Australian Government
Department of Health

AUSTRALIAN NATIONAL BREASTFEEDING STRATEGY: 2017 AND BEYOND

Report on stakeholder consultation

October 2017

The views and opinions expressed in this document are those of the participants and/or the organisations that they represent and do not necessarily reflect the official policy or position of any agency of the Australian Government.

Title: Australian National Breastfeeding Strategy: 2017 and Beyond - Report on stakeholder consultation

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OVERVIEW

Introduction

This paper presents the findings from consultations which were undertaken in April and May 2017 to inform the development of an enduring National Breastfeeding Strategy. These included targeted stakeholder consultation workshops in all capital cities and Alice Springs, conferences, written submissions, and stakeholder meetings and visits.

Purpose of consultation

The purpose of consultations was to:

- enable stakeholders with an interest in breastfeeding to provide information, advice and feedback on the draft strategy and
- provide opportunities for stakeholders to ask questions and identify areas of concern.

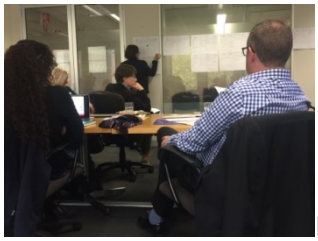
STAKEHOLDER CONSULTATION WORKSHOPS

In April and May 2017, the Australian Government Department of Health, in collaboration with the Breastfeeding Jurisdictional Officers Group, organised 12 workshops across Australia. Workshops were held in all capital cities and Alice Springs. Over 200 stakeholders attended the workshops, including experts in midwifery, lactation, maternal, child and family health, population health, nutrition and dietetics, General Practitioners and Indigenous health.

Date	Location	Number of participants
3 April 2017	Sydney	35
5 April 2017	Brisbane	30
1 May 2017	Canberra	36
2 May 2017	Melbourne	34
3 May 2017	Hobart	16
11 May 2017	Adelaide	15
15 May 2017	Perth	31
17 May 2017	Alice Springs	14
19 May 2017	Darwin	10
TOTAL		**221**

Table 1 – Dates, locations and numbers of workshop participants

Workshop process



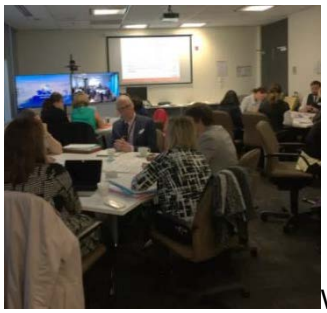
Prior to each workshop, all participants received a copy of the *Australian National Breastfeeding Strategy: 2017 and Beyond (the Strategy) Discussion Guide.* The Guide provided background information and proposed a vision, objectives, principles, enablers and strategic priorities. Participants provided feedback on the principles, enablers and strategic priorities through a series of small group exercises. At the end of each workshop, participants chose their most important points that they thought should be included in the Strategy.

Key themes from the workshops

Many of the same themes were raised through all of the workshops. Through the weighting exercise at the end of each workshop, participants highlighted the following key themes, in no particular order, as critical in the Strategy (see Figure 1).

Figure 1: Key themes from workshops: More detail is available in Table 2 at **Appendix A**.

Feedback from workshop participants



Workshop participants completed a brief feedback survey at the end of the workshop. Figure 2 shows the number of respondents that selected each response on the rating scale from 1 to 5 where 5 is the most positive. Figure 2 shows that most participants were most positive about their ability to participate in the discussion, and its relevance to their work.

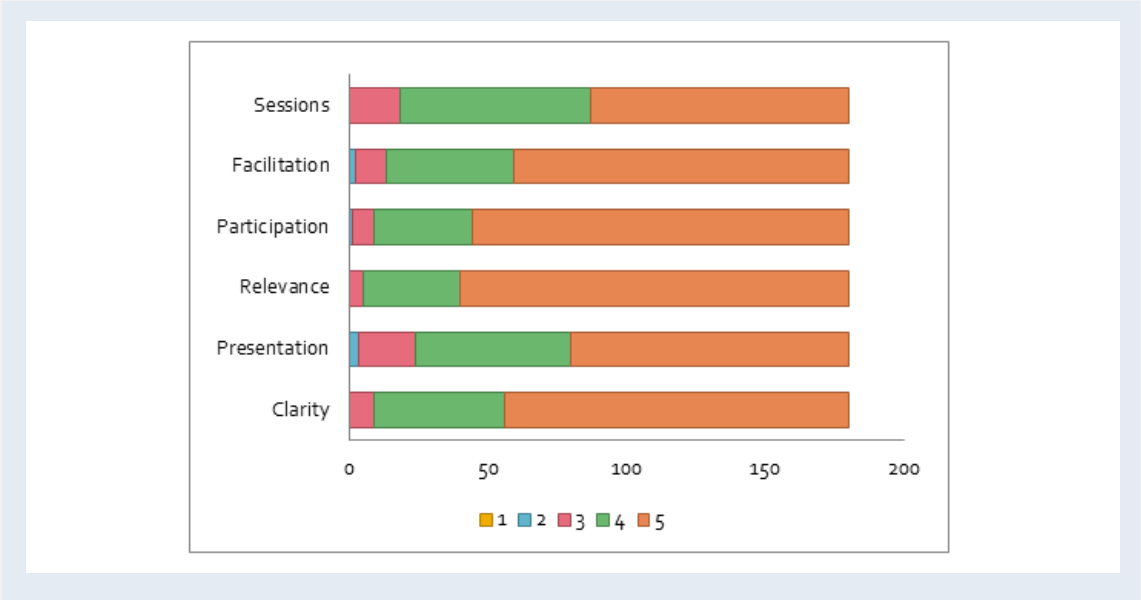


Figure 2: Participants' ratings of the workshops

SEMINARS AND CONFERENCES

Department of Health staff attended the Australian Breastfeeding Association (ABA) Health Professional Seminars held from 14-18 March 2017 to:

- raise awareness of the development of the Strategy and
- learn from experts about the latest evidence-based information and research on breastmilk and breastfeeding.

