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Submission No. 310
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"The Committee shall 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."

Dear Members of the House Standing Committee on Health and Ageing

Re: Inquiry into Breastfeeding

Introduction

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.

WEL Australia wishes to express support for the recognition of the importance of breastfeeding for promoting the health and well being of Australians that this Parliamentary Inquiry represents. As well as the 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.

WEL respectfully requests that this Inquiry delivers findings that fully acknowledge the real benefits of breastfeeding to both the child AND the mother.

It must be recognised that the overwhelming majority of Australian mothers want to breastfeed with figures from the 2004 Longitudinal Study of Australia Children showing that over 90% of women initiate breastfeeding while in hospital.[1] However, this soon falls away dramatically once they are discharged from hospital. It is often said that women choose to breastfeed or not but WEL questions how many women have a real choice. Our society does not do enough to support breastfeeding, leaving women with the only 'choice' or option, of using artificial breast milk. It is this

[1] Australian Institute of Family Studies 2005, The Longitudinal Study of Australian Children 2004 Annual Report, Melbourne

lack of real choice that hurts and will continue to hurt the health and well-being of current and future Australian mothers and their babies.

WEL hopes that this Inquiry will deliver real, informed and supported choices to Australian women thus allowing many more to breastfeed for longer.

a. the extent of the health benefits of breastfeeding

Physical and Emotional Benefits to Mothers who Breastfeed

Immediately after birth the commencement of breastfeeding reduces uterine bleeding and assists in the quicker return of the uterus to its normal size. It also assists the mother bond with her child in these critical first few hours when a baby is alert and can self-attach. This early establishment of breastfeeding reduces difficulties that may be experienced with delayed breastfeeding after birth which can in turn reduce the likelihood of breastfeeding and its benefits to both babies and their mothers.

The beneficial health effects of breastfeeding for women are now widely and irrevocably known and supported by science. These include, but are not limited to a reduced risk of, ovarian cancer, pre-menopausal breast cancer, heart disease and osteoporosis.[2] Other benefits to the mother of breastfeeding include contraceptive protection whilst exclusively breastfeeding, less sleep deprivation from not having to prepare and feed artificial milk at night, particularly if safe co-sleeping is practised, but also as the child grows up due to the protection and immunity from illness that breast milk gives infants which means less sleepless nights and worry for parents of healthy infants. There is also less stress from the financial worries where the cost of artificial milk can be a real and unnecessary cost burden on families carrying the cost of a new child. The added health care costs to individual families, communities, employers and government is also significant.

Mental Health Benefits of Breastfeeding

There is increasing research into the mental health benefits for both mothers and their children who breastfeed: including decreasing issues of stress, anxiety, attention deficit disorder and less attachment disorders. Stress in early childhood when the brain is developing physically is now being scientifically linked to sub-optimal brain development and the lifelong health and well being issues this poses.

Post-natal depression is also real health issue for approximately 15% of Australian mothers. Again this is a fairly new area of research but successful establishment and ongoing breastfeeding is thought to be beneficial in lowering the likelihood of post-natal depression.[3] For some women poor breastfeeding outcomes can also contribute to post-natal depression.[4] Increased breastfeeding support for women in the early days and weeks when breastfeeding is being established and when most breastfeeding difficulties often arise would help those women most at risk of breastfeeding related post-natal depression.[5]

b. evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;

WEL is particularly concerned with the inadequacy of the *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (1992)* (MAIF Agreement). In its current form this agreement does not protect women from advertising of artificial breast milk and "follow-on/toddler

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[2] See for example Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, Eidelman AI, American Academy of Pediatrics Section on Breastfeeding 2005, Breastfeeding and the use of human milk. *Pediatrics* 115(2): 496-506.

[3] Mohrbacher, 2004 *The Breastfeeding Answer Book.* La Leche League, USA cited in Postnatal Depression and Breastfeeding, ABA and Post and Antenatal Depression Association 2006.

[4] Dunnewold & Crenshwa 1996 Breastfeeding and postpartum depression: is there a connection? *Breastfeeding Abstracts* 15(4): 25-26 cited in Postnatal Depression and Breastfeeding, ABA and Post and Antenatal Depression Association 2006

[5] ABA and Post and Antenatal Depression Association 2006, *Postnatal Depression and Breastfeeding*, p. 23-27

formula". There is indirect marketing of artificial breast milk such as a recent 'discussion' or advertorial on a popular morning television show of different brands and attitudes that indicate that artificial breast milk is an equivalent healthy substitute for breast milk which it is not. Distribution of free follow-on/toddler formula samples to playgroups, pharmacies, baby expos, parenting magazines etc is a common practice by artificial breast milk manufacturers. Advertising of these products, both in print and on television (again a common practice), with unsubstantiated claims of their similarity to breastmilk, help undermine women's confidence in the nutritional value of her breastmilk and also prey on women's desire to do what's best for her child.

WHO states:

> "Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. *(As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28–30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4). See also resolution WHA54.2.)* Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production."[6]

So women can, with the right support, supply all the nutritional needs of their baby and toddler without the need to resort to artificial breast milk.

