

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 4 September 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Ms Susan Day, President, and

Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association.

The CHAIR — I declare open the public hearings for the Family and Community Development Committee’s inquiry into perinatal services in Victoria. Welcome to the first of the committee’s hearings for this very important inquiry. Under the terms of reference for this inquiry the committee will examine the quality and safety of health services delivered to women and their babies during the perinatal period, the provision of an appropriately qualified workforce, the disparity and outcomes between regional and metropolitan locations, and perinatal mental health services for women. We will also consider the quality and safety of current methods to reduce the incidence of maternal and infant mortality.

The committee called for submissions earlier this year and has received almost 80 submissions to the inquiry. Many are from women and detail their personal experiences of perinatal care. We have received submissions from peak bodies, health professionals, including midwives, perinatal researchers, local councils and a range of individuals and support groups. Submissions to the inquiry are published on the committee’s website.

The hearings for this inquiry will be open to the public and the transcripts from these hearings will also be published. The committee will hold further hearings in Melbourne and in regional Victoria and will be conducting community forums to encourage participation from as many people as possible. Please see our website for details of upcoming hearings.

These proceedings today are covered by parliamentary privilege, and as such nothing that is said here today can be the subject of any action by any court. If you have any special needs today, please see the committee staff, who will assist you. Please note that broadcasting or recording of this hearing by anyone other than accredited media is not permitted and all mobile telephones should now be turned to silent.

I welcome to the public hearings our first witnesses, Ms Susan Day, president of the Australian Breastfeeding Association, and Dr Susan Tawia, manager for breastfeeding information and research from the ABA. Thank you for attending here today. All evidence at this hearing taken by the committee 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 any 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 are being recorded, and you will be sent a proof copy of the transcript.

I invite you to make a 10-minute statement followed by questions from members of the committee.

Visual presentation.

Dr TAWIA — Okay, for 10 minutes I might be talking quickly, because we were told 15 to 20 minutes. We have done our introductions. We represent the Australian Breastfeeding Association. Before proceeding, we would like to acknowledge the traditional owners and custodians of the land on which we meet today. Together we would like to pay our respects to the elders past, present and future and pay our respects to all Aboriginal people here today, wherever you may come from.

A little bit about the Australian Breastfeeding Association, or the ABA. It is Australia’s largest breastfeeding information and support service. The ABA vision is that breastfeeding be recognised as important by all Australians and is culturally normal. The ABA mission is that as Australia’s leading authority on breastfeeding we support, educate and advocate for a breastfeeding-inclusive society. The ABA is a not-for-profit or, as Tim Costello would say, a for-purpose association started by six Melbourne mothers in the 1960s, who, being frustrated at the invisibility of breastfeeding information and support, saw a need and formed the association to assist mothers like themselves to breastfeed. It has come a long way since those early days.

What does the ABA look like today? The ABA gets 2 million hits per year on its website and gets more than 88 000 calls per year to the National Breastfeeding Helpline, which is staffed by trained volunteer ABA counsellors 24 hours a day, seven days a week. That is almost 1700 calls a week. That is an extraordinary number of women seeking information and support on their breastfeeding journey. The ABA has 1300 trained volunteer counsellors and educators, 230 local ABA groups supporting women to breastfeed in their own communities and 1200 health professional members. It has certainly grown since 50 years ago when it was first started.

Now on to the importance of breastfeeding to babies. Breastmilk contains all the requirements for a baby’s development for the first six months of life and remains the most important part of a baby’s diet, with the

addition of family foods, until around 12 months. It continues to be a valuable source of nutrition and immune protection for two years and beyond. It is also an important part of a mother's and child's physical and emotional wellbeing for as long as the child breastfeeds. Breastfeeding reduces the risk of childhood infections and hospitalisation for such infections in the first year of life and possibly beyond. Breastfeeding reduces the risk of sudden infant death syndrome — SIDS — and is included in the practice that is known to reduce SIDS risk in the Red Nose, formerly SIDS and Kids, safe sleep literature in Australia. Breastfed children have higher IQs — I am happy to discuss this statement later — and breastfeeding is likely to protect against obesity and diabetes in later life.

When speaking about changes in risk or the chance of developing an illness or disease it is important to understand that these claims are made about populations and there are no guarantees of avoiding an illness or disease at the level of an individual. In a population of babies, those that are breastfed are less likely to get, say, gastrointestinal infections than formula-fed babies, but some breastfed babies will still get a gastrointestinal infection, although the number will be smaller.

Breastfeeding is also important for mothers. It benefits them, it reduces the risk of breast cancer and it is likely to reduce the risk of ovarian cancer and diabetes. Breastfeeding is protective of maternal mental health because it buffers against negative mood, decreases anxiety and downregulates the stress response. Being breastfed is important for the babies of depressed mothers because it encourages mothers to interact with their babies, which may ameliorate adverse effects on their babies.