Departmental staff also attended two conferences and sought feedback on the development of the Strategy. These were the:

- Australian Primary Health Care Nurses Association (APNA) 2017 National Conference (Hobart, 4-6 May 2017); and
- Maternal, Child and Family Health Nurses Australia (MCAFHNA) Conference (Melbourne, 1-3 June 2017).

APNA and MCAFHNA Conference participants raised similar issues to those raised during the workshops.

WRITTEN SUBMISSIONS

The Department of Health received over 20 written submissions from stakeholders who were unable to attend the workshops or those who attended the workshops but wanted to provide further input.

Key themes from submissions

The key themes arising from the submissions were similar to those mentioned at the workshops and are outlined in no particular order below (Figure 3).

Figure 3: Key themes from written submissions- These are presented in Table 3 at **Appendix B**.

Mothers' feedback on barriers to breastfeeding

Breastfeeding Advocacy Australia (BAA) provided feedback from mothers who shared personal experiences of breastfeeding on the following Facebook pages: *BAA*; *Breastfeeders in Australia*; and *The Gentle Breastfeeder*. Some of this feedback is summarised in **Appendix C**.

Mothers were requested to identify issues that hindered their breastfeeding journeys, specifically:

- examples of inaccurate breastfeeding information/advice provided by health professionals;
- lack of support from hospitals in relation to breastfeeding; and
- the impact on breastfeeding of having to return to work in the first 12 months after birth and the importance of paid maternity leave to support breastfeeding.

Inaccurate advice from health professionals

Table 4 (**Appendix C**) presents mothers' stories of inaccurate advice provided by health professionals. A number of women raised the issue of formula top-ups and that it seems to "fix all issues". Mothers have been advised by various health professionals (paediatrician, maternal and child health nurse, midwife, GP) that they would need to supplement their breastmilk with formula so that their babies don't lose too much weight. BAA's submission has noted that "Health Professionals lack expertise and in that void turn to artificial powder as a stop gap rather than address the cause and breastfeeding function for many problems faced".

There were a number of mothers who cited lip and/or tongue ties which have led to latching difficulties, nipple pain, constant feeding, and low weight gain. Some health professionals dismissed tongue ties as just a fad, were not concerned or did not know about them. Mothers noted that breastfeeding was no longer difficult once lip/tongue ties were resolved.

Lack of support from hospitals

Mothers cited examples of hospital staff providing no breastfeeding support, giving the wrong advice, or 'forcing' them to use infant formula. These are summarised in Table 5 (**Appendix C**).

Returning to work in the first 12 months

Women provided examples of the barriers they faced when juggling working with breastfeeding in the first 12 months after the birth of their babies (see Table 6, **Appendix C**). These include:

- lack of time or appropriate facilities to pump while at work which leads to reduced milk supply;
- breasts not responding to pumps;
- negative attitudes of work colleagues to lactation breaks;
- stress and its impact on milk supply; and
- return to work and its impact on women's and their babies' health and wellbeing.

A number of women have not returned to work because they have prioritised breastfeeding but are struggling financially. Some are able to access employer paid maternity leave as well as the Paid Parental Leave payments but others are not eligible for one or the other or both. There were a few women who have returned to supportive work environments and are able to take lactation breaks and flexible work arrangements to enable them to continue breastfeeding.

ABORIGINAL AND TORRES STRAIT ISLANDER GROUPS

In early 2017, Departmental staff sought input from the **National Aboriginal and Torres Strait Islander Health Standing Committee or NATSIHSC** (a standing committee of the Community Care and Population Health Principal Committee of the Australian Health Ministers' Advisory Council). The Project Team also attended **Aboriginal Health Partnership Forums** from March to June 2017, and received a copy of the **Victorian Aboriginal Community Controlled Health Organisation's (VACCHO)** breastfeeding paper tabled at the **Victorian Advisory Council on Koori Health** meeting in March 2017.

The NATSIHSC feedback is summarised below:

- Due to significant disparity in Aboriginal and non-Aboriginal breastfeeding rates, NATSIHSC suggests developing a separate section/priority or specific actions for Aboriginal people within the *Strategic Priorities across the Breastfeeding Continuum* part of the Strategy.
- It is suggested that the Strategy be linked with the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* and address the need for culturally appropriate services and resources to be made available to Aboriginal women and their families.
- Strategies may include but are not limited to:
    - Working in collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs), community services and other stakeholders to inform the delivery of culturally secure and responsive care.
    - Initiatives to address the risk factors and behaviour that can impact on breastfeeding. This is applicable to all population groups but is of particular relevance and importance to Aboriginal people. Examples include health promotion and education initiatives, for mothers, partners, extended family and communities that inform of:
        - the damage that risk behaviours such as alcohol and other drug use and smoking can have on breastmilk and the health of the baby; and
        - the effects that smoking, including passive smoking within the household, can have on the production of breastmilk. The 2014-15 NATSISS showed that 54% of Aboriginal infants aged 0-3 years were living with a current daily smoker.
- It is also suggested that the *National Evidence-Based Antenatal Care Guidelines* be included as a strategy/activity relevant to breastfeeding.
- It is suggested that additional consultation targeting Aboriginal and Torres Strait Islander key stakeholders would be of value (e.g. Aboriginal Health Practitioners).