Advertising of follow-on/toddler milks contravenes the International *Code of Marketing of Breast-milk Substitutes* (The WHO Code)[7] however it does not breech the MAIF Agreement. The WHO Code was formulated in 1981 and the MAIF Agreement in 1992. The MAIF Agreement, as a voluntary code, does not go far enough in its role to promote and protect breastfeeding within Australia. While WEL acknowledges the need for breast milk substitutes, distribution and use of these products needs to be monitored more closely to ensure women's right to breastfeed is not undermined by unethical and misleading advertising by "formula" manufacturers. Company profits should not be put before the health of Australian mothers and babies. We believe there is a strong case for the Government to implement and vigorously enforce the WHO Code, the global standard for the marketing of infant formula.

c. the potential short and long term impact on the health of Australians of increasing the rate of breastfeeding;

WEL would draw the Committee's attention to Chapter One of the Australian National Health and Medical Research Council's *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*[8]. This document has extensive information on the short and long term health benefits of breastfeeding.

d. initiatives to encourage breastfeeding;

The need for NGO Funding Initiatives

WEL Australia believes that an important step the Commonwealth could take is to properly fund the important community and research work undertaken and disseminated by the community sector, often through unpaid but trained volunteers.

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[6] WHO 2003, *Global Strategy for Infant and Young Child Feeding*, p.7-8, Geneva.

[7] http://www.who.int/nutrition/publications/code_english.pdf accessed 18/3/07

[8] NHMRC 2003, *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*, Canberra

The need for Breastfeeding Education Initiatives

A women's family, friends and particularly her partner's attitude to breastfeeding can have a huge impact on her breastfeeding outcomes.[9] Education of all members of society as to the benefits of breastfeeding and the risks of breast milk substitutes should be a Government priority.

Normalising Breastfeeding of Babies and Children

The Commonwealth could also play a role in normalising the breastfeeding of both babies and older infants in popular culture by undertaking an advertising/education campaign. In conjunction with this all government publications and advertising images should be sensitive to the infant feeding models they depict. This also applies to older infants and children breastfeeding, as older children are still receiving the emotional as well as physical health benefits of breastfeeding and thus should not be ignored because of the lack of societal acceptance of extended breastfeeding.

The Government should work with the States to develop an educational program, from primary to secondary school, around breastfeeding. Traditionally young learn the art of breastfeeding by watching others in their immediate and extended family. Australia's low rate and duration of breastfeeding means many Australian children today never, or infrequently, see a baby or infant being breastfed. When these children have their own children most do not have the generational/familial breastfeeding support and knowledge to successfully commence and continue to breastfeed without professional support. An educational campaign aimed at school aged children around breastfeeding would be an important first step towards the normalization of breastfeeding in Australian culture.

Indigenous Women

Studies have shown that Indigenous women living in remote areas of Australia are more likely to breastfeed, and for longer, then urban or non-remote rural Indigenous women. These studies have also found that the rates of breastfeeding in urban Indigenous women are less then the rate in non-Indigenous women. [10] [11] [12]

WEL Australia acknowledges the chronic health problems and lack of housing facing many Indigenous Australians and believes the Commonwealth Government can play a much greater role in improving the lives of Indigenous Australians and the health of their babies. Increasing breastfeeding rates and duration within Indigenous communities should be an integral part of any health program targeting Indigenous Australians. When formulating strategies to promote and support breastfeeding in Indigenous communities WEL asks that the Government liaise closely with individual communities and works closely with Indigenous women to formulate the most effective strategies for improved health outcomes.

Migrant and Non-English Speaking Background (NESB) Women

To our knowledge there is very little current Australian research specifically dealing with breastfeeding rates and attitudes of migrant NESB women. What research there is indicates that cultural background does play a role in infant feeding decisions for NESB women[13] [14]. However,

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[9] NHMRC 2003, *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*, p. 287, Canberra

[10] Zubrick SR, Lawrence DM, Silburn SR, Blair EM, Milroy H, Wilkes T, Eades S, D'Antoine H, Read A, Ishiguchi and Doyle S, 2005. *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People*. Curtin University of Technology, Perth.

[11] Engeler T, McDonald M, Miller M, Groos A, Black M, and Leonard D, 1998, *Review of current interventions and identification of best practice currently used by community based Aboriginal and Torres Strait Island health service providers in promoting and supporting breastfeeding and appropriate infant nutrition.* Canberra: Office for Aboriginal and Torres Strait Islander Health Services.

[12] Holmes W, Thorpe L, and Phillips J, 1997. *Influences on infant-feeding beliefs and practices in an urban aboriginal community*. Australian and New Zealand Journal of Public Health 21: 504-510.

[13] Diong S, Johnson M, Langdon R. 2000 *Breastfeeding and Chinese mothers living in Australia*. Breastfeeding Review;. p. 17-23.

[14] Homer C, Sheehan A, and Cooke M, 2002. *Initial infant feeding decisions and duration of breastfeeding in women from English, Arabic and Chinese-speaking backgrounds in Australia*. Breastfeeding Review; 10(2): 27-32

research has also shown that women who have migrated from countries where extended breastfeeding is the norm are being influenced by the dominant bottle feeding culture of broader Australian community and prematurely weaning their infants.[15]

When formulating strategies to promote and support breastfeeding in migrant and NESB communities WEL asks that the Government takes into consideration, the specific cultural backgrounds of mothers, in conjunction with the multicultural setting of the broader Australian community.