There are some breastfeeding recommendations, and the last two slides compare the difference in health outcomes between babies and mothers who breastfed for longer periods compared to those who breastfed for shorter periods or not at all. However, the World Health Organization recommends exclusive breastfeeding — and I have highlighted that because that is a really important term, and I will talk about it in a moment — for babies to six months of age and for breastfeeding to continue for two years and beyond to achieve optimal growth, health and development. The Australian National Health and Medical Research Council recommends exclusive breastfeeding for around six months and then for breastfeeding to continue until 12 months of age and beyond for as long as the mother and child desire.

The third little arrow gives a definition of exclusive breastfeeding. This means that the baby receives only breastmilk. No other liquids or solids are given — not even water — with the exception of medically indicated things like oral rehydration solutions, drops, syrups, vitamins and minerals if there are deficiencies, and medicines. Exclusive breastfeeding means the baby receives only breastmilk, and exclusive breastfeeding is important to babies.

Despite the very clear recommendations, very few babies are actually exclusively breastfed to six months, especially in high-income countries. Often the importance of exclusive breastfeeding in developed countries is dismissed because babies do not die of the types of infections that breastfeeding protects against such as gastrointestinal infections, since here in a country like Australia there is access to clean water and good-quality medical and hospital care. However, the evidence is mounting that this view is misguided, and in high-income, developed countries the way babies are fed is important and exclusive breastfeeding is paramount. When babies are exclusively breastfed to six months there are further reductions in the risk of SIDS. In fact the risk is reduced by 73 per cent. There are further reductions in infections in the first year and further reductions in hospitalisations due to those kinds of infections.

I am talking about longer term chronic diseases now, not the infant diseases. There is a health economist in Australia, Dr Julie Smith, who has a particular interest in breastfeeding. By using data on breastfeeding and disease development and data about breastfeeding rates in Australia from 1945 to 2005 she was able to calculate the proportion of chronic disease in the adult population that can be attributed to not being exclusively breastfed to six months.

Looking at the first line highlighted in red, if 90 per cent of the population are not exclusively breastfed to six months — or to put it another way, if only 10 per cent of the population are exclusively breastfed to six months — then 20 per cent of the obesity in that population can be attributed to being weaned prematurely. Similarly, when only 10 per cent of the population are exclusively breastfed to six months, 37 per cent of type 2 diabetes and 15 per cent of cardiovascular disease can be attributed to the fact that they were not exclusively breastfed to six months. It does not explain it all but a proportion is due to the differences in the way we develop when we are actually exclusively breastfed to six months. As a result of this research Dr Smith concluded that

encouraging greater duration and exclusivity of breastfeeding is a potential avenue for reducing future chronic disease burden and health system costs.

So what are the exclusive breastfeeding rates in Australia? Here are the results from the latest national Australian infant feeding survey, which was conducted in 2010. As you can see on the left-hand side, exclusive breastfeeding rates start high. Nearly all Australian women initiate breastfeeding. They want to breastfeed. But within a month only 60 per cent are still exclusively breastfeeding, and by the end of the fifth month — described in this survey as less than six months — only 15 per cent, at the very right-hand side, are still exclusively breastfed. Remember Dr Smith's calculations of chronic disease due to not being exclusively breastfed were based on 10 per cent exclusive breastfeeding at six months, so her worst-case scenario calculations are not far from the current reality.

Of particular concern is the rate at which babies are being supplemented with formula in Victorian hospitals. That is the fourth row down, where the red numbers are highlighted. In this table again we see that almost all Victorian women initiate breastfeeding. They want to breastfeed. But we can also see that in Victorian public hospitals 25 per cent of what are described as 'term, breastfed' babies are given formula, and 39 per cent are supplemented in private hospitals. So even before Victorian babies leave hospital almost 30 per cent are not exclusively breastfed. The confidence of these mothers may have been undermined. They are being given the message by healthcare professionals that they are not sufficient and their bodies are not capable rather than being provided with skilled lactation support when it is needed. This, after they have just created a baby.

It is inexcusable that so many Victorian babies are being supplemented with formula contrary to the best practice guidelines developed by the leading global health authority, the World Health Organization, and repeated in the Victorian breastfeeding guidelines, which state that supplementary feeds of infant formula, water or glucose water should only be given for medical indications or at least at the mother's informed consent. A mother's informed consent is required because she needs to be fully informed of the short-term and long-term consequences of formula use in hospital.

