

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warrnambool — 11 October 2017

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Witness

Dr Alison Stuebe, associate professor, maternal-fetal medicine, University of North Carolina school of medicine.

The CHAIR — I might just read out the equivalent of our committee Miranda rights. I welcome to these public hearings Dr Alison Stuebe, associate professor of maternal-fetal medicine at the University of North Carolina school of medicine. Thank you for taking your time for being here today, especially since we know that you were grabbed by Barb and she forced you here under duress today. But I know it was late notice, and thank you so much. We do appreciate it. As I have previously said, all evidence taken by the committee at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I note you have already apologised to us about your president, so thank you very much for that.

Visual presentation.

Dr STUEBE — Happy to be here, hopefully making a more positive impression of our nation than typically arises. I am really delighted to be here. I am part of the Barb Glare fan club and independently a big advocate of breastfeeding. What I want to talk with you all this afternoon about is the importance of breastfeeding and then specific strategies that have been proven in studies to enable women to achieve their breastfeeding goals. I will talk very briefly about current breastfeeding recommendations and practices, present some data on the associations between breastfeeding and long-term health for mothers and children, and then discuss strategies for enabling more women to initiate and sustain breastfeeding.

The World Health Organization recommends exclusive breastfeeding for six months of age with continued breastfeeding to two years of age and beyond. In Australia the recommendations are six months of exclusive breastfeeding and then continuing until 12 months of age and beyond for as long as the mother and child choose. These are data from the 2010 Australian national infant feeding survey. My understanding is that this was a comprehensive national study that was done, but there have not been updated national statistics on breastfeeding rates, which makes it a bit difficult to see where we are right now. But what we see is that there is about 90 per cent breastfeeding initiation and 61 per cent exclusive breastfeeding at birth, with continued breastfeeding for about 7 per cent of mothers extending to 19 to 24 months at the time of the study.

I wanted to talk a bit about the implications of breastfeeding rates for outcomes for mums and children. We published last year a study looking at the impact of suboptimal breastfeeding in the United States on maternal and paediatric health outcomes and costs. What we did in this study was take health outcomes that have been associated with breastfeeding rates in mothers and in children, consider current breastfeeding rates in the US and then compare them with an optimal state where 90 per cent of women breastfed according to recommendations — so that is six months exclusive breastfeeding continuing for at least one year. We spent a great deal of time running a simulation contemplating birth rates in the United States and essentially took a population of women who were 15 in 2002, followed them across their lifetimes and looked at the health cost for them and their children if they breastfed under current conditions or under optimal conditions.

Just recently we published a calculator that allowed one to take the data from individual states in the US and get at, in Alabama, if breastfeeding rates were to increase by this, what would that look like? Once Barb invited me and you were all kind enough to have me speak today, I have done a back-of-the-envelope Australian version. I want to be clear that this has not been carefully checked by a non-jet-lagged researcher. This is looking at the number of cases that would be prevented if we went from breastfeeding rates as recorded in Australia in 2010 to 90 per cent in terms of preventing cases of breast cancer, type 2 diabetes, hypertension and heart attacks for women.

When you look at the cost of that in medical costs for maternal health, it is about AUD\$179 million with today's exchange rates, and within Victoria that is about \$47 million. We also looked at non-medical costs: so missed work for your chemotherapy for your breast cancer, for example. What is quite stunning about this work is that the maternal health impact actually dwarfs the child health impact. So when we often talk of breastfeeding as a child health issue, the dollars and the case burden is actually much higher for mothers in terms of the severity of the diseases in question.

On the next slide we look at the child health outcomes, and what we see is that if Victoria were to get to optimal, we would have 10 000 fewer cases of ear infections annually and 55 000 fewer cases of GI infections. If you think about if you have ever had a child with an ear infection and had to get that child to take their antibiotics, that is a significant nuisance. If you have had a child with a GI infection and had to clean up what

that entails, that is a significant nuisance factor as well. When we look at the medical and non-medical costs, the non-medical costs are actually higher for children's diseases because they take into account missed work for parents to care for the child and extra nappies for GI illness — but we are looking at about \$66 million for Australia in medical costs and about \$19 million for Victoria. So if we wanted to make an investment — I understand there are billions of extra dollars available — but even if we did not talk about the billions of extra dollars, we are looking at millions of dollars in cost savings if we were able to enable women to achieve their breastfeeding goals.