The need for Breastfeeding Friendly Health Initiatives

Health outcomes of the more vulnerable Australian communities, particularly Aboriginal and Torres Strait Islander, could be significantly boosted by concentrating on infant feeding and implementation of breastfeeding support programs.[16] There needs to be a much stronger commitment to public health campaigning, and public health initiatives, for breastfeeding so that all women and children do not miss out on the lifelong health benefits of breastfeeding.

Baby Friendly Health Initiative

The Commonwealth through its role in funding public health should increase funding to ensure ante-natal preparation for mothers as well as mid-wife care and lactation consultant support services are not add-ons to the birth experience for Australian mothers and their babies but integral to a successful delivery. In effect the birth process is not complete until breastfeeding is successfully established.

At a bare minimum the Commonwealth, should fund the States, to undertake a program to introduce the Baby Friendly Health Initiative (previously the Baby Friendly Hospital Initiative) (BFHI) to all maternity hospitals and wards around Australia as a mandatory program. The BFHI was launched by UNICEF and the World Health Organization (WHO) in 1991, to ensure all maternity units (hospital based or not) became centres of breastfeeding support. UNICEF and WHO developed the program in recognition of the vital importance of breastfeeding to the immediate and long term health of both mother and baby.[17] The BFHI is currently taken up by Australian maternity services on a voluntary basis. As a result only a small percentage of hospitals in Australia have BFHI accreditation, for example, 13% in Qld, 4% in NSW and 18% in Vic.[18] This means the level of breastfeeding related care that pregnant and new mothers encounter throughout Australia is not consistent, or benchmarked to the globally recognised standards as outlined in UNICEF/WHO's BFHI. WHO recommends that governments be responsible for education on infant health, therefore a nationwide implementation of the BFHI could be an integral way in which the Federal Government could demonstrate their commitment to encouraging breastfeeding and thus improved maternal and infant health outcomes.

Milk Banks

The Commonwealth should set up a program for the funding of Milk Banks. Artificial breast milk is considered the fourth best substitute for breastfeeding. The second is expressed milk from the mother for her child; the third is the breast milk from another lactating mother; and then fourth only breast milk substitutes. Currently only one breast milk bank operates in Australia. This is unacceptable and gives mothers experiencing breastfeeding difficulties, who are unable to express enough of their own milk, no other option other then breast milk substitutes. Breast milk banks should be a national health priority, and not left to the private or volunteer sector to fund and maintain. There needs to be more done to support mothers (who for health reasons are unable to provide breastmilk to their babies) provide human milk rather then artificial milk to their baby. Again this is an area for public health funding and infrastructure provision and research.

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[15] Rossiter, J. C. 1992. *Attitudes of Vietnamese women to baby feeding practices before and after immigration to Sydney, Australia.* Midwifery 8(3): 103-112.

[16] Madden, R and Trewin, D, 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples 2005*, Australian Bureau of Statistics, Australian Institute of Health and Welfare, Canberra.

[17] http://www.unicef.org/programme/breastfeeding/baby.htm, accessed 17/3/07

[18] http://www.bfhi.org.au/text/bfhi_hospitals.html and http://www.bubhub.com.au/serviceshospitals.shtml accessed 17/3/07

Improved Midwifery Care

The Inquiry should also seek input from midwives on models of continuous care during birthing which allow a mid-wife to establish breastfeeding as part of the birthing process. Mid-wives and other health professionals involved in the birth process and postpartum care need to be adequately trained and knowledgeable about breastfeeding. Good breastfeeding counselling skills used postpartum have been shown to significantly increase successful breastfeeding outcomes.[19]

Early discharge programs from hospital should be reviewed to ascertain their impact on breastfeeding success in the postpartum period. Successful breastfeeding establishment should be used as one of the criterion when determining when hospital discharge takes place. Often women are discharged from hospital before breastfeeding is successfully established and often before their "milk comes in". Where this occurs, there should be automatic home visiting support services which follow up in the first few days to ensure that the process is established. Women need to be adequately supported in the early days and weeks when breastfeeding problems and thus premature weaning can occur. Routine follow-up by trained breastfeeding counsellors or lactation consultants after women are discharged from hospital would be a first step. The question arises of how these can be funded so they are equally available across income groups and communities.

The need for a Parenting-Friendly Society

We live in a society that is not baby friendly or supportive of parenting needs as the norm – mothers and babies have to fit in as though being with a child and parenting, including breastfeeding, are not natural and vital roles. Supporting breastfeeding as a national health priority is an important step to being a parenting friendly society and workplace issues often conflict with this possibility.

A major area of Commonwealth Government powers is over conditions in the workplace and industrial relations legislation. Women are less likely to be in a strong bargaining position compared to male workers. This is compounded when they become a mother. Individual bargaining even where a mother is in a strong position is unlikely to gain workplace based childcare or help to facilitate breastfeeding at work. The Commonwealth should use its power in devising industrial relations requirements to support breastfeeding as a workplace right through awards and minimum conditions for AWAs as well as continue tax incentives to encourage workplace based childcare facilities, particularly for very young children

Paid Maternity Leave

According to OECD figures 25 percent of Australian mothers with a child less than twelve months of age were in the paid labour force in 1996.[20] Figures from the recent Longitudinal Survey of Australia's Children suggest that approximately 44 percent of mothers are now employed in the paid workforce by the time their child is twelve months old, with 25 per cent having returned to work before their child was six months old with, and some within a few weeks of giving birth.[21] Thus the trend is for more women to return to some form of work with younger and younger children. What these figures do not indicate is the reasons for women's increased labour force participation.