Bendigo and District Aboriginal Cooperative provided the following comments:

- The disparity in health and life outcomes between Aboriginal and non-Aboriginal people is well documented and this includes disparity in rates of breastfeeding. Addressing this disparity requires a concentrated effort in preventative programs including programs

designed to improve the rates of breastfeeding. These programs may be small but they need to be well funded and well targeted. They need to recognise and address the barriers Aboriginal face in accessing mainstream services.

- The provision of maternal and child health nursing services and lactation specialists in Aboriginal Community Controlled Organisation is key. We need people who can work with pregnant women from early as possible in pregnancy to increase their understanding of the benefits of breastfeeding and to reduce the associated stigma which is a troubling feature experienced by this particular target group of women.

- It was disappointing that the documentation that you provided on the day did not include any reference to Aboriginal and Torres Strait Islander women and their babies - and that there was not an Aboriginal specific consultation in Victoria. It is not appropriate to include any strategies for Aboriginal and Torres Strait Island women under the headline 'diversity'.

<u>The VACCHO provided the following input:</u>

- Any Strategy in Aboriginal communities must come from an Aboriginal Community Controlled, strengths based perspective which empowers women and families as well as environmental settings.

- 'Feeding our Future – Aboriginal Early Childhood Nutrition and Physical Activity Needs Assessment Report' by VACCHO (2013) includes recommendations for improving breastfeeding outcomes, and components for an Aboriginal breastfeeding strategy. An example of a strengths based approach to sharing stories about breastfeeding in Aboriginal Communities can be found in 'Yarning about Breastfeeding' by VACCHO (2016).

- The Koori Maternity Services Workforce, coordinated by VACCHO, are well positioned to operationalise breastfeeding strategies. Building capacity and resourcing workforces is vital for successful breastfeeding strategies on the ground.

STAKEHOLDER MEETINGS AND VISITS

During April and May 2017, the Department met separately with stakeholders who were unable to attend the stakeholder consultation workshops or wanted to provide further input. Meetings were held with:

- Ms Melinda Boss, Senior Research Fellow, Pharmacy Division, School of Allied Health, University of Western Australia;
- Professor Karen Simmer, Professor of Newborn Medicine and Director, NICU, King Edward Memorial Hospital;
- Dr Ben Hartmann, PREM Bank Manager, Neonatology Clinical Care Unit and Senior Lecturer, UWA School of Paediatrics and Child Health;
- a group of rural and remote nurses from Western Australia and the Northern Territory; and
- Dr Julie Smith from the Australian National University.

Departmental staff also visited the:

- Royal Brisbane and Women's Hospital Milk Bank;
- King Edward Memorial Hospital (WA) Milk Bank;
- Birth and Beyond Parent Resource Centre in Alice Springs;
- Boyd Community Hub (Maternal and Child Health Clinic) and the Southbank-Boyd Community Hub in Melbourne (as part of the MCAFHNA Conference).

Western Australia meetings

- Ms Melinda Boss, Senior Research Fellow, Pharmacy Division, School of Allied Health, University of Western Australia – discussed *Lactapedia*, a glossary for human lactation being developed by the UWA and supported by the Family Larsson-Rosenquist Foundation. *Lactapedia* is intended to define lactation terminology specifically for scientific research and medical purposes and provide a common understanding of human lactation.
- Professor Karen Simmer, Professor of Newborn Medicine and Director, NICU, King Edward Memorial Hospital – highlighted the importance of research on breastfeeding and breastmilk. The Hartmann Human Lactation Research Group at the UWA undertakes research on breastmilk.
- Dr Ben Hartmann, PREM Bank Manager, Neonatology Clinical Care Unit and Senior Lecturer, UWA School of Pediatrics and Child Health – discussed issues in establishing donor human milk banks, including safe clinical practice and social responsibility in milk banking.

Meeting with rural and remote nurses

- Breastfeeding is the first option in remote areas so there are good breastfeeding rates including among Aboriginal and Torres Strait Islander communities. In most remote communities it is culturally acceptable to breastfeed. However, there is a *lack of access to support groups*. In East Arnhem in the NT, it would be good if traditional elders could form a support group for young women.
- *Food insecurity and its impact on maternal nutrition* is a huge issue. An example was provided of a 13-year old who hadn't eaten for 3 days yet was breastfeeding. Food is communal and is shared with extended family, there are fewer places to get bush tucker and there is a lot of high sugar, processed foods in remote stores. If a woman's partner is gambling, food budget is last priority.

- The Strategy should specify *how support can be provided for priority groups*.
- It is important to *address the social determinants of health*. There is a need to involve other agencies to support breastfeeding in remote communities. These include remote stores, community organisations, child care centres, community child health centres.
- *Education for health professionals* is important. They need to empower women to take ownership of their own breastfeeding journey.
- Even if medically indicated, hospitals do not provide infant formula. Hospitals are not allowed to promote one brand over another so mothers are asked to bring their own milk.

Meeting with Dr Julie Smith

Economics of breastfeeding

Dr Smith discussed a conceptual framework on the economic importance of breastfeeding and its relation to the market economy, highlighted relevant literature and lessons for the Australian National Breastfeeding Strategy.