So how can we actually increase breastfeeding rates? The traditional approach — this is a 1940s US poster saying that we should tell mothers more loudly and more insistently that they should breastfeed their children. If we shout louder, surely they will do it. We have come to appreciate that while certainly the message that breastfeeding is important does not reach all women, it is not enough simply to tell people to do something. We must make it possible for them to do it.

This is a slide that is actually stolen from the patient safety literature where we talk about a Swiss cheese model — that for something bad to happen the holes in the cheese have to line up. I would argue that for something good to happen in breastfeeding we also have to line up the holes in the Swiss cheese. We are going to talk a bit about direct prenatal and postnatal support, about baby-friendly maternity care, about limits on formula marketing and then about dyadic community-based support.

The CHAIR — Alison, what is dyadic community-based support?

Dr STUEBE — So that is taking care of mum and baby together in the community — sorry, I am jargonising.

First, direct pre and postnatal support. Just recently there was a meta-analysis published in the US looking at the impact of primary care-based interventions to support breastfeeding. One of the studies that was the most effective was done by Karen Bonuck, who is a researcher working in the Bronx in New York City. I want to talk about her strategy. This was published a few years ago and was a primary care-based intervention. I was struck by the discussion of embedding, for example, screening for maternal and emotional health in routine care versus saying, 'You need to go to a special place to check on your emotional health'. This approach says, 'What if we embed lactation support in routine care so that when you come for your appointment you automatically get to interact with a breastfeeding specialist?'

Karen Bonuck's study: prenatally a lactation consultant met with patients at two prenatal visits. So while they were in the waiting room waiting for their appointment or while they were in the room in between waiting for the clinician to come in the lactation consultant went over a standardised set of teaching. Then in the perinatal period the lactation consultant rounded on the mum and baby in the hospital, and then they received weekly phone calls for the first month. The average amount of time was about 4 hours per mother-baby dyad with this intervention across this whole treatment plan, and what Karen Bonuck found is that she doubled the rate of high-intensity breastfeeding at three months. I think it is quite important to appreciate that this was the population in the Bronx in New York City, so this was a primarily non-white low-income population. This was not well-to-do middle-class white women; it was women facing numerous challenges in their personal lives, and we were able to double the high-intensity breastfeeding rate with this intervention. I think this speaks to the importance of embedding lactation support in care.

So next is evidence-based maternity care. Several people have mentioned the baby-friendly hospital initiative. This was actually studied in Belarus in the late 1990s when hospitals were randomised to the baby-friendly hospital initiative versus usual care. This is a stat of World Health Organization-specified interventions that include educating mums about breastfeeding during prenatal care, ensuring that babies go skin to skin at birth — when mums and babies are together their blood sugars are higher, their respiratory rates are better and the initiation of breastfeeding is more effective — and then ensuring that mums and babies stay together on the postnatal ward and receive community support.

What we see here is that all babies in the study started out breastfeeding — that was an inclusion criterion — but all the way out to one year after delivery, maternity care had an impact on breastfeeding rates, so if we were able to have more baby-friendly hospitals in Australia that practised the 10 steps, we would enable more women to be successful. And it is not necessarily all 10 steps — any number of steps convey improvement.

This was a study in the US looking at the number of steps a mum had experienced and her chances of meeting her own breastfeeding goals, and what the authors found was that if none of those steps were encountered — if the mum had baby-hostile care — 30 per cent of women failed to meet their own goals of breastfeeding for at least two months. So we are setting mothers up to fail if we do not deliver baby-friendly care. In contrast if women received all six of those steps, just 3 per cent were unable to meet their goals. So when we do a good job in the maternity care we provide and when we follow WHO recommendations, we enable women to meet their own goals.

This is a list of BFHI-accredited facilities in Victoria as of the last thing I was able to google, and I believe this data is from September 2017, so it is fairly up-to-date. I do not know how many maternity facilities there are in the state, but I imagine there are more than these, so this is another opportunity.