WEL supports the right of women to choose whether or not to enter the paid workforce after the birth of a baby. However, we believe women need a real choice around the timing of this return to work. The first 12 to 14 weeks postpartum are very important in the successful establishment of breastfeeding as well as to allow mothers to physically recover from the hard labour of labour and giving birth. WEL believes a Government funded universal paid maternity leave scheme for at least the OECD average of 14 weeks is an essential policy initiative to allow women the optimal chance of successfully establishing breastfeeding before they return to paid work.

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[19] Ekstrom A, Widstrom A, and Nissen E, 2006, *Does Continuity of Care by Well-Trained Breastfeeding Counselors Improve a Mother's Perception of Support?*, Birth 33 (2), 123-130.

[20] Organisation for Economic Cooperation and Development 2002, Babies and bosses: Reconciling work and family life, Australia, Denmark and the Netherlands, OECD, Paris.

[21] Australian Institute of Family Studies 2005, *The Longitudinal Study of Australian Children 2004 Annual Report*, Melbourne

The introduction of a universal paid maternity scheme would give women a real choice by providing them with adequate financial support in those crucial first weeks and months of their baby's life. Extending the time a mother can be with her baby through the provision of adequate financial support should be seen as an investment in the physical and psychological health of families, and recognition of women's unpaid as well as paid work.

Employer funded maternity leave is available to only a limited number of Australian women with the vast majority of female workers in small to medium sized workplaces being excluded. Research indicates that the average period of leave currently available to Australian women is only 8 weeks and offered by only 23% of workplaces[22] and the more a woman earns the more likely she is to receive paid maternity leave. [23] This may explain and account for other research findings which have shown that lower socio-economic groups are significantly less likely to breastfeed beyond the early weeks.[24] WEL is concerned that some women are returning to work out of financial necessity rather then by choice, which then impacts on their breastfeeding outcomes. It is the Government's responsibility to ensure that paid maternity leave is not just available to a small privileged section of the Australian workforce.

Government funded paid maternity leave for all women for at least the OECD average of 14 weeks is very important to allow the successful establishment of breastfeeding as well as to allow mothers to physically recover from the birth. However, if Australia was serious about breastfeeding this Inquiry should support paid maternity leave for at least six months (as in the United Kingdom where mothers have 6mths/26 wks paid maternity leave which from 1st April this year becomes 9 mths/39 wks paid maternity leave) to better help mothers to exclusively breastfeed to the recommended health guidelines. See below for recommendations from HREOC on this issue.

Breastfeeding Friendly Workplaces

Many Australian women today have a strong attachment to the workforce before they have their first child. Breastfeeding should not stop women returning to work, just as returning to work should not stop women breastfeeding. As the WHO points out:

> "Women in paid employment can be helped to continue breastfeeding by being provided with minimum enabling conditions, for example paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks."[25]

The Commonwealth Government has the power under CEDAW and domestic anti-discrimination laws to protect a women's right to combine breastfeeding and work. Women should not have to make the difficult choice between returning to work and prematurely weaning their child. It is also inequitable that only women with significant influence or those who have forward-thinking employers should be able to have access to a breastfeeding friendly workplace. Breastfeeding friendly provisions need to become part of all Australian workplaces.

All mothers and babies irrespective of their socio-economic background should have access to the following if they choose to combine breastfeeding and work:

- flexible lactation breaks
- a private place in which to breastfeed or express breastmilk
- a fridge/freezer (or equivalent) to store breastmilk, and storage space for related equipment
- support of the employer and her colleagues

This is in line with ILO minimum recommendations for a supportive workplace environment for breastfeeding women.[26] Lactation breaks are an essential feature of a breastfeeding friendly

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[22] Pocock, B, The Work Life Collision, Centre for Labour Research, Adelaide University, 2003.
[23] Work Research Cluster, Sydney University, March 2003.
[24] Donath, S. and L.H. Amir, Rates of breastfeeding in Australia by State and socio-economic status: Evidence from the 1995 National Health Survey. J Paediatr. Child Health, 2000. 36: p. 164-168.
[25] WHO 2003, *Global Strategy for Infant and Young Child Feeding*, p.8, Geneva.
[26] International Labour Organisation, Maternity Protection Convention (revised), 1952 (no. C183) – article 10 http://www.ilo.org/ilolex/english/convdisp2.htm accessed 26/06/2005.

workplace and without this all else fails.[27] Amendments in 2002 to the Federal *Sex Discrimination Act 1984* made it unlawful to discriminate against breastfeeding women in the workplace. However the right to lactation breaks is not included in the Federal award under work and family policies, which currently only covers: part-time work, carer's leave and parental leave.[28] The International Labour Organisation (ILO) recommends one or more daily breaks or a daily reduction of hours of work should be counted as working time and remunerated accordingly.[29] These ILO recommended lactation breaks have only been adopted by the Australian Capital Territory (ACT).[30]

For lactation breaks and other breastfeeding friendly provisions to be more widely implemented and accessible to Australian women, it is not sufficient to rely on the efficacy of the *Sex Discrimination Act* or the goodwill of Australian employers. WEL calls on the government to introduce legislation mandating breastfeeding friendly workplaces. WEL recognises that any such legislation needs be crafted and introduced in such a way as to prevent further discrimination against lactating women. Tax concessions, financial assistance to small business and a gradual phasing in of the guidelines could help elevate these concerns.