Dr Smith noted that an economic perspective can provide new insights into the value and determinants of infant feeding behaviour and can enable more effective design of interventions. Breastfeeding has economic value. It is part of a food economy for infants and young children and competes with the labour market for a mother's time. As such, breastmilk should be included in the Gross Domestic Product (GDP), just like commercial baby food products including infant formula and toddler formula. The value of breastmilk produced by mothers for their own babies is estimated at over $4 billion a year, and meets Australian Bureau of Statistics (ABS) criteria for inclusion in GDP.[1]

Between 1999 and 2013, sales of commercial baby food in Australia has nearly doubled. This has led to increased acute illness costs of milk formula exposure. Dr Smith (2002) found that Australian hospital costs of premature weaning were estimated at $60-120m per annum for just 4 conditions (gastrointestinal illness, respiratory illness, eczema and necrotizing enterocolitis (NEC)[2]. A US study showed avoidable child health treatment costs including later life chronic illness of $10.5 billion per annum from poor US breastfeeding rates.[3] Dr Smith estimates that around 8-24% of current chronic disease cases in Australia are attributable to high formula feeding of infants in previous generations[4]

[1] Smith, J.P. ""Lost Milk?" Counting the Economic Value of Breast Milk in Gross Domestic Product," *Journal of Human Lactation,* **29**, 537-46, 2013.
[2] Smith JP, Thompson JF, Ellwood DA: Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory. Australian and New Zealand Journal of Public Health 2002, 26(6):543-551.
[3] Bartick, M and Reinhold (2010). "The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis." Pediatrics 125(5).
[4] Smith JP, Harvey PJ: Chronic disease and infant nutrition: is it significant to public health? Public Health Nutrition 2011, 14(02):279-289.

Breastfeeding should be viewed as an economic investment. Keith Hansen, World Bank Global Practices Vice-President states, "While 'breast is best' for lifelong health, it is also excellent economics. Breastfeeding is a child's first inoculation against death, disease and poverty, but also their most enduring investment in physical, cognitive, and social capacity"[5].

Infant formula manufacturers have developed marketing strategies to avoid regulation and restrictions on advertising: market segmentation and marketing to health professionals. Aggressive and misleading marketing undermines the WHO Code and the NHMRC Infant Feeding Guidelines.

Dr Smith has suggested that all milk formula including infant formula be subject to the Goods and Services Tax (GST) just like breast pumps and other infant feeding items. Otherwise there are financial disincentives to breastfeeding, especially for low income families. According to the WHO, toddler milk is not necessary and possibly harmful. There is no tax policy rationale for including toddler milks in the GST exemption for 'basic food', and it is unlikely to have been the tax policy intention to include toddler milks in this exemption. Removing the GST exemption could fund a national marketing campaign to promote breastfeeding and counteract misleading marketing claims, particularly among low socio-economic status families.

Baby Friendly Health Initiative

The Baby Friendly Health Initiative (BFHI) has been shown to be effective in increasing exclusive breastfeeding rates. Evidence exists for the effectiveness of individual steps but even more so for full implementation of all steps together (WHO, 2009). Dr Smith notes that the keys to BFHI success are avoidance of milk formula and linking to peer support. The hardest BFHI Step to implement is Step 6 – avoiding supplementation. Dr Smith gave examples of ways in which infant formula companies can provide free or low cost branded products for use in hospitals, thus creating financial incentives working against hospitals providing more staff time directed at breastfeeding support. Consideration could be given to requiring that any essential use of milk formula products in hospitals should be without branding (that is, it should be plain packaged), to avoid creating customer loyalty[6] and therefore retail markets for particular company products. This could be a condition of Commonwealth funding for state government hospital maternity care services.

[5] Hansen, K 2016. *Breastfeeding: a smart investment in people and in economies*. The Lancet Vol 387, January 30, 2016:416.

[6] Dr Smith notes that as birth rates decline, developing brand loyalty early becomes more important in the baby food industry. Industry studies cited in evidence to the ACCC inquiry into the 2016 MAIF revealed the deliberate creation of market segments such as specialised formulas, follow up or follow on or toddler milks to avoid regulatory measures intended to restrain milk formula marketing. A recent September 2016 Euromonitor report observes that: Due to the falling birth rate, brand owners will have even more reason to strengthen their "up-ageing" strategy. The influence of "up-ageing" will be felt most keenly within other baby food, where new product developments will continue to grow.

Dr Smith also provided information on the Ten Steps to Unsuccessful Breastfeeding or evidence-based ways to prevent breastfeeding[7,8]:

- medicated birth
- restricted number and duration of feeds
- separation of mother and infant
- test weighing
- routine supplementation with formula or other fluids
- early introduction of solids and juices
- dummies
- weight charts based on formula fed infants
- scheduled feeds
- lack of skilled, sensitive support

WHO Code and MAIF

Health provider practices influence milk formula sales. It is important to provide training to pharmacists and other health professionals regarding the WHO Code. The infant formula industry also needs to be more accountable for marketing and labelling as set out in the WHO Code and subsequent World Health Assembly (WHA) resolutions. There are notable differences between WHO Code and the Marketing in Australia of Infant Formula (MAIF) Agreement which need to be reviewed (see Figure 4).

The International Baby Food Action Network's 2007 assessment even before the abolition of the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) in 2014 was that MAIF falls short of the recommended minimum standards set by the International Code and subsequent WHA resolutions which Australia had endorsed at the international level[9]. In view of the updated (2016) WHO guidance on inappropriate promotion of breastmilk substitutes, the present industry agreement bears little resemblance to the current International Code and Australia's implementation of the International Code needs major reconsideration to strengthen it.