Authors of the *Lancet* breastfeeding series, the prestigious British medical journal, acknowledge that breastfeeding is one of the few positive health behaviours that is more prevalent in poor countries than in rich countries, including Australia. Whose responsibility is it? We all need to acknowledge that improving breastfeeding rates is not the responsibility of individual women, it is a public health challenge. Governments, community health facilities and groups, health professionals and peer support groups, as well as women and their supporters, share the responsibility.

To increase breastfeeding rates, particularly exclusive breastfeeding rates, in Victoria the Australian Breastfeeding Association calls on the committee to support the overwhelming majority of mothers who want to breastfeed their babies by making Baby Friendly Health Initiative accreditation mandatory in all places babies are born. We know BFHI has a positive impact on breastfeeding rates. A large-cluster randomised control trial of a BFHI intervention showed that it significantly increased the proportion of mothers breastfeeding throughout the first year and significantly increased exclusive breastfeeding at three and six months.

The 10 steps to successful breastfeeding are central to and defining of the Baby Friendly Health Initiative in hospitals. Just to highlight some of the steps: health professionals should encourage breastfeeding early, within an hour of birth, step 4; they should encourage mothers to breastfeed according to their baby's needs, step 8; health professionals should give no food or drink except breastmilk to newborn babies unless medically indicated, step 6; and hospitals should train all staff in the skills necessary to promote and support breastfeeding, step 2. The Royal Women's Hospital has taken the lead in Victoria and has been BFHI-accredited continuously since 1994.

Ensure all health professionals who encounter mothers and their breastfed babies understand and follow the evidence-based National Health and Medical Research Council Australian infant feeding guidelines. We know exclusive breastfeeding has a positive impact on the health outcomes of babies. The NHMRC recommends exclusive breastfeeding for around six months to ensure optimal health, growth and development of Australian babies. Ensure the evidence-based Victorian breastfeeding guidelines are implemented. They have been here since 2014, and one of the developers is sitting in this room today. The guidelines state the purpose of them is to protect, promote and support breastfeeding in Victoria. They are a readily accessible, concise guide to help professionals who work with pregnant and breastfeeding women. These guidelines are a source of

evidence-based breastfeeding information for health professionals to use when working with women and families during the continuum of breastfeeding. The work has been done.

Facilitate compulsory and adequate education of all health professionals who may encounter women of reproductive age both during their initial training and when undertaking ongoing professional development. There is a lack of knowledge about breastfeeding in those health professionals who are most likely to encounter women of reproductive age. Such health professionals have an obligation and a duty of care to ensure they provide women with correct information and support to help them make informed decisions when breastfeeding their babies.

We must ensure government services, especially health services, lead by example by becoming accredited breastfeeding-friendly workplaces so that their staff can continue to breastfeed after they return to work from maternity leave. Employer-based programs that support breastfeeding mothers when they return to work result in positive breastfeeding outcomes and/or employee satisfaction ratings. BFW accreditation in Victorian government health services would send a strong message to health professionals that breastfeeding is important. It would also send a strong supportive message to their clients. A culture would be created where breastfeeding is protected, promoted and supported.

Just finally, the Australian Breastfeeding Association appreciates the opportunity to appear before the committee to present the evidence that shows the importance of breastfeeding for the health and wellbeing of all Victorians. We all need to work together to protect and promote breastfeeding and support mothers to breastfeed.

The CHAIR — Thanks, Susan. Thanks very much for that informative presentation. Are you happy to now take some questions?

Dr TAWIA — Yes.

The CHAIR — If I can start, I appreciate the importance of exclusive breastfeeding to six months of age. I have got to say I am a little bit surprised that the supplementary use of formula in private hospitals is up to 38.7 per cent. What are the issues there? What actually causes that? What causes a mother to choose between breastmilk and formula? Is it choice, is it trouble with the baby attaching, is it misinformation or people that are not educated?

Ms DAY — There are a lot of different reasons. In the first hours and the first two or three days after birth it is a new experience, it is a hazy time and there is not always a lot of knowledge to new mothers on what to actually expect, what is normal breastfed baby behaviour and what is normal behaviour after birth. Babies can be upset, fractious, all these things, and at that time mothers are extremely vulnerable to an ill-spoken word or a mistaken comment, and that can come from a variety of people.

Their confidence can be very easily eroded that their bodies are sufficient after they just created this baby, when in fact that is seldom actually the case. During that time they actually need really skilled, supportive people, particularly the hospital staff, around them so that in the middle of the night when the baby is crying and they are not quite sure how to attach their baby, rather than, ‘Oh, it’s all too hard. I don’t know what to do now. I’ll just put the baby on formula because I’m really tired, my baby’s upset, something must be wrong’, they actually have a skilled lactation support worker coming and guiding them through what needs to happen: ‘Actually this is normal behaviour. Let’s just calm baby down. Let me show you how to attach your baby, get baby feeding’. These are often crises at the time in the eyes of the mother, but it is, most of the time, quite normal behaviour for the babies, so it is in that time when women are vulnerable that they are not receiving the adequate information and support that they do need.