The Government's industrial relations legislation should support and protect breastfeeding as the physiological and social norm of infant feeding. Breastfeeding is not a lifestyle choice and should not be treated as such.

Unpaid Parental Leave

WEL asks the Government to ensure all employees have access to concurrent parental leave immediately following the birth of their child and extended unpaid parental leave, for fathers.

Fathers play a crucial role in the success of a mother/baby breastfeeding relationship.[31] Many women take up to 16 weeks to fully recover from the birth of their child and at least 6 to 12 weeks for a successful breastfeeding relationship to develop. Many mothers also find the early weeks emotionally challenging. Therefore new mothers early weeks and months with their babies could be greatly enhanced by allowing fathers to request concurrent leave in the first weeks. This will not only facilitate the establishment of a good breastfeeding relationship but also contribute to a stronger father/child bond and thus stronger families.

Access to unpaid concurrent parental leave would also give women more choice and flexibility when wishing to maintain their connection to the workplace.

Workplace Discrimination

Employees and employers awareness and knowledge of Anti-discrimination legislation protecting pregnant and lactating women, and maternity leave provisions, is very poor. Women trying to access maternity leave still face significant levels of discrimination.[32] Further research needs to be undertaken into the discrimination women face when still breastfeeding on returning to work. Figures from the Australian Bureau of Statistics NHS indicate workforce participation by new mothers does adversely affect breastfeeding with one in ten mothers reported returning to work as a reason for introducing solids and breast milk substitutes early and for premature weaning.[33]

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[27] Bar-Yam, Naomi Bromberg. Workplace lactation support, Part 11: Working with the workplace. *Journal of Human Lactation* 1988 (December); 14:321-325.

[28] Information and Research Services Parliamentary Library, *Research Paper No. 2 2004-05, Work and Family Policies as Industrial Employment Entitlements*, Department of Parliamentary Services, 2004.

[29] International Labour Organisation, Maternity Protection Convention (revised), 1952 (no. C183) – article 10 http://www.ilo.org/ilolex/english/convdisp2.htm accessed 26/06/2005.

[30] Industrial Relations and Public Sector Management Group 2003, *ACT Public Service Certified Agreement Template 2003*. ACT Government Chief Minister's Department URL: http://www.psm.act.gov.au/publications/ACTPSTemplateCAfinalfeb03.doc Accessed 14/06/2005.

[31] Scott, J., Binns, C., and Aroni, R. 1997. *Infant feeding practices in Perth and Melbourne; factors associated with duration of breastfeeding and women's breastfeeding experiences*, National Better Health Program, National Health and Medical Research Council, Curtin University of Technology, Perth; La Trobe University, Melbourne, January.

[32] Information and Research Services Parliamentary Library, *Research Paper No. 2 2004-05, Work and Family Policies as Industrial Employment Entitlements*, Department of Parliamentary Services, 2004.

[33] Australian Bureau of Statistics 2003, *Breastfeeding in Australia*, Canberra.

The Government in its own research paper suggested that an agency oversee notification of relevant employee rights and pregnancy to the employer be established.[34] We would welcome and support such an initiative (or similar), and feel it would be a perfect avenue through which breastfeeding information could be distributed, with the additional benefit of allowing women to forward plan their infant feeding choices. A notification agency, as suggested above, could be a critical first step in the breastfeeding education chain.

Discrimination may be legally outlawed but practical discrimination again is an area that the Commonwealth can improve monitoring of through the Human Rights and Equal Opportunity Commission (HREOC). HREOC recommendations for action (detailed below) should be acted on promptly.

Breastfeeding and Family Separation

The Family Court when addressing custody issues has taken into account the breastfeeding needs of children and their mothers in a number of cases. The continuation of breastfeeding should be considered when all judgements are made as very important to the health and welfare of the child as well as the mother. Wherever possible premature or forced weaning should not be considered in managing ongoing custody arrangements with both parents.

e. examine the effectiveness of current measures to promote breastfeeding;

Peer Based Support Networks

WEL Australia basically supports the submission to this Inquiry by the Australian Breastfeeding Association (ABA) and recognises the importance of peer support and community based voluntary services in this area. Recent research also supports this and indicates that peer support can be a more important contributing factor in increasing the duration of breastfeeding then health professional support.[35] [36] Young mothers see their mothers' groups as primary sources of information and social support and many recognise the importance that both ABA and other, sometimes more formal services, provide. However, Government funding for volunteer organizations (such as ABA) and other breastfeeding support service providers is often very limited. This lack of funding has a significant impact on the scope and availability of the breastfeeding services they can provide. This means they have limited services for low income, isolated and often less advantaged groups. At present those with funds can access professional services, but not those who cannot afford to pay such differential access may contribute to differential levels of breastfeeding by socio economic groupings.

