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SUBMISSION TO THE PARLIAMENTARY INQUIRY INTO THE HEALTH BENEFITS OF BREASTFEEDING.

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We are a group of Maternal and Child Health Nurses working in the outer eastern suburbs of Melbourne.

In our submission we have addressed issues raised by the terms of reference:

- -Initiatives to encourage breastfeeding, and
- -The effectiveness of current measures to promote breastfeeding.

Introduction.

As Maternal and Child Health Nurses working closely with mothers and their newborns from as early as five days postpartum, we applaud this inquiry into breastfeeding, and the effectiveness of current measures to promote its practice.

As Maternal and Child Health Nurses we believe that inadequate time and education is given to mothers in the early days and weeks of their breastfeeding experience and that this contributes to lower than ideal breastfeeding rates.

We also believe that many babies are classified as breastfeeding when they are discharged from hospital, when they are actually receiving expressed breast milk in a bottle. This is not breastfeeding.

Reasons put forward for this include:

- Current hospital discharge policies encourage the early discharge of postnatal women before effective breast feeding techniques are established for mother and baby. As a result women may be discharged home expressing breast milk, which is fed to the baby via a bottle. Early discharge may also result in the mother being discharged with painful damaged nipples which can have a negative effect on the continuation of breast feeding. (Biancuzzo 2003, Brodribb 2004).

- Inadequate education of maternity staff and poor staffing levels in post natal wards may lead to mothers being incorrectly assessed as breastfeeding effectively when they are in fact not.

- Minimal community supports available to assist breastfeeding mothers post discharge from hospital, which are timely, accessible and cost effective to mothers.

- With the increase in sleep and settling centres in recent years to support families with difficulties in this area, the education given to promote sleeping patterns does not encourage demand feeding. There is an increased need or desire to have routine among families. It appears that many mothers try to limit their baby to 4 hourly feeds rather than stimulating supply by putting baby to the breast as the baby demands. The expectation of 3-4 hourly breast feeds is an unrealistic expectation, and may encourage the belief that breast milk supply is inadequate. The resulting practice of the introducing formula to supplement their breast milk, has the *negative* effect of reducing supply.

Within Maternal and Child Health nursing practice, statistics indicate many mothers wean their babies before six months. Anecdotally insufficient supply of breast milk is often given as a reason. Low supply is often given as a reason worldwide for ceasing breastfeeding in the first 6-8 weeks and often around 4 months (Hoover in Walker 2002).This perception of low supply may be due to the baby waking at night, having shorter feeds or having a weight gain that is perceived to be lower than it should be. These issues may have nothing to do with actual milk supply and mothers require support and well informed advice from health professionals such as Maternal and Child health Nurses, Lactation consultants and GP's to help them through this period.

Cultural and social factors must not be forgotten as they have a large impact on a mother's decision to initiate and maintain breastfeeding. Fathers' beliefs and attitudes towards breastfeeding influence the exclusivity and duration of breastfeeding (Biancuzzo, 2003, Bromberg Bar-Yam,N., & Darby, L.1997).Returning to work can also influence a mother to completely abandon breastfeeding (Walker, 2004) if she is not given timely, well informed advice from health professionals or supported in her workplace to continue breastfeeding.

There are many initiatives to promote and encourage breastfeeding but not enough easily accessible, ongoing, affordable services to support, encourage and educate women throughout their breastfeeding.
The Australian Breastfeeding Association, an extremely effective peer support group. It offers 24 hr help from lactation advisors who are committed to the practice of breast feeding and is well received by the breast feeding community. This service could be expanded and appropriately funded to run lactation clinics as well as the work they already do.

There is a noticeable lack of NEW government endorsed supportive literature or advertising to encourage breastfeeding in the community. There is some within the health profession, in particular the maternity area, but little if any is put out to the general public. This is so important if we want women to breastfeed because they need support from everyone at every age. For example there are no television advertisements to promote breastfeeding but we regularly see media advertising and sponsorship from the formula companies.

We know through our health promotion role as Maternal and Child Health Nurses the enormous benefits of breastfeeding to the long-term health and well-being of infants and their mothers. Therefore it is crucial that we offer some well-considered initiatives that may have a positive impact on increasing breastfeeding rates in Australia.

They are as follows:

To re-evaluate DRG funding in hospitals to allow mothers who are having difficulties breastfeeding to have a longer post natal stay. Mothers who are discharged home when breastfeeding is not established should be referred to a lactation clinic automatically and within days, not weeks as is current practice.

Expansion of lactation support services within the community such as lactation clinics within hospitals or Maternal and Child health services.

Provision of additional funding from the Department of Human Services to provide extra home visits/ lactation visits by Maternal and Child health Nurses.

Provide ready access to private Lactation consultants for those mothers who may not normally be able to afford such assistance. Mothers wishing to breastfeed should be allowed to attend Lactation consultants or clinics as often and for as long as necessary to establish breastfeeding.
This could be done with Medicare rebates.

Encourage and provide financial incentives for more midwives, Maternal and Child Health nurses and GP's to undertake further education in lactation. This will help to ensure mothers have access to well informed health professionals who can offer current and consistent advice regarding breastfeeding.

A government advertising campaign to the general public to promote the advantages of breastfeeding for both infant and mother, using television advertisements, posters and magazines. Target populations could be youth, men and fathers to be, working mothers and extended families of parents to be.
More government literature that is research based promoting breastfeeding, including the promotion of breastfeeding beyond 6 months.

More education of employers on the provision of a breast feeding friendly workplace.

Conclusion
We have addressed the terms of reference on which we feel most able to comment, as we are confronted with these issues frequently in our practice. We believe that given appropriate information, ongoing professional support, and ready access to lactation services, many women would continue to confidently breast feed their babies for longer, and enjoy the process.

References.

Biancuzzo, M.(2003). Breastfeeding the Newborn. Clinical strategies for Nurses (2nd Ed)
St Louis, Mosby.

.Brodribb, W.(2004). Breastfeeding Management (3rd Ed). Melbourne, Australian Breastfeeding Association.

Bromberg Bar-Yam, N., &Darby,L. (1997). Fathers and Breastfeeding: a review of the literature. Journal of Human lactation 13(1), 45-50.

Walker, M,. (2002). Core curriculum for Lactation Consultant Practice. Boston, ILCA