In the United States we have taken an approach at the state level to offer stars or points or steps for implementing some of the steps, so for example in North Carolina we have a five-star program. If a hospital is doing eight steps, they get four stars, then they complete a questionnaire and get listed as a four-out-of-five-star hospital. And if they implement all five steps, they get five stars. That is an acknowledgement of the fact that it is difficult to change practice, but the state is rewarding and incentivising hospitals that make step-based progress. There are a variety of different models across the US, and I would be happy to share specifics if that would be of interest.

Then I want to talk a bit about the influence of formula marketing. This was a study that randomised women to receive a packet of information and a breastfeeding support packet early in prenatal care that was commercially provided by a formula company or that was non-commercial, and it looked at the rate of women stopping breastfeeding after birth. That packet at the very first prenatal visit had an impact eight months later in whether mums continued to breastfeed. I think there is a reason for that. It would be foolish for a for-profit company to distribute something for free that did not sell their product, but I think it is very important to appreciate what business the formula companies are in.

This is a recent statement from the WHO that:

Promotion of breastmilk substitutes by manufacturers and lack of corporate accountability for the adverse consequences ... pose a major obstacle to breastfeeding.

This is just showing the size of the global breastmilk substitutes market. In 2014 it was US\$44.8 billion, and it is anticipated to go up to US\$70.6 billion in 2019, so a great deal of money is at stake. You can sort of see the mindset. The CEO of Mead Johnson, which manufactures one of the major brands in the US, said at a shareholder meeting:

On a positive note, we believe the strengthening labour market and workforce participation rates have caused a rise in breastfeeding rates to level off over the last four months or so.

From a formula company's perspective, every time a baby goes to breast, a formula company loses a sale. They are in the business of selling their product as an alternative to and as a replacement for breastfeeding. I think we have to appreciate that.

I just wanted to show you this. It is from a website from one of the formula companies. It was for breastfeeding support, but you will notice in these images here that the happiest baby in the image is receiving a bottle — in the lower left, yes? Then if you click the animation, they have instructions for transitioning from breastmilk to formula, and you will notice that in the beginning there are the sort of cool blue circles for breastmilk and one red, happy, fat heart for formula. Look, by 14 days it is all love and none of those cold circles that are not about loving your baby! This is a breastfeeding support website, and this is the kind of business that they are in.

I think it is also very important to appreciate the influence of the follow-on formula market. This is a scientific opinion from the European Food Safety Authority that notes that there is:

No ... role of young-child formulae with respect to ... critical nutrients in the diet of infants and young children ... in Europe ...

and:

... they cannot be considered as a necessity to satisfy the nutritional requirements ...

Perhaps more importantly many of them are sweetened with sugar or corn syrup and may play a role in childhood obesity. This is from a Euromonitor blog noting that toddler milk formula is the Hello Kitty of packaged food, because it is taking over the world as an enormous money-making opportunity for formula companies. These toddler formulas are important because they are not regulated.

I got off the plane in Melbourne and walked out to the SkyBus and there was a giant ad for one of the follow-on formulas. That was the first thing I saw in Australia, which was a little upsetting. I think that it speaks to the fact that the brand gets out there in the name of the follow-on formulas and then mums go to the grocery store and see the infant formula and say, 'Oh, that brand had the lovely ad that I saw on the highway. Maybe I should buy that one'. So it is a quite underhanded effort on the part of the formula companies. I think that regulation rather than trying to come up with a budget for a counter-advertising campaign is critical.

Then lastly, speaking to the cynicism of formula companies, this is a quote from a training manual for one of the formula companies in the US. It says:

Never underestimate the importance of nurses. If they are sold and serviced properly, they can be strong allies. A nurse who supports Ross is like an extra salesperson.

The formula companies are in the business of selling and servicing healthcare professionals, of marketing their products, and in order to support breastfeeding we need to protect women from this insidious influence.