International Code	MAIF
Applies to all countries and companies as a minimum standard.	Coverage is limited to six major baby food companies. - others not bound to follow MAIF.
Applies to all breastmilk substitutes including other milk products, foods and beverages marketed to replace breastmilk, feeding bottles and teats.	Applies only to infant formula. Products such as baby cereals, infant meals and drinks are not covered even if marketed for infants below 6 months of age. MAIF does not cover feeding bottles and teats.

[7] WHO. Division of Child Health and Development. *Evidence for the Ten Steps to Successful Breastfeeding*. Vol. WHO/CHD/98.9. Geneva: World Health Organisation. 1998.
[8] Enkin MW, Keirse MJ et al. *A guide to effective care in pregnancy and childbirth*. Oxford: OUP, 1995.
[9] IBFAN, Australia Code Violations at: http://www.ibfan.org/art/298-12.pdf

International Code	MAIF
Covers 'retailers' under its definition of 'Distributor' and forbids promotion at retail level.	Distributors are not covered and MAIF is silent on promotion at the retail level.
Governments have the responsibility to ensure that objective and consistent information is provided on infant feeding.	No equivalent responsibility exists. Information materials by companies are often distributed through health care systems and usually contain conflicting messages about breastfeeding.
No point-of-sale advertising or any other promotion device such as special displays, discount coupons, premiums, special sales, loss leaders and tie-in sales at the retail level.	No equivalent provision on promotion at the retail level. Thus promotion at the retail level is not forbidden.
Health authorities have the responsibility to encourage and protect breastfeeding and promote the principles of the Code.	No equivalent responsibility exists.
Free or subsidised supplies are banned in any part of the health care system (WHA 47.5 [1994]).	Allows certain free supplies as it is based on 1981 Code Article 6.6 which is superseded by WHA resolution 47.5.
Information to health professionals should be restricted to scientific and factual matters, and should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding.	Requires companies to give health care professionals product information reflecting current knowledge and responsible opinion which are clearly identified with company and brand names.
Governments have overall responsibility to implement and monitor the Code. Monitoring should be carried out in a transparent and independent manner.	Advisory Panel which administers MAIF and decides on complaints is partly represented and funded by industry, giving rise to conflict of interests.

Figure 4: Differences between the WHO Code and MAIF10

Dr Smith noted that in New Zealand, the regulator requires all baby milk companies to comply with the MAIF as implemented in New Zealand. She also observed that the Australian Government no longer takes responsibility for implementing and monitoring the Code. Monitoring is not carried out in a transparent and independent manner as the limited monitoring that does occur through industry gives rise to conflict of interest.

Milk banks

Dr Smith proposes the establishment of community-based not for profit milk banking and mother-to-mother milk sharing via local charitable organisations or networks having a central focus on supporting maternal breastfeeding. Public health measures to support this could include health services' certification of donors and NHMRC guidelines on hygienic milk expression, storage and transportation to promote safe sharing. Companies should be

[10] IBFAN, Australia Code Violations at: http://www.ibfan.org/art/298-12.pdf

required to pay for their access to women's donated milk for research and this funding should be earmarked for breastfeeding promotion.

Supportive environments

Dr Smith suggests that the Strategy should also focus on social and economic institutions (such as anti-discrimination laws, employment regulations, and policies and procedures in workplaces and child care centres) and their role in respecting and protecting breastfeeding and lactating women and children from any economic or commercial influences which undermine it.

Studies by Smith and Forrester looking at mothers' time investments in infant nutrition and care found that mothers spent 18 hours a week on exclusive breastfeeding[11] and 23 hours a week on 'cuddling, soothing, and feeding'[12].

Dr Smith also reiterated the importance of adequate duration of paid parental leave and statutory job protection rights (under the Fair Work Act) in supporting families to care for their infants and young children. She cited evidence that breastfeeding is 10 per cent higher among working mothers of infants aged 4-12 months who use only parental care rather than other forms of child care[13]. Further, Paid Parental Leave (PPL) has been shown to have an impact on mothers' health outcomes and infant health[14]:

- To the extent that PPL delays return to work for mothers it has the potential to impact positively on both mental and physical health. The secure, predictable income not only reduces financial but also relationship stress in some families. The associated leave delays return to work, gives mothers more time to recover, and delays the time pressures that negatively impact on mental and physical health.
- PPL had a small, but significant, impact in reducing the likelihood that mothers would report that their baby had experienced an illness of one week or more during the first year of life.

Workplace factors which have been linked with exclusive breastfeeding for six months[15] include:

- can adjust hours to accommodate need to breastfeed or express milk.
- written policy of supporting mothers who express breastmilk or breastfeed at work.

According to Dr Smith, child care settings are increasingly and regularly used by industry to promote breastmilk substitutes, although childcare services have a legal obligation not to

[11] Smith, JP and Forrester, R (2013). Who pays for the health benefits of exclusive breastfeeding? An analysis of maternal time costs. Journal of Human Lactation, 29(4), 547-555.
[12] Smith JP and Forrester R. Maternal time use and nurturing: Analysis of the association between breastfeeding practice and time spent interacting with baby. Breast Feeding Medicine, May 2017.
[13] Baxter J. Breastfeeding, employment and leave: an analysis of mothers in Growing Up in Australia. Family Matters. 2008; 80:17-26.
[14] Martin B et al (2014). PPL Evaluation: Final Report. Queensland: Institute for Social Science Research, pp 88-89.
[15] Smith JP, McIntyre PE, Craig APL, Javanparast DS, Mortensen K. Workplace support, breastfeeding, and health. Family Matters 2013; 93(December):58-73.

discriminate against parents wanting to continue breastfeeding of children in childcare[16]. The WHO Code is clear that this is inappropriate. Dr Smith developed and tested a model of breastfeeding-friendly childcare for the Australian Breastfeeding Association (ABA) to run along the lines of the Breastfeeding Friendly Workplace Accreditation. However the model has not yet been tested due to the ABA's lack of resources.