Of course there are always exceptions. There are ill babies and that. With those ill and medically compromised babies, they are the ones that actually need breastmilk even more importantly than a well or term baby. Breastmilk’s immunological components are the medicine for babies in these cases, so they need that support even more. And if baby gets separated from mother, that mother needs help to express her milk so that the baby, while it is perhaps in special care and things like that, continues to receive that breastmilk that is so important.

The CHAIR — Thank you. How many international board-certified lactation consultants are there in Victoria? Do you know?

Ms DAY — Off the top of my head I could not answer that. International board-certified lactation consultancy is a professional credential. Australian Breastfeeding Association counsellors are peer counsellors, so it is a different credential. The peer-to-peer support that our breastfeeding counsellors do provides ongoing support and information for what we consider normal, everyday things that happen, and as you see, we get a lot of phone calls. When a mother encounters something outside the scope of normal and she needs specialised care, that is when a peer-to-peer or a breastfeeding counsellor would refer that onto the IBCLC to get that next level of support and care. So I cannot give that answer, but I can certainly find out and get back to you.

The CHAIR — Thank you, Susan. I now pass to my colleagues to ask some questions.

Ms EDWARDS — Thanks very much, Susan and Susan. Thank you for coming along this morning. I was a nursing mothers counsellor back in the old days and did breastfeed all four of my children. I am very pleased to say that my new grandchild is also being breastfed as of two weeks ago.

Dr TAWIA — Fantastic.

Ms EDWARDS — I recall doing the counselling course. It took me about 12 months to do that course with a doula who helped me through that process. I was just curious about how many Victorian counsellors we have. There are a couple of questions within that. How many counsellors do we have currently in Victoria? What is the training program now? Is it an accredited course now — a qualification, if you like? What is the time frame around doing it? And also, what is the cost?

Ms DAY — Okay, I can answer most of those. To become a qualified breastfeeding counsellor it is a certificate IV course, so it is a nationally recognised course that the ABA does run. It takes on average around 12 months, but we have flexible training so some are short and some are longer. A lot of our people start off as trainees. They go and have a baby in the middle of their training, so on average about 12 months. They come out at the end with a nationally recognised course qualification. We still continue to have mentors for those new counsellors, so when they first are qualified they are mentored in their early days on the breastfeeding helpline through a practicum session, and they continue to receive ongoing continuing education through that time. We have got around 1300 trained volunteers. Some of those are counsellors and some of them are community educators.

Ms EDWARDS — Is that just in Victoria?

Dr TAWIA — No, that is Australia.

Ms DAY — That is Australia. I will get to the breakdown of how many there are in Victoria, but certainly Victoria and New South Wales are where we have got the biggest numbers. I am a West Australian and we have got a lot less over in WA. What was the other part of your question?

Ms EDWARDS — Just in terms of the cost, yes.

Ms DAY — The cost to the trainee. Apart from a small administration fee for enrolment, which is around \$100, the ABA does not charge for that certificate IV course. We do it as a volunteer traineeship and in return we ask those that complete the course to give back to the association by committing to man the breastfeeding helpline for at least two years. We actually find that a lot of our volunteers are long-term volunteers and stay with us multiple years and even decades, so we get good value for our money out of that.

Ms EDWARDS — Do you receive any funding support?

Ms DAY — We do. We receive a grant federally, and that grant allows us to run the National Breastfeeding Helpline and it contributes to the cost of the training of our breastfeeding counsellors and community educators.

Ms EDWARDS — Do know how much that is per annum?

Dr TAWIA — Didn't we just get \$3 million?

Ms DAY — It was \$3 million for three years. We are in our first year of that; it was a recurring grant. When it was renewed this time it did not go up so we have not got any more CPI, so in effect we are doing more with less.

Ms EDWARDS — So it has been \$1 million approximately per annum for quite some time?

Ms DAY — That is correct, yes.

Ms EDWARDS — Just on the counsellors, who I think do a brilliant job, are they trained now to support women from CALD backgrounds and also Aboriginal and Torres Strait Islander backgrounds?

Ms DAY — Absolutely. That is part of our training. We also have some specific courses in ABA where we go out into the community to, I suppose, target and provide specialised services to those communities. We have got one course, a community breastfeeding mentor course, where we have actually gone into Indigenous and CALD communities. We have done quite a bit of work in New South Wales and Victoria with the Indigenous communities, and we actually train some of their community members — the aunties and the elders — to become not breastfeeding counsellors but mentors to the young girls coming through, like a breastfeeding champion in their community. We have been running that community breastfeeding mentor course in a number of areas, and although it is early days we are getting positive results from those communities that they are seeing increased breastfeeding rates in their local communities, because they are getting the support from the people around them.