Women Don't Have Real Choice about Whether to Breastfeed or Not

As previously mentioned Australian women recognise that "breast is best" and most initiate breastfeeding in hospital, however, exclusivity and duration of breastfeeding, decline dramatically once women are discharged from hospital, and both fall well short of the World Health Organisation (WHO) and NHMRC guidelines for infant feeding. WHO recommend that infants are exclusively breastfed for the first six months of life with ongoing breastfeeding until two years[37], a recommendation supported by the NHMRC Dietary Guidelines for Infant Feeding[38]. However, Australia's record of exclusive breastfeeding to six months, and then breastfeeding past 12 months, is not good. The 2001 National Health Survey (NHS) showed that fewer than one in three

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[34] Information and Research Services Parliamentary Library, *Research Paper No. 2 2004-05, Work and Family Policies as Industrial Employment Entitlements*, Department of Parliamentary Services, 2004.

[35] Health Promotion Agency for Northern Ireland, 2004, *Peer support as an intervention to increase the incidence and duration of breastfeeding in Northern Ireland: what is the evidence?*, Belfast.

[36] Hoddinott P, Chalmers M, and Pill R, 2006, *One-to-One or Group-Based Peer Support for Breastfeeding? Women's Perceptions of a Breastfeeding Peer Coaching Intervention*, Birth 33 (2), 139-146.

[37] World Health Assembly (Fifty Fourth) 2001, Infant and Young Child Nutrition: Resolution 54.2.

[38] NHMRC 2003, *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*, Canberra.

of all babies were being exclusively breastfeed to six months. [39] Figures reported in the Longitudinal Study of Australian Children 2004 Annual Report, found that 91% of infants started solids before six months of age and 72% of mothers had ceased breastfeeding by their infants first birthday.[40]

As previously mentioned most woman want to breastfeed, and for the vast majority of women there is no physiological reason why they cannot. However most do not continue breastfeeding long term, as shown above. This raises the question of what economic and social pressures are faced by women and curtailing their choices and how such pressures could be relieved.

Both WHO and NHMRC support this assumption:

> "Even though it is a natural act, breastfeeding is also a learned behaviour. Virtually all mothers can breastfeed provided they have accurate information, and support within their families and communities and from the health care system."[41]

and

> "Almost all mothers are capable of breastfeeding their infants. Outcomes are much improved where the mother has the support and encouragement of the infant's father, other family members, the hospital, and the community. Many mothers - perhaps the majority - encounter some difficulties with breastfeeding but, with support and encouragement from health professionals and community organisations, they can nearly always continue to breastfeed." [42]

WEL sees this as an issue of choice and is concerned that figures like these may indicate that Australian women are not being well served by the current maternal and breastfeeding support services available to them. We are particularly concerned by data which shows that higher levels of breastfeeding is often related to income and education, which is counter intuitive as it is often less costly. Not commencing breastfeeding, or the premature weaning of a child, is more likely in disadvantaged groups of Australian society.[43] This suggests that messages are confused and work is needed to support those children in low income families who are losing out on even 6 months of breastfeeding. Inequalities of nutrition, and other well being indicators, may start with early withdrawal from breastfeeding and need close attention, particularly in some migrant and indigenous communities.[44] [45]

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

As previously mentioned breastfeeding rates after hospital discharge and breastfeeding duration do not match WHO or NHMRC infant feeding guidelines. Governments should be concerned by these figures and not just because of the health implications for thousands of Australia women and children. The economic implications of premature weaning are also significant. It is estimated that the hospitalisation cost for just five common childhood illnesses is around $60-120 million

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[39] Australian Bureau of Statistics 2003, *Breastfeeding in Australia*, Canberra.

[40] Australian Institute of Family Studies 2005, *The Longitudinal Study of Australian Children 2004 Annual Report*, Melbourne

[41] WHO 2003, *Global Strategy for Infant and Young Child Feeding*, p.8, Geneva.

[42] NHMRC 2003, *Dietary Guidelines for Children and Adolescents in Australia, incorporating the Infant Feeding Guidelines for Health Workers*, p. 287, Canberra.

[43] Donath, S. and L.H. Amir, *Rates of breastfeeding in Australia by State and socio-economic status: Evidence from the 1995 National Health Survey*. J Paediatr. Child Health, 2000. 36: p. 164-168.

[44] Zubrick SR, Lawrence DM, Silburn SR, Blair EM, Milroy H, Wilkes T, Eades S, D'Antoine H, Read A, Ishiguchi & Doyle S 2005. *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People*. Curtin University of Technology, Perth

[45] Homer C, Sheehan A, and Cooke M, 2002. *Initial infant feeding decisions and duration of breastfeeding in women from English, Arabic and Chinese-speaking backgrounds in Australia*. Breastfeeding Review; 10(2): 27-32, Melbourne

annually.[46] This cost burden is carried by both the public health system and individual Australian families. These figures take into consideration only five common childhood illnesses.

On health grounds alone supporting and promoting breastfeeding as the biological norm, and to the health guidelines, would significantly benefit the Australian economy and individual family budgets.