Suggestions for the enduring breastfeeding strategy

Dr Smith proposed that the following be considered in developing the enduring Australian National Breastfeeding Strategy.

1. Consider the wider context for breastfeeding, including:

    a. the human rights of mother and child to optimal health including through breastfeeding, and for informed decision-making at all stages without commercial pressures (the *Convention on the Elimination of All Forms of Discrimination Against Women* and *the Convention on the Rights of the Child*), and

    b. the societal valuation of the contribution of breastfeeding to conserving economic and environmental resources, such as by counting human milk in Gross Domestic Product (GDP) as part of the national food production system. She noted that greenhouse gas emissions from milk formula production is four times higher than cow's milk.

2. Consider the following vision and overarching objective for the strategy:

    ***Vision**: Women's contribution to society through breastfeeding is recognised, and the human rights of women and children to optimally breastfeed without commercial influence on decisions, is enabled at all levels of society especially in the health care system.*

    ***Objective**: For every mother to achieve her aspirations for breastfeeding her child, by actions enabling more women in Australia to initiate and maintain exclusive breastfeeding to six months and to continue breastfeeding into early childhood for as long as mutually desired.*

3. Implement the WHO International Code fully, including through enforceable food and consumer regulation of all forms of inappropriate marketing of all breastmilk substitutes in all settings.

4. Consider a more sustainable funding model for the ABA, wider promotion of breastfeeding friendly workplaces and child care settings.

5. Support for BFHI accreditation is crucial to deal with ethical issues and conflict of interest issues regarding industry sponsorship of conferences. Consider financial support from government for BFHI accreditation for both hospitals and community health services.

[16] Smith, J.P., S. Javanparast, E. McIntyre, L. Craig, K. Mortensen, and C. Koh. "Discrimination against Breastfeeding Mothers in Childcare," Australian Journal of Labour Economics, 16, 65, 2013.

SUMMARY OF KEY RECOMMENDATIONS

The Department of Health would like to thank all participants for their valuable input to the development of the Australian National Breastfeeding Strategy. Feedback has indicated that there are national issues that should be considered as well as local issues and that it is time to take action on these.

Stakeholders recommended that the following actions be considered in the development of the Australian National Breastfeeding Strategy:

- Require health professionals to undertake evidence-based breastfeeding education and training and provide CPD points for undertaking this training. Evidence-based breastfeeding education should be part of the undergraduate curriculum for midwives, nurses, neonatologists, and doctors. There needs to be funding for clinical support of breastfeeding research to add to the evidence base.
- Empower and support women with their infant feeding decisions. Breastfeeding should be experienced as the normal, healthy, and easy way to feed a young child, accepted as a social and family responsibility rather than an individual's, and valued in economic and fiscal policy.
- Fund a national marketing campaign on breastfeeding for breastfeeding to be accepted as normal and as a collective responsibility.
- Strengthen or fully implement the WHO Code and subsequent resolutions. The MAIF Agreement falls short of the internationally agreed WHO Code on the marketing of breastmilk substitutes.
- Transform settings that can positively influence a mother's infant feeding choices:
    - Health settings:
        - Ensure expectant mothers are given breastfeeding education during the antenatal period.
        - Increase government support for the BFHI to be reflected across the health sector (hospitals and community health services), including financial support and alignment with the Australian Council on Healthcare Standards (ACHS) accreditation.
        - Provide continuity of care from the hospital to home/community.
        - Ensure mothers and their families continue to receive breastfeeding education and support after discharge from hospital.
        - Provide access to publicly funded specialist lactation support services.
    - Workplaces and child care settings:
        - Ensure that workplaces and child care services have written policies to support breastfeeding.
        - Enact and enforce employment legislation for paid lactation breaks, facilities and work health and safety provisions in all Australian workplaces.
        - Reconsider extending paid maternity leave for 12 months as there is evidence that Paid Parental Leave increases breastfeeding rates.

- Community settings:
    - Plan for and provide breastfeeding-friendly spaces in the community.
    - Fund peer support groups in the community and provide targeted support for those with complex breastfeeding needs.
    - Provide public health system support for establishment of local milk banks and safe milk sharing networks for mothers who have breastfeeding difficulties.

- Introduce and standardise regular data collection on breastfeeding, establish a monitoring and evaluation framework, and provide funding for research to monitor progress on the Strategy and on health outcomes.