Dr TAWIA — That is a slightly different model where we embed the breastfeeding knowledge within the community. They are more comfortable getting the information from their mothers and their aunties and the women in their community so we embed the correct information. They say to us, ‘Can we pass it on’ and we say, ‘Yes, that is what we want you to do’.

Ms EDWARDS — Just one last question in relation to why women choose not to breastfeed. Obviously there are a lot of reasons, but it seems to me that the reasons now are becoming a little more confusing, I suppose, about why and why not.

Dr TAWIA — Yes, they are complex.

Ms EDWARDS — But I just wondered, has there been an analysis done of the cost per week for a new family? What is the average cost to a family for a newborn, say, over a week?

Dr TAWIA — I am not aware of anything being done in Australia; I am sure it has been done. The thing I know that Julie Smith has done is she has sort of done the converse thing — the cost of exclusively breastfeeding. I do not know the numbers but she has certainly worked out that there is a cost, because usually the woman stays home from work and various things like that, so there is not no cost to breastfeeding. In terms of formula feeding, we do not have those kinds of numbers. We say it is less than breastfeeding, and often the mums are staying home anyway, especially early on. I am sorry I do not have those figures.

Mr FINN — I would regard breastfeeding as a no-brainer. You have outlined here very conclusively that anybody who is not involved in breastfeeding —

Dr TAWIA — Protecting, promoting and supporting breastfeeding.

Mr FINN — probably should have a pretty good reason, but still from time to time there is an outbreak of controversy about breastfeeding, which mystifies me I have to say. I am just wondering, has there been a change in community attitudes towards breastfeeding over a period of time? Are we seeing people perhaps in more prosperous areas going against it or what is the feeling of the community on this?

Ms DAY — The media loves to sensationalise the mummy wars of those who do and those who do not. It sells. What we do know is in Australia we have really high initiation rates. That tells us that the vast majority of mothers want to breastfeed. It is what is happening afterwards that, for one reason or another, they are not able to continue. Then with those that do wean prematurely, whatever the reason is, often that comes with quite an emotional cost to the mother and then I suppose subsequent comments later on that they are often defensive and they are vulnerable. That is what you find the media will play on. Rather than saying all women need support, they will try and create a divide.

In the community, when you actually speak to mothers, most mothers, even those who are bottle-feeding, say, ‘I wish I could have breastfed’ or, ‘I wish I could have breastfed longer’, and a lot of those have a lot of ongoing — I am just trying to think of the right word — it is a grief that they have lost that relationship

prematurely, particularly when they find out afterwards, ‘Actually I was told one thing in the early days and I put my baby on formula and now I find there were other options I could have taken’. So it comes to that informed consent. Sometimes weaning is absolutely the right thing for a mother and baby, and if she makes that with totally informed consent, then she can feel comfortable and not have that grief. Some mums say they feel guilt later on, so it is a very complex area with no, I suppose, easy answer to that question.

Dr TAWIA — Sorry, I was just going to just say I suppose what we really want is, however women decide to feed their babies, that they are fully informed of the options and the choices and the consequences of those, and then they can make an informed choice.

Mr FINN — As you mentioned, the media do love it, and these sorts of controversies, it would seem to me, may have an impact on women — mothers who wish to breastfeed and indeed who are breastfeeding. Is there any evidence that that has occurred or is occurring?

Dr TAWIA — That those kinds of things are influencing — we have not looked at that. We are just more collecting basic reasons why they are making choices like struggling in the beginning or returning to work with things like that. I mean, sometimes when we get that kind of media we get a groundswell of support for our work and what we are doing, and in fact it gives us an opportunity to push out some right, correct information in a moderate way. So we actually get a chance to push better information out there, and people are hearing it because they are alert to it. We found that sometimes we can sort of push out more good information — flood the poor information.

Mr FINN — Thank you. Just one last question. I notice one of the points that you make there is that there should be no soothers or dummies for babies who are being breastfed. As a father that makes me shudder, I have to say.

Dr TAWIA — It is very early on when you are trying to establish breastfeeding, because to get the milk you need suckling at the breast, and the more suckling at the breast, the more milk you make. So if you interrupt that by either trying to stretch out time between feeds or putting something else in a baby’s mouth, then you are not going to get the stimulation you need, and therefore you may not get the amount of milk that you need. So then you are sort of behind the eight ball. So they sort of say six to eight weeks, maybe — is that kind of what they are saying? I would say longer, but —

Ms DAY — Yes, and that particular point is part of the 10 steps, which is an international document brought out by UNICEF. Certainly as ABA counsellors, whilst we look at population-level information and that sort of thing, we deal one on one with a mother. In a particular mother’s case it may well be that using a pacifier or dummy is the best information in that, and when our ABA counsellors are working one on one with a mother we meet a mother wherever she is and respect her choices and work with her and say, ‘If you’re going to use a dummy, you can use it selectively. So use it help soothe Baby and put Baby to sleep, but then remove the dummy and do not have it in there for hours and missing those feeds’. It is one thing for population-level information and it is another for one-on-one, direct-to-the-mother information.