Recommendations

1. The Commonwealth Government adopt and implement supporting breastfeeding as a national health priority.
2. The Commonwealth Government initiate a nation-wide public health campaign on the risks associated with not breastfeeding for children and their mothers which also includes resources for schools.
3. The Commonwealth Government increase funding for improved breastfeeding services and support in hospitals, including early discharge programs.
4. The Commonwealth Government assist in the establishment and running of milk banks in every State and Territory.
5. The Commonwealth Government take a lead role in ensuring every maternity hospital and ward in Australia adopts and meets the requirements of the *Baby Friendly Health Initiative.*
6. The Commonwealth Government recognise the importance of a breastfeeding skilled health workforce and fund a wide range of health professionals being trained in the importance and skills of supporting breastfeeding. As well as ensuring more training places for specialist lactation staff.
7. The Commonwealth Government recognise and fund the importance of community and volunteer peer support organisations and programs that support women establishing and continuing breastfeeding.
8. The Commonwealth Government adopt and implement the WHO *International Code of Marketing of Breast-milk Substitutes 1981.*
9. The Commonwealth Government incorporate ILO standards for breastfeeding in workplaces in industrial relations legislation and standards which includes the right to flexible lactation breaks. Breastfeeding friendly workplaces should be mandated in legislation.
10. The Commonwealth Government provide paid maternity leave to all women for a minimum of 14 weeks as well as provide men with the right to concurrent unpaid paternity leave at the birth of their child.
11. The Commonwealth Government extend its provisions for tax incentives to provide work-based childcare facilities.
12. The Commonwealth Government establish an agency to oversee notification of relevant employee rights and pregnancy to employers.
13. The Commonwealth Government investigate the practical discrimination women face trying to breastfeed and take action to reduce practical discrimination in workplaces and the broader community.
14. The Commonwealth Government take an active role in providing a broad range of images of breastfeeding mothers and their children in its publications.
15. The Commonwealth Government must ensure custody decisions enable breastfeeding to continue.

WEL would also like to draw the Committee's attention to the recent Human Rights and Equal Opportunity Commission (HREOC) report *It's About Time: Women, men, work and family* and it's

[46] Smith J, Thompson J, Ellwood D 2002, Hospital system costs of artificial infant feeding: Estimates for the Australian Capital Territory. *ANZ J Public Health* 26(6): 542–551.

recommendations to enhance the work/life balance of Australian working men and women. Below we have listed those recommendations from the report which are specifically relevant to women returning to the workforce (and thus breastfeeding women returning to work).[47] All these recommendations would make it easier for mothers to combine breastfeeding and paid work. Unfortunately the HREOC report did not specifically mention the special needs of breastfeeding women in their recommendations. Therefore, where necessary, WEL has added additional recommendations specifically relevant to breastfeeding women for the Committee to consider.

It's About Time: Women, men, work and family - Recommendations

Chapter 1: Background

Recommendation 2

That the Australian Bureau of Statistics be funded to develop a set of questions on experiences of child care, elder care and care for people with disability for distribution either in appropriate regular national surveys of households, or a new specialist survey, in order to collect comparable data on the range of informal and formal care provided within Australia.

WEL notes this should include questions on breastfeeding.

CHAPTER 3: Legal protection for workers with family and carer responsibilities

Recommendation 4:

That a federal *Family Responsibilities and Carers' Rights Act* be introduced to provide protection from discrimination for employees with family and carer responsibilities and a right to request flexible work arrangements.

WEL recommends this should include breastfeeding leave and related issues.

Recommendation 5:

That the Australian Government fund HREOC to establish a Family Responsibilities and Carers' Rights Unit to promote the principles of the new legislation, undertake educational and promotional activities, and contribute to policy and legislative development in the area of family responsibilities discrimination and carers' rights.

WEL recommends this should include education and promotional activities on the importance of breastfeeding and related issues.

Recommendation 6:

That the Family Responsibilities and Carers' Rights Act include a right for workers with family and carer responsibilities to request flexible work arrangements with a corresponding duty on employers to reasonably consider these requests. Refusal to reasonably consider a request for flexible work arrangements could then be the subject of a complaint to HREOC.

CHAPTER 4: Striking the balance in the workplace

Recommendation 7:

That the Australian Government establish a national working hours framework which promotes flexibility and encourages workplaces to limit long hours working.

In developing this framework, the Australian Government should consider the following:

a. a program to address long and unpredictable working hours;

b. a program to encourage workplace level negotiations about working time arrangements;

c. incentives to employers to offer flexible working arrangements which reflect employee needs across the life cycle; and

d. initiatives aimed at changing the organisation of work so that it better meets the needs of employees with family and carer responsibilities.

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[47] HREOC, 2007, *It's About Time: Women, men, work and family. Final Paper 2007*. Sex and Age Discrimination Unit, HREOC, Sydney.

WEL recommends that the Government mandate breastfeeding friendly workplaces.

Recommendation 8:

That the Department of Employment and Workplace Relations develop industry specific resources in consultation with relevant employer and employee organisations in both blue and white collar industries to encourage the development of quality part time work.

Recommendation 9:

That the Australian Government establish a grants program to assist businesses to increase the number of senior and quality jobs that are available part time. This initiative would supply matched funding to businesses and voluntary organisations for projects designed to embed quality part time work in their organisations.

Recommendation 13:

That the Australian Government as a matter of priority introduce a national, government funded scheme of paid maternity leave of 14 weeks at the level of the federal minimum wage, as recommended by HREOC in *A Time to Value: Proposal for a National Paid Maternity Leave Scheme* (2002).

Recommendation 14:

Following the introduction of a 14 week paid maternity leave scheme, the Australian Government should consider phasing in a more comprehensive scheme of paid parental leave consisting of:

a. At a minimum, two weeks of paid paternity leave to be taken at the birth of the child; and
b. A further 38 weeks of paid parental leave that is available to either parent.