Then finally I want to speak about dyadic support after birth, and I just want to speak to the fact that mums have a lot to deal with in the months following birth. This is a US study that asked mothers about major and minor health problems that they faced in the months after delivery. They range from breast infection and haemorrhoids to painful sex to heavy bleeding, backaches, sore nipples, weight control, exhaustion, stress, sleep loss — there is a lot going on for these mothers. Whereas we provide pretty intensive support during pregnancy with weekly visits at the end of pregnancy, the focus on mothers tends to fall off once the baby is born.

Next slide: this is again US data, so maybe it is better here, but it looked at whether when women went to their postpartum care they received enough information. You can see 100 per cent is over on the right, but the only thing that is over 60 per cent, which is passing in an uncurved exam, is midwives speaking about birth control methods after giving birth. Less than half of mothers got enough information about changes in their sexual response and feelings, which is quite important to one's relationship with one's partner, about exercise, healthy eating, how long to wait before becoming pregnant again or postnatal depression. So we are really failing women by not providing them adequate support for these issues.

I like to say with deliberate provocation that once the candy is out of the wrapper, the wrapper gets cast aside. We have to appreciate that taking care of the wrapper is intrinsic to the wellbeing of both the mother and the child.

Interestingly Elizabeth Howell, who is a researcher in New York City, has done a study where she trained social workers to provide information about common postpartum problems. These included baby blues, bleeding, pain, urinary incontinence — there is a list of issues here. There is a 15-minute conversation on the postnatal ward accompanied by a little booklet that said things like, 'Bleeding: five out of 10 women are still bleeding two weeks after delivery. Don't wear white; wear a pad' — very practical, hands-on kinds of issues. This intervention reduced depression symptoms through to six months postpartum. So simply telling women, 'These are some things that you might have to deal with and here's how you can cope with them' had a powerful effect out to six months. It also improved breastfeeding rates.

When we think about improving breastfeeding rates — and this is a graph where the red line is the mothers who received the intervention, and you can see that line is higher than the blue line, which is the control group, all the way out to six months — and when we help mothers take care of themselves, they are better able to care for their babies. I think what is offered by things like the breastfeeding centre is a venue not only to figure out how to latch the baby but also to have a chat with other mums and say, 'Oh, so I shouldn't wear white until four weeks — got it', and not have the embarrassment of coping with that particular issue. So I have a shout-out to the Warrnambool Breastfeeding Centre. We need to provide spaces for women to come together and to receive support.

For most of human history there was a red tent: there was a place where mothers gathered with other women to receive support and guidance and talk amongst themselves, and that community has been lost, certainly in the

US. My sense is that maternal and child health nurse groups help with that, but really you need a place to go where you can show up and see other women and have a conversation and know that you are not crazy — that this is just part of what happens, and if it is more than what usually happens, this is how to get help.

Again when we look at this Swiss cheese model, we need to tackle multiple levels in order to make breastfeeding possible for women, and if we can address those multiple levels, we can achieve those higher breastfeeding rates that are going to cut costs as well as improve the wellbeing of mums and babies.

In summary we recommend at least six months of exclusive breastfeeding. There is data linking breastfeeding with multiple outcomes for mothers and babies, and there are strategies that can make these things better. So as you all consider different possibilities and interventions, I hope that this is helpful in finding ways to advance the wellbeing of mums and babies. Thank you.

The CHAIR — Thank you so much. Are you okay to take some questions?

Dr STUEBE — Absolutely.

The CHAIR — I have just got one fairly basic one. In regard to all the information you have shown up there, it seems we have lost some of what we should have had culturally, especially in the States, as you say. What would be your number one priority in helping mums, bubs and dads in Australia at the moment if you were a legislator?

Dr STUEBE — Can I be an Australian citizen just in general?

The CHAIR — We will sort that mess out in the next couple of days I think. I was going to make a joke about that earlier. Is there something that is on the precipice of us losing at the moment that we could easily step in and say, ‘Let’s fund this’.