Mr FINN — Thank you.

Dr CARLING-JENKINS — I want to thank you for your excellent submission. I love the way that you identified gaps and gave solutions, so that is exactly what this committee is looking for. As a mother who loved breastfeeding I was quite disturbed with some of the stats that you gave — I think it was on pages 3 and 4 — about how low, I thought personally, the stats are now. Did you say it was the Royal Women’s who have been accredited with the Baby Friendly Health Initiative?

Dr TAWIA — The public part of the Royal Women’s Hospital.

Dr CARLING-JENKINS — Right, since 1994?

Dr TAWIA — Yes.

Dr CARLING-JENKINS — What percentage of other hospitals in Victoria are accredited?

Dr TAWIA — Not very many. Can somebody help? Am I allowed to talk to somebody who is here?

Dr CARLING-JENKINS — Or you can get back to us on that.

Dr TAWIA — Get it back to you? Yes, but you might get the answer here.

The CHAIR — Yes, perhaps if you just get back to us.

Dr CARLING-JENKINS — That would be fascinating.

Dr TAWIA — Yes. Virtually no private hospitals.

Dr CARLING-JENKINS — No private hospitals.

Dr TAWIA — And they are mostly regional hospitals. There are very few in the city of Melbourne.

Dr CARLING-JENKINS — So more regional are accredited than the metro hospitals?

Dr TAWIA — Yes. Maybe Sunshine Hospital?

Dr CARLING-JENKINS — That is very interesting.

Dr TAWIA — There is a web page. I can send that information, but actually it is the Australian College of Midwives. They have a page, and they have got every facility in Australia, and it is not very many. It is about 60 something all around Australia that are accredited.

Dr CARLING-JENKINS — Okay, so we are talking quite a low percentage here in Victoria.

Dr TAWIA — Very low numbers, yes.

Dr CARLING-JENKINS — And would that be, do you think, because there is just no consistent training and monitoring? I noticed in your submission as well you said there was not a lot of evaluation of breastfeeding, and there certainly does not seem to be compulsory professional development in this area.

Dr TAWIA — Lots of questions there. The BFHI is a big commitment, and I know that there are hospitals — there are a few accredited facilities. It is a procedure to go through, and they have got to have a full commitment to this. It is costly. They have got to get all the staff on board. So I think in those terms the college of midwives actually administrates the process, and I think they need more support to do that. There are places in Victoria — certainly in Melbourne — that claim they are BFHI-like. So they are happy to be supporting breastfeeding but they have not gone down this process.

Dr CARLING-JENKINS — But not the full accreditation.

Dr TAWIA — Yes, the full accreditation.

Dr CARLING-JENKINS — Which brings the confidence, I guess.

Dr TAWIA — Yes. My understanding is that in somewhere like New Zealand nearly all the hospitals are BFHI accredited there, and I think nearly all the ones in Tassie are BFHI accredited. We have got strong people there pushing.

Ms DAY — Tasmania has all of their maternity facilities as BFHI accredited, and whilst there is a cost to become accredited through BFHI, those costs are paid back because when you increase exclusive breastfeeding rates you decrease a lot of other health and ongoing costs. So it does pay for itself, but it requires commitment, and part of BFHI includes educating staff, so you are sort of heading two —

Dr CARLING-JENKINS — Professional development.

Ms DAY — Yes, things in one go. So you are tackling the issue of sometimes inadequate staff knowledge and training as well as that environment.

Dr TAIWA — Something that has really resonated with me while I have been working in this area is that if the health professional is not seen to actively support breastfeeding, and exclusive breastfeeding, if they try to stay neutral because it is the mother's choice — they do not want to make them feel guilty or whatever — that

is actually seen as not supportive. So if they are not actively supporting it, if they are neutral or against it, that is all seen as against. So if we are going to keep pushing this to support the mothers who want to do it, they need to see their health professionals being overtly supportive of breastfeeding.

Dr CARLING-JENKINS — Just one very quick last question. Given the benefits of breastmilk, there are some tragic circumstances where a mother is ill or a baby may be adopted under quite tragic circumstances where the mother is unable or unavailable to breastfeed. In those circumstances do you support initiatives such as a breastmilk bank?

Ms DAY — Absolutely.