Recommendation 16:

That HREOC develop Employer and Employee Guidelines in relation to workers with family and carer responsibilities, setting out rights and responsibilities, including a specific focus on small business.

WEL recommends that any Guidelines specifically mention the importance of breastfeeding and the issues surrounding breastfeeding women and work.

Recommendation 17:

That HREOC, in consultation with the Office of Workplace Services, be funded to develop comprehensive new resources and a major public awareness campaign focused on employers' and employees' rights and responsibilities under the new *Family Responsibilities and Carers' Rights Act.*

WEL would like to see any resources and major public awareness campaign specifically mention the importance of breastfeeding and the issues surrounding breastfeeding women and work.

Recommendation 19:

That an interdepartmental committee (including the Department of Families, Community Services, and Indigenous Affairs, the Department of Employment and Workplace Relations and HREOC) should be established to examine initiatives to assist in improving the family-friendly culture within workplaces, including ideas such as:

- developing more broadly recognised resources for employers focusing on the business case benefits of implementing family-friendly work practices;
- developing training packages about the benefits of family-friendly work practices for middle and senior management; and
- developing community awareness programs focused on limiting working hours and discouraging presenteeism through workplace campaigns such as a "daddy go home on time" day.

WEL would like to see breastfeeding flexibility specifically included.

Recommendation 20:

That HREOC, in consultation with the Office of the Employment Advocate, develop community resources to assist women with workplace negotiation and individual bargaining.

WEL would like to see any resources include information about breastfeeding and returning to work.

CHAPTER 5: Striking the balance in the family

Recommendation 21:

That HREOC develop education materials for use in high schools around the country about sharing care and other unpaid work.

WEL would like to see breastfeeding information and the important role fathers play in the breastfeeding relationship included in any education materials developed.

Recommendation 22:

That the Australian Government fund a national multi-media community awareness campaign about workers with family/carer responsibilities, including the diversity of workers and families and with a targeted component for men with family/carer responsibilities.

WEL would like to see the issue of breastfeeding, women and work included in any national multi-media community awareness campaign.

Recommendation 23:

That the Australian Government conduct an audit of Commonwealth, State and Territory programs in family and health services to assess how well they prepare families for sharing care. The audit should include an assessment of current mainstream antenatal and early parenting programs and programs designed for separated fathers in order to identify best practice methods of increasing the engagement of fathers in care work.

WEL would like to see the importance of breastfeeding, including the roles fathers play in the breastfeeding relationship, included in these programs.

Recommendation 24:

That the Australian Government fund the development of resources to assist newly partnered couples, and in particular prospective and new parents, to consider options and discuss arrangements for sharing care. These resources should be distributed through Family Relationship Centres and relevant community organisations.

WEL would like issues of breastfeeding included in these packages.

CHAPTER 6: Government support: Welfare and tax

Recommendation 25:

That Family Tax Benefit Part B be modified to support couple families to share paid work and care and Australia move towards a system of progressive individual income tax in which child benefits are provided on a universal basis.

Recommendation 27:

That the Australian Government examine the option of moving towards a system of earned income tax credits for working families which would encompass current Family Tax Benefit payments and the child care tax rebate. Such an examination should consider the circumstances of families where parents are not in paid work which may be eligible for a set proportion of the full level of tax credit support and a premium should be considered for children with specific needs, in particular disability.

Recommendation 30:

That the Fringe Benefits Tax (FBT) exemption be expanded for all employers who subsidise dependent care through the establishment of a child care service either on or off their own premises or through subsidies/allowances paid towards employees' care costs (such as vacation

care allowances, frail aged day programs, respite care and in-home support for people with disability).

CHAPTER 7: Early childhood and care

Recommendation 33:

That the Australian, State and Territory governments finalise the National Agenda for Early Childhood as a matter of urgency to identify priorities for reform in early childhood education and care, and the responsibilities of all stakeholders in delivering these priorities.

Recommendation 38:

That Australian early childhood education and care services be required to comply with Disability Standards for Education 2005 as a prerequisite for federal funding such as Child Care Benefit (CCB).

Recommendation 40:

That the Australian Government with the cooperation of the States and Territories institute a comprehensive national review of early childhood education and care (ECEC) services, grounded in a commitment to children's wellbeing, with the aim of:

- ensuring that all children can access quality programs regardless of their socio-economic circumstances, geographic location or abilities;
- establishing the extent of demand for ECEC services so as to provide a better planning framework for the establishment and accreditation of children's services;
- providing greater options for families for non-standard hours child care services;
- ensuring that the funding formula and mode of payment most effectively reflect the needs of children; and
- improving affordability for working parents.

WEL would like to add breastfeeding care options for younger children.

Conclusion

In conclusion WEL Australia would like to commend the Committee for investigating this important public health issue for the future of Australia. WEL Australia would be pleased to appear before the committee should this be requested and/or provide additional information. The preventative health benefits of breastfeeding are no widely recognized and accepted in the scientific and medical community. If we are serious about the health of Australian women and children, and thus the future of our nation, the Commonwealth needs to be playing a lead role in ensuring that as a society we move beyond breastfeeding being seen as 'embarrassing' or an optional "lifestyle" choice.