Dr STUEBE — So I think it is creating that village. There is a wonderful anthropology book called *Costly and Cute: Helpless Infants and Human Evolution*. The authors make the point that non-human primates have this tremendous advantage as lactating mamas, because they have hairy chests and babies with prehensile hands and feet. So if you are a mother orangutan, you can continue to move about the forest while your baby is nursing a breast with no trouble. Humans do not have hairy chests, hopefully at least the mums, and our babies do not have prehensile hands and feet. What that means is that we cannot take care of a newborn by ourselves. We must have a village. They argue that human civilisation, in essence, evolved because you could not have human babies unless you had more than one person caring for that baby. So I think figuring out how to reconstitute that village and make it possible for women to have support is critically important.

Obviously I am a Barb Glare fan, so I see the breastfeeding centre as a really powerful model. I know that across Victoria there are various kinds of community centres and mother-baby centres. I think that, honestly, if they were to put out a grant proposal to say, ‘Invent the village. Here’s a lump sum of money to do it, and let’s try it across the state in different models’, that could be a really powerful way to find out what works and then tailor it to local communities. Because if you are from Warrnambool and many of your mums are coming from 80 kilometres away, it is quite different than if you are from South Yarra and people can walk to the centre. So it will be important to tailor that to individual priorities, but we need to bring back the village.

Dr CARLING-JENKINS — Thank you for your presentation, Doctor. I really appreciate it. As a former academic, we have got a couple of articles attached here which I will be interested in reading. It is great that you were here for the last presentation, although that is probably hard for you, because you have just provided us with all the academic backup to all the anecdotal stories in the service planning and the gaps that we have been talking about today. I was very interested in your calculator — the modelling. I would love to get a copy of the PowerPoint for the committee if that is possible.

Dr STUEBE — Yes, absolutely. It is right there. I can also let you all see the underlying numbers, and we can make sure that they are strong. But I think they are certainly in the order of magnitude range.

Dr CARLING-JENKINS — Sure. The figures were just staggering, quite honestly. I have kind of known the value of breastfeeding, but to see the fiscal benefits is probably a really good way of convincing some of our colleagues to actually take this up. To be honest I do not really have an awful lot of questions because you covered so much. What is your main message for Victoria? Obviously the advertising was a bit confronting.

Dr STUEBE — I think the advertising is something that is really important. Barb has organised the conference ‘In whose interest?’, about the ethics of infant feeding. In preparing for that and reading a variety of articles, there was a really thoughtful essay on when a public health campaign is needed and when that is a restraint on the freedom of individual citizens for the government to tell them what to do. The author made a very compelling point. One argument is that if we do not do a public health campaign, the commercial entities are going to convince people to do things that are not healthy, and we need to counter that. The argument was that it is sort of ridiculous to spend money to counter an advertising campaign that is advertising a negative health behaviour. So I think there are restrictions on the advertising of infant formula in Australia before six months, so there is precedent. You do not have the pesky first amendment issues that we have across the Pacific.

So it would be very reasonable to say, ‘Yes, this product can exist’. But if you can wrap cigarettes in brown paper, why should there be billboards on the highway saying, ‘Buy this product’, which has as its first ingredient sugar, to give to toddlers. We have an obesity epidemic in the States. I believe there is one here as well. There is no reason to feed toddlers sugared milk, and yet companies are making money doing that. I think that is a real opportunity, without money being spent by the legislature.

I think also it is good to look at the Baby-friendly Hospital Initiative. I do not know the nuances of how that is encouraged here, but the CDC in the US has funded a large project for tactical assistance to help hospitals implement baby-friendly, and the Carolina Global Breastfeeding Institute, of which I am a member, provides the technical assistance. We have quality improvement folks coming in and showing hospitals how to do it. So I think there are opportunities to help care be provided in a way that makes it easier for women to be successful.

I think there are the challenges of reaching rural populations, so what can we do with telemedicine? There was a Google Glass experiment a few years back for a Google Glass breastfeeding support that the ABA worked on. Mum could wear her Google Glass, which does not exist anymore, look down at her baby and an ABA counsellor could pop up and say, ‘Oh, yes, adjust it this way’. It did not quite come to market, but I think there are innovative solutions to bring women support.

Again, grant funding from the NHMRC — if there are requests for proposals for innovative solutions, that is another way to get people thinking creatively.

Dr CARLING-JENKINS — For sure. Excellent. My only other question is: could you provide a reference list for any of those articles that you have been drawing on? It would be fantastic to read those.

