision of maternity services. Kildea recommends the development of a "service delivery model

- that has been requested by Aboriginal communities
- that has a primary health care focus
- in collaboration with community members;
- that strengthens community capacity to be involved in decisions that affect their health." (p4)

MCs recommends to the Inquiry:

6 That the promotion, protection and support of breastfeeding be valued as a priority in health promotion in all communities.

Fourth Inquiry Question

4 Initiatives to encourage breastfeeding;

4.1 Australian Breastfeeding Association - ABA

A major initiative in Australia since the 1960s has been the Nursing Mothers' Association of Australia, now Australian Breastfeeding Association (ABA), through which generations of mothers and babies have benefited from mother to mother support in the community.

4.2 Birthing and Babies Information, Education and Support - BaBs

Maternity Coalition recognises the importance of grass-roots peer support for new mothers, and has established Birthing and Babies (BaBs) groups in several communities.

The purpose of BaBs groups is to educate and support mothers, using peer group support as a forum to share information and knowledge of mothers, midwives, birth advocates, educators and researchers in the area of childbirth and early parenting. We work to support women and their families to make informed choices and take action about pregnancy, birth and parenting and to feel empowered and confident in their choices to improve their parenting experiences, health and life skills.

There is scope for great expansion of the BaBs groups in any Australian community.

4.3 Baby Friendly Health Initiative

The Baby Friendly Health Initiative (BFHI) is administered by the Australian College of Midwives. Hospitals providing maternity services are encouraged to seek ongoing assessment and accreditation as 'Baby Friendly Hospitals'. The paper 'Ten Steps to Successful Breastfeeding: A summary of the Rationale and Scientific Evidence' (Saadeh and Akre 1996), published in the peer-reviewed journal *Birth*, addresses the rationale for the Baby Friendly Hospital Initiative.

MCs recommends to the Inquiry:

7 That all hospitals providing maternity services be required to achieve BFHI accreditation, or demonstrate that they are working towards BFHI accreditation, as part of their funding agreements.

8 That funding be provided to support the work of organisations such as MC and ABA, in establishing community based peer support groups for mothers.

5 Examine the effectiveness of current measures to promote breastfeeding

We recognise many positive and effective measures to promote and support breastfeeding, including matters that have been discussed above. We stress the fact that, from the mother's and baby's point of view, breastfeeding is their own resource. Once lactation has been suppressed, a mother's ability to produce milk for her baby is severely curtailed. Likewise for the newborn baby, successful breastfeeding leads to confidence and security, whereas interventions such as the use of artificial substitutes for breastmilk, and bottle feeding and dummies, can lead to loss of confidence in the process of breastfeeding, and a rejection of breastfeeding by the baby.

The measures that are most effective in promoting breastfeeding include:

- Maternity services have a written infant feeding policy that is routinely and carefully communicated to health care staff
- All health care staff who advise mothers about infant feeding receive up to date education, and receive ongoing support and monitoring of the skills necessary to implement the infant feeding policy
- All pregnant women are informed and offered appropriate education in the value and management of breastfeeding, and the potentially harmful effects to themselves and their babies of not breastfeeding
- All mothers are given support and help to initiate breastfeeding after birth. Mothers whose babies are well at birth are able to have immediate skin-to-skin contact that enables spontaneous intitiation of breastfeeding. If mothers and babies are impaired in some way, such as after surgery, or after administration of drugs which affect the baby's neurological response (such as opoids, sedatives, etc administered to the mother in labour), expert help is provided to mother and baby until spontaneous breastfeeding is established.
- All mothers are supported in developing skills of breastfeeding, and expressing and storing breastmilk. If mothers and babies are separated, the mother's own breastmilk is used for feeding the baby.
- Newborn babies whose mothers plan to breastfeed are given no food or drink other than breastmilk, unless medically indicated. Where the mother's own breastmilk is insufficient for the baby's need, the first alternative should be breastmilk from other mothers provided through human milk banking.
- Babies are not separated from mothers except for valid medical reasons.
- Babies are breastfed whenever they are interested in feeding, and not to any schedule.
- Mothers are encouraged to join community groups in which they receive ongoing peer support and information about breastfeeding and baby care.

The above set of dot points represent, in effect, the 'Ten Steps to Successful Breastfeeding'; the WHO-UNICEF global criteria of the Baby Friendly Health Initiative. The evidence for these ten steps and rationale are discussed in Saadeh and Akre 1996.

In addressing this issue we submit Appendix C, which contains examples of negative experiences, reported by consumers in an internet forum, in which health care professionals may have undermined breastfeeding, and giving advice about breastfeeding that is not based on contemporary evidence. These discussions have been sourced from: http://www.lrc.asn.au/forum/viewtopic.php?t=6269

MCs recommends to the Inquiry:

9 That a multi-disciplinary review, with representatives of consumer organisations, be established to investigate and advise the Government on the education and accountability of health care professionals who advise mothers on infant feeding.

Sixth Inquiry Question

6 The impact of breastfeeding on the long term sustainability of Australia's health system.

Smith et al (2002) summarise the conclusions and implications drawn from their study: "Early weaning from breastmilk is associated with significant hospital costs for treatment of gastrointestinal illness, respiratory illness and otitis media, eczema and necrotising enterocolitis. These costs are minimum estimates of the costs of early weaning as they exclude numerous other chronic or common illnesses and out-of-hospital health care costs. Higher rates of exclusive breastfeeding would reduce these costs. Interventions to protect and support breastfeeding are likely to be cost-effective for the public health system." (p 543)

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