Ms COUZENS — Thank you very much for your presentation this morning. You mentioned in your submission the drop-in centre. I know in a region like Geelong, where I come from, a lot of young mums complain about being put under pressure and being given lots of different information, which they find very distressing. Would you see a drop-in centre as being an area where mums could go that would prevent a lot of that confusion and assist them to continue to breastfeed?

Ms DAY — Yes.

Ms COUZENS — Good. You talked about the volunteers earlier. Do you have a breakdown of how many would be in regional and rural areas?

Ms DAY — I can get that for you.

Ms COUZENS — That would be great, thank you. The other question I had was that you talked about women returning to work and being able to continue to breastfeed. Would you see that as a campaign going into changes to enterprise bargaining agreements and awards, along that line?

Ms DAY — It could be. At the moment there are a number of businesses in the private, public and not-for-profit sectors that have already become baby-friendly workplaces. One of the things that all of those places which have been accredited have found is that they might start off going, ‘This is really good for our staff. It’s part of our enterprise bargaining. It’s part of our social responsibility’, but as employers they find that they actually get something out of it — they get a lot more employee loyalty and satisfaction. The evidence shows that mothers who are able to continue to breastfeed their babies after they return to work, because usually the child is in child care at that time, actually have fewer sick days off work to go and care for a sick child because their child is less likely to become ill, so there is actually a cost-benefit to the employer as well.

You talked before about breastfeeding being a no-brainer in your eyes. When you speak to employers that are already breastfeeding-friendly workplace accredited, they talk about the small changes that they have to implement to become a breastfeeding-friendly workplace — it becomes a no-brainer for them. It really is a good deal for the employer and a wonderful deal for the mother. She can continue to provide breastmilk and continue her breastfeeding relationship after her return to work.

Ms COUZENS — How could you make that happen?

Ms DAY — To become a breastfeeding-friendly accredited workplace there are three things — allow the employee the time, so lactation breaks. When the employee returns to work, say, in the first six months of life, and there are quite a significant portion who do, that mum may need one or two breaks during the day to go and express her milk — or at some places they have a child close for feeding. As the baby gets older, that drops down to one lactation break and then by the time the child is older there might not be any. So they need time for a lactation break and a private space where the mother can go.

A lot of mums do not necessarily mind feeding their baby in a room with others, but fewer mothers are comfortable actually getting out their breast pump to express, so just a private room which she can lock so she can express her breastmilk and also having a written breastfeeding policy for what BFW is about — that enshrines that a mother has the time for lactation breaks and a private space to express or feed her baby so that every time a new employee comes through the system they do not have to fight the battle with their manager to say, ‘I need this’. It is a written policy. Everyone knows it has happened. Those three things are not a big thing for an employee to do and they are generally not very difficult to implement. Particularly having a breastfeeding

policy in place, it embeds in the whole organisation that this is actually something that is really important to our organisation. We care about the health and wellbeing of our staff and their extended family.

Ms COUZENS — Would you see the benefits of having a standard clause within awards and EBAs?

Ms DAY — Absolutely.

The CHAIR — We could lead by example in —

Ms EDWARDS — the Victorian Parliament.

Ms COUZENS — That is right.

Ms BRITNELL — I have quite a few questions actually. I hope that is okay. First of all, does midwifery training curriculum support the concept of exclusive breastfeeding, and if it does, why is comp feeding condoned as acceptable practice on mid floors?

Ms DAY — This is probably outside ABA's area of remit to talk about the training of midwifery staff. What I can say is that it varies from place to place. Generally most of the midwives I come in contact with are very highly supportive of breastfeeding. A lot of the issues arrive not at the individual midwife level but more at the hospital level and hospital policies as to what happens. I think that question is probably better directed to the Australian College of Midwives.

Ms BRITNELL — Very good. You have been an organisation since the 1960s. You showed us the statistics of breastfeeding decreasing significantly — 50 per cent by four months and 15 per cent by six months. Have you been keeping stats since the 1960s? What were the initial breastfeeding stats at the start? Have they changed, or are they getting worse?

Dr TAWIA — The maternal and child health nurses in Victoria have kept very, very good statistics, and there is a website where you can see all of those. I have actually graphed them; I do not have it here today with me. In the 60s in Australia it was very, very low rates, even of initiation — it was way down. What we have now is those kind of figures have plateaued for the last 20 or 30 years. Something dramatic needs to be done to change breastfeeding rates. We have kind of got — I do not know what to call it — peak breastfeeding at the moment. No more women, with the way we have it set up at the moment, are going to be breastfeeding. Women who come into contact with the ABA breastfeed at higher rates than the Australian population, but that is because they are part of a community where they are supported in the choices that they are making. So they have kind of flatlined since the 90s.