Dr STUEBE — Absolutely. Happy to help.

Ms BRITNELL — The baby-friendly hospitals — I am not familiar with the 10 steps, but the couple you mentioned, with mum and baby rooming in together, that has kind of been happening, I would have thought, for a good 20-odd years now. So what are the steps? Is it more post-discharge or early discharge where we are missing out on the last seven steps or —

Dr STUEBE — One of the key steps is that staff have to be educated. There have been a lot of references in the course of the morning to physicians not having great lactation knowledge. With nurses working in maternity, at least in the States, a lot of them will say, ‘I breastfed my kid and this worked and therefore you should do that’. I would not say, ‘I had a caesar, and I liked the stitches they used, so that’s what I am going to use on you’. That is crazy, but often people draw on personal experience.

So standardised training for staff is step two. That includes 20 hours of training for nurses. The way it has been implemented in the US is that it is 3 hours of training for physicians, I think because physicians just will not do 20 hours — not because they do not need it. But it is making sure that everybody knows how breastfeeding works and is not saying, ‘Your baby fell asleep at breast, so you must not have enough milk’, which is what babies do when they are two weeks old.

Skin to skin is an important piece. In some hospitals babies are routinely brought to the warmer, taken off to the nursery and do not see their mum for 3 hours. If babies can have skin to skin, that facilitates early breastfeeding. I do not know what the practice is here.

Ms BRITNELL — You would not see that here anymore, would you? Never.

Ms FACEY — All our policies are based on that.

Dr STUEBE — Perfect, so they are already doing it. There you go.

Ms BRITNELL — That is why I was saying it is normal.

Dr STUEBE — In the US they have done something called the mPINC survey, which maternity centres fill out as a self-assessment questionnaire, looking at the extent to which they are routinely doing BFHI. I do not know how it is monitored here, whether that is useful. But it is great to hear that that is already in place.

Ms BRITNELL — Very much.

Dr STUEBE — So what is the difference between the hospitals that are designated and what everyone does?

Ms BRITNELL — That is what I could not work out. That was my next question.

Dr STUEBE — The hospitals that are designated BFHI, how are they different?

Ms FACEY — We were designated one, but —

Dr STUEBE — On the list?

Ms FACEY — No, we were about five or 10 years ago —

Ms BRITNELL — The effort of accreditation.

The CHAIR — Just to get that on the record, can I invite you back up to the table?

Ms FACEY — What do you want me to say?

The CHAIR — Just the answer to that question.

Ms BRITNELL — Why were we not BFHI accredited here at —

Ms FACEY — Because we were not re-funded, probably about five years ago. It was all about policies.

The CHAIR — But you still carry on most of the practice, though?

Ms FACEY — Yes, we do.

Dr STUEBE — That is great to hear. That is really good.

The CHAIR — Thanks so much for your time.

Ms BRITNELL — That was my second question. Thank you for asking that one for me. The last question I have is: the formula marketing is quite interesting because you are right, there is a market failure because no-one is going to market the breast. So that is probably a role for government when there is no market failure possibly. In China we have seen the rise of formula being used over the last, say, five to 10 years. Has any research been done after the — I cannot remember what they put in the milk.

Dr STUEBE — The melamine scare, yes.

Ms BRITNELL — Thank you. The melamine scare. Has there been any return? I know they went to Australian products and New Zealand products and away from Chinese products, but did they get back to breast at all?

Dr STUEBE — I do not know the data —

Ms BRITNELL — Probably no-one would.

Dr STUEBE — In the *Hello Kitty* argument I think that the Asian market is the fastest growing segment for the breastmilk substitutes market. They see it as an amazing place to sell their wares, and if I were a

businessperson, I would want to go where the market has the opportunity to expand. So then the question becomes: how do we get them to pay for the consequences of that?

I think also — and this is a value not a scientific thing — that when the mum is able to breastfeed her baby, whether that is every single drop of milk or some of the baby's milk, and have that experience of looking down at her baby and her baby looking up at her, and saying, 'Wow, look what I'm doing', that is a remarkably empowering and positive piece. Even if there were no health differences, I would argue that we would lose something; even if the baby who is formula fed had exactly the same outcomes as the baby who is breastfed — if mums did not have the ability to say, 'Look what my body can do. I did this'.