APPENDICES

Appendix A: Key themes from stakeholder consultation workshops

Themes	Description	SYD 1	SYD 2	BNE	CBR 1	CBR 2	MEL 1	MEL 2	HOB	ADL	PER	ASP	DRW
Access	Access to breastfeeding support and associated equipment is a challenge for Central Australia.											X	
Access	Increase availability of trained lactation consultants in the community.				X							X	
Access	Provide increased access to breastmilk, including increased access to breastmilk banks. Promote breastfeeding in NICU – currently financially discouraged.			X									
Access	Provide support services early, particularly in the antenatal period and the first 6 weeks after birth.					X		X	X	X			
Care Models	Develop feedback mechanisms back to the hospital and maternity care system without relying on hospital emergency departments.				X								
Care Models	Identify lactation risk factors at birth.										X		
Care Models	Improve continuity of care between midwifery/maternity services, neonatal intensive care units and community organisations and peer support groups.	X			X								
Care Models	Support collaboration with mental health professionals to support women and breastfeeding.												X

Themes	Description	SYD 1	SYD 2	BNE	CBR 1	CBR 2	MEL 1	MEL 2	HOB	ADL	PER	ASP	DRW
Care Models	Support a midwifery led continuity of care model for caseload management.											X	
Data	Build Performance Indicators that include breastfed at 1 hour, exclusively breastfed at discharge and each month up to 6 months.										X		
Data	Establish breastfeeding KPIs (perhaps as part of the national KPIs for Aboriginal health services) and use this to guide measurable data collection.											X	
Data	Standardise data definitions for collection and reporting; need for a central electronic database – to allow for monitoring and evaluation of health outcomes.	X	X	X	X				X	X			
Education - schools	Breastfeeding should be taught in schools as the 'normal' way for babies to be fed.			X									
Education and Training – Health Professionals	Require breastfeeding training for all health professionals who work with families, including culturally sensitive education. Standardise education and competencies across health professionals.		X	X				X			X		
Executive support/leadership - BFHI	Link breastfeeding outcomes as KPIs for CEOs and Senior Managers and could be used to encourage take-up of BFHI.		X										
Funding	Financial support for breastmilk banks.		X										
Funding	Fund national campaigns to raise awareness of the importance of breastfeeding.		X	X									
Funding	Fund the implementation of the Strategy.		X										

Themes	Description	SYD 1	SYD 2	BNE	CBR 1	CBR 2	MEL 1	MEL 2	HOB	ADL	PER	ASP	DRW
Funding - BFHI	Increase support for the BFHI to be reflected across the health sector, including funding and link to ACHS accreditation.		X				X			X	X		X
Funding - PHC	Provide financial incentives for primary health care facilities to engage and prioritise breastfeeding.			X									
Funding and access	Fund breastfeeding specialist support (lactation consultants) through the Medicare Benefits Schedule.		X	X	X		X				X	X	
Leadership	Leadership and coordination of the whole strategy.			X									
Priority Groups	Acknowledge and support the role of organisations such as ACCHOs and the Aboriginal Family Birthing Program in delivering culturally appropriate support.									X			
Priority Groups	Consider support for non-Medicare eligible women, such as refugees, temporary visa holders, etc.						X						
Priority Groups	Define them, understand their needs and develop tailored strategies to meet their needs. Educate professional staff working with these groups.	X					X		X				
Priority Groups	Increase breastfeeding support for priority groups, particularly in the first 10 days.												X

Themes	Description	SYD 1	SYD 2	BNE	CBR 1	CBR 2	MEL 1	MEL 2	HOB	ADL	PER	ASP	DRW
Promotion	Breastfeeding promotion needs to target more than just the mother – include partner, extended family, all health experts and the community at large. It is a shared responsibility between family, society, health professionals, government, etc.			X	X			X					
Promotion	Develop a marketing and promotions campaign that assists in re-establishing breastfeeding as the biological and social norm; ensure this incorporates tailored messages for Indigenous and non-English speaking backgrounds; and undertake community consultation around what and how to promote it.			X					X	X		X	
Promotion	Utilise technology (including apps) and media/social media to provide breastfeeding education, evidence-based information and support, combat misinformation, and reduce toddler milk advertising.			X		X				X	X		
Regulation	Strengthen Australia's response to the WHO Code and regulate marketing of infant formula/Fully implement the WHO Code and subsequent resolutions.	X		X			X	X	X	X			

Table 2: Summary of key themes from the workshops

Appendix B: Key themes from written submissions

Themes	Description	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
Access	Increase availability of trained lactation consultants in the community.		X																		
Access	Provide increased access to breastmilk, including increased access to breastmilk banks. Promote breastfeeding in NICU – currently financially discouraged.																X				
Access	Public Maternity Hospitals to have outpatient breastfeeding clinics staffed by experienced and qualified lactation professionals.		X																		
Access	Breastfeeding Clinics in regional centres.		X																		
Access	Fund breastfeeding specialist support (lactation consultants) through the Medicare Benefits Schedule.		X			X						X							X		
Access	Work with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need.							X													
BFHI	Increase support for the BFHI to be reflected across the health sector, including funding and link to ACHS accreditation.			X			X								X						X
Breastfeeding Strategy	Objectives in the time period 8 weeks to 6 months and beyond, include: ensure parents and caregivers know to wait until around 6 months before giving solids to a breastfed baby. Ensure all health professionals advising parents follow the NHMRC Infant Feeding Guidelines and WHO recommendation.					X															
Breastfeeding Strategy	'Goals' should be more woman and child-centred.							X													

Themes	Description	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
Breastfeeding Strategy	Performance Indicators should align with goals and objectives. They are currently hospital-oriented. Suggest they reflect broader range of settings.							X													
Care Models	Improve continuity of care between midwifery/maternity services, neonatal intensive care units and community organisations and peer support groups.			X			X														
Care Models	Support for a midwifery led continuity of care model for caseload management.								X												
Care Models	Support collaboration with mental health professionals to support women and breastfeeding.		X																		
Child care	Childcare workers actively support breastfed babies and continued breastfeeding.					X	X														
Data	Standardise data definitions for collection and reporting; need for a central electronic database – to allow for monitoring and evaluation of health outcomes.			X				X	X									X	X		
Donor Milk	To protect exclusive breastfeeding in hospital - babies aged 0-4 days who need supplements should receive donor breastmilk if the mother is unable to provide enough colostrum or breastmilk herself.					X															
Education on safe sleep	Amending safe sleep material to include information about safe bed sharing particularly with regard to breastfeeding.		X																		
Executive support/ leadership	Link breastfeeding outcomes as KPIs for CEOs and Senior Managers and could be used to encourage take-up of BFHI.																		X		
Financial incentives and disincentives	Review financial incentives and disincentives to breastfeeding ie GST is applied to lactation aids, but not infant formula.							X													

Themes	Description	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
Funding	Fund the implementation of the Strategy.														X						
Health Professionals Education and Training	An ongoing funded national education program should be implemented, both undergraduate/pre-registration programs throughout all maternity services. The program should be guided by national standards.			X																	
Health Professionals Education and Training	Require breastfeeding training for all health professionals who work with families, including culturally sensitive education. Standardise education and competencies across health professionals. All relevant support professionals have ongoing, up to date breastfeeding knowledge.		X		X	X	X	X	X		X				X			X	X		X
Leadership	Leadership and coordination of the whole Strategy.	X		X				X			X										
Maternity protection	Expand parental leave provisions (consideration of the Nordic System).		X																		
Maternity protection	Australia should introduce protective workplace breastfeeding breaks and facilities legislation and specific work health and safety legal provisions for women to breastfeed at work safely.		X			X	X									X					
Milk Banks/donor milk	Expansion of milk banks and availability of donor milk, particularly for premature babies. Include an objective in the Strategy: Set up a milk bank in each major city, to provide safe donor breastmilk to all hospitals where infants and babies are cared for.		X		X	X															
Priority Groups	Define priority groups, understand their needs and develop tailored strategies to meet their needs. Educate professional staff working with these groups.							X													
Priority Groups	Increase breastfeeding support for priority groups, particularly in the first 10 days.										X										

Themes	Description	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
Promotion	Fund national campaigns to raise awareness of the importance of breastfeeding.		X												X						
Promotion	Develop a marketing and promotions campaign that assists in re-establishing breastfeeding as the biological and social norm; ensure this incorporates tailored messages for Indigenous and non-English speaking backgrounds; and undertake community consultation around what and how to promote it.				X	X													X		
Promotion	Utilise technology (including apps) and media/social media to provide breastfeeding education, evidence-based information and support, combat misinformation, and reduce toddler milk advertising.		X				X														
Promotion	Breastfeeding promotion needs to target more than just the mother – include partner, extended family, all health experts and the community at large. It is a shared responsibility between family, society, health professionals, government, etc. The wider community has a major role in maintaining a breastfeeding-friendly society.				X	X												X			X
Research	Research priorities, coordinated efforts to build sound evidence base.							X													X
School Education	Breastfeeding should be taught in schools as the 'normal' way for babies to be fed.								X												
WHO Code implementation	Strengthen Australia's response to the WHO Code and regulate marketing of infant formula by manufacturers and retailers. Stop aggressive marketing of toddler milk and sponsorship of baby and parenting expos by industrial powder companies.	X	X										X	X	X					X	

Table 3: Summary of key themes from written submissions

Appendix C: Mothers' feedback on barriers to breastfeeding

Examples of inaccurate advice from health professionals on breastfeeding issues

Issue	Inaccurate Advice
Breastfeed less	*I was told by a child health nurse that my daughter was too big and I should breastfeed her less.*
Breastfeed less	*When my youngest was 2 months old, I was told in hospital to space his breastfeeding out to 4 hours minimum as he was "obese". This recommendation was made on an isolated weight and not considered alongside length and head circumference measurements. I called the paediatrician out on his advice being in direct breach of the BFHI 10 steps. His only response was "well infant obesity is a bigger issue".*
Breastfeeding and antibiotics	*My GP told me I had to stop breastfeeding to go on a course of antibiotics because that drug wasn't safe for breastfeeding. The antibiotic is safe for use when breastfeeding.*
Breastfeeding and teeth	*I was told I should be brushing her (two) teeth more often because she was breastfed.*
Breastfeeding and weight gain	*After I had my first baby I was seeing the local MCHN because I believed that's what you had to do. I had trouble getting the hang of breastfeeding in the first 6 weeks and so had been mix feeding for most of that time. In a last ditch attempt to get back to exclusive breastfeeding I ditched all bottles for 1 week and just breastfed round the clock. That week my son gained 120 grams which even the health nurse said was on the low end of okay . . . but somehow she still made me feel like I was starving him! She even mentioned how great it was to formula feed and how underweight many breastfed babies are. It destroyed me and it ended my attempts to breastfeed my son. On the day he turned 7 weeks I fed him his final breastfeed. I will always regret not feeding him for longer.*
Breastfeeding and weight gain	*With my first baby they kept saying that I wouldn't be able to leave hospital until the baby had put on a sufficient amount of weight, they kept threatening me with formula, it was horrific.*
Breastfeeding at night	*When my son was about 8 months, I had an appointment with child health nurse and she told me I shouldn't be breastfeeding my son at night at all and to just offer water. Also he needed to be eating at least 3 meals a day before feeds and also only have 3 breast feeds a day. I am proud to say still breastfeeding my son now at just over 2 years.*
Breastfeeding at night	*My son had his 8 month check yesterday and we had a different lady for the appointment (she was useless). She asked if he eats 3 meals a day and