Ms BRITNELL — Is there evidence that the active ingredient of the immunoglobulins that are found in breastmilk is able to be copied into formula, or is that debate still —

Dr TAWIA — There are hundreds and hundreds, possibly thousands, of components in breastmilk. Occasionally you will see the formula companies will put one in, say lutein or some oils or something like that, and make a claim that it is close to breastfeeding. The immunoglobulins are actually actively put in.

So let us say there is a little bit of some kind of cold or flu going around. The mother creates the immunoglobulin and it gets transferred into the milk, so it is very specifically that one at the right time for that baby and mother that have been exposed. So they could maybe put something broad in, but on heating some of these things will possibly get destroyed. One or two things is not going to come close to what is in breastmilk even in terms of immune protection. There are actually white blood cells as well that are in there that will not be in formula; there are living cells.

Ms BRITNELL — Your breastmilk bank concept — back in the 80s we stopped doing that in the hospitals because of the challenge that HIV presented around 1984–85; I cannot remember exactly. The benefits of breastmilk from a bank perspective versus the risk of diseases — where is that at now with regard to protection of breastmilk?

Dr TAWIA — Breastmilk banking in Australia and in Victoria, say like at the Mercy, is highly formalised, and the milk is pasteurised so anything that is likely to be infectious in it is killed before it gets to the baby. In those situations at the moment the premie babies, who are the most vulnerable and who most need to not be

exposed to formula, are the ones getting that milk. It is seen that it is important. The benefits for them are huge, and the problems with infections have basically been overcome so long as that milk is treated in the milk bank.

Ms BRITNELL — Do you think that the discharge from hospital that has got earlier and earlier over the last 30 years is resulting in any of the lack of confidence that we are seeing, that you are talking about? It does not seem that the message of putting the baby to the breast, stimulating prolactin causing the pituitary gland to work is the message that is coming through. Comping is still very, very strong. ‘I can’t do this because I am not good enough’, which is I think what you were hinting at. It has been a real struggle to get people to understand the balance between increasing production by suckling. How do you explain how we address that?

Ms DAY — I suppose early discharges can be an issue. Often mothers are discharged hours or within a day after birth, which is prior to their milk coming in. When you have early discharge it is really important to have continuity of care, so home visiting service in those early days. We certainly know that even in places where they do have maternal and child health nurses visiting after birth, that is not equitable across the state. For people in regional and rural areas there might only be one in their area, and sometimes that staff member is away on holidays and things like that. So we have gaps in the current services, and where there are gaps, women fall through those gaps.

Ms BRITNELL — And that leads me to my last question — the difference between rural and city when it comes to having lactation consultants or just support of any sort if you are an hour away from the hospital that you have been discharged from two days post delivery. How do the stats pan out from city to country?

Ms DAY — Predominantly the lactation consultants are city based. Of course there are some through the country, but there is a lot less access to services in rural and regional Victoria, and at the moment because there is no Medicare rebate for going and visiting a lactation consultant or having them come to you, it is only those women that can actually afford the cost of a private lactation consultant that can access that.

Dr TAWIA — They can ring our counsellors. Anywhere from Australia will get a counsellor, will get an answer to the phone call, and a lot of women do use that service.

The CHAIR — Thank you so much. If there are no other questions, I would just like to thank you on behalf of my family, who utilised your support very successfully.

I do have one last question though. How can we support dads to be more involved in breastfeeding and understand how important breastfeeding is while at the same time there seem to be cohorts that are encouraging families to ensure that formula is used so dad can form a bond with baby as well?

Ms DAY — Encourage mums and dads, or mum and support partner whoever that might be, to attend a breastfeeding education class before birth. They are classes that ABA runs across the state, and they are I suppose complementary to hospital-based antenatal programs where they will focus on the birth. The breastfeeding education class is a 3-hour session, and they are run by trained volunteers. We often have a new dad come in and speak to the dads, and really they tell what it is like. We are not glossing it over and making it look wonderful. It is, ‘This is the reality. Dads, when you get home, here are some practical things that you can do, and in those first few days after birth when mum’s hormones are all over the place and she feeling very vulnerable, you can be her champion and you can support her. Here are some positive things’.

Dr TAWIA — When we are speaking with women, and this is part of the training, there is that question: dad wants to bond with the baby so wants to go to formula. We have a whole lot of other options of the kinds of things he can do with his baby to bond that do not involve introducing formula, like skin to skin, lots of cuddles and all those things that support the mum and at the same time bond with the dad. So there are other things they can do, and we make them aware of those options.

The CHAIR — Fantastic. Thank you for your submission and thank you for attending today and giving us your time.

Dr TAWIA — Thank you.

Ms DAY — Thank you.

Witnesses withdrew.