I think that intervention, that taking away of something that women have done with their bodies for millions of years, is a loss, and I cannot put a number on that; that does not go in the calculator. But it is a loss, and the formula companies deliberately prey on women's susceptibilities, with that little heart shape: 'If you love your baby, give them our product, not your nasty breastmilk', and that is what they are doing. I do not think that is good.

Mr FINN — I have just one question, because you have covered it so comprehensively.

Dr STUEBE — I talk a bit fast. It is my New York background!

Mr FINN — I could not even begin to delve into it, because you have just covered everything. This issue that you have raised and the arguments you have put and the arguments we have heard today from quite a number of people is a no-brainer. Yet there is still an attitude abroad from some people that breastfeeding is something that is antisocial or dirty — you know, something quite bizarre. Is it just the advertising that does that? It seems to me that it is not, that there is something that is more deep-seated than that.

Dr STUEBE — I think with the \$44 billion breastmilk substitutes industry, if they spend 10 per cent of their funding on advertising, which is modest — you know, it is a \$4 billion budget to make people think formula is better, that cannot be underestimated. I can speak to American puritanical insanity. I do not know enough about Australian history to know what puritan roots have come here. One of the classic examples is that there was a mother in a Victoria's Secret shop in Massachusetts — is Victoria's Secret here? It is a lingerie place. She sat down in Victoria's Secret and began to breastfeed and was told that that was indecent and she needed to leave the store.

Dr CARLING-JENKINS — In a lingerie shop?

Dr STUEBE — Never mind that there is double-D silicon in Victoria's Secret all over the place, five times larger than life, but 'Oh, my God!'. I think there is a concept in Western, perhaps Anglo-Saxon culture, that says, 'Ew!' about breastfeeding.

I think that part of overcoming that is simply to have it visible. As long as women feel that they have to be under a blanket to breastfeed, then no-one is going to know that women are breastfeeding. One of the efforts that a number of folks in the States have made is to make life-sized cardboard cut-outs of photographs of women breastfeeding and then position them around the community so that you see breastfeeding women. Then no woman has to sit there breastfeeding, waiting for people to come by and make ugly comments. But there is this sort of 'Oh, yes, this is happening. It is there; it is visible' and that can help to make it normal.

My grandfather-in-law was in his early 90s when my sister-in-law had her first baby. They went to dinner. It was the grandparents, my brother-in-law and his wife and the baby. The baby started fussing and Max said, 'You're going to go to the car, right?'. Rachael said no and popped out the breast and latched the baby. Max said, 'Now I've seen everything', but he got over it. So there is a certain amount of having to get over it, and if women feel comfortable breastfeeding in public and feel supported, then if a person goes, 'Ew!', you say, 'You go to the bathroom if you've got a problem with it'. But we need mums to have that sense that they are safe, and that is going to take time.

Mr FINN — So do you think that the millions of dollars that will be coming from the state government shortly can be directed towards advertising to that effect?

Dr STUEBE — I think that absolutely needs to be a piece of it, but I think it is critically important that the advertisements do not land on mum's shoulders to say, 'See, this is so important. You need to do it'. We need to

make it possible. So we need the person who is disgusted to say why you should not do that or why you should go put a bag over your head if they have a problem. Maybe that is what the ad should be about, as opposed to, ‘Mothers, if you’re good mums, you will do this’, because the reality is that a lot of women lack support, and if you are told to do something and you cannot do it, that makes you angry; that does not make you do it.

Mr FINN — Thank you very much, and enjoy your stay.

Dr STUEBE — Thank you so much.

The CHAIR — That concludes our hearing for today. I thank our Hansard team for listening to us today and also our committee secretariat, Greg and Rachel. Thank you so much. Thank you to everyone who has given time today to come in and tell us all about their experiences or their profession in the sector. We will be using that information of course to contribute to the recommendations that this committee formulates. Thank you so much.

Committee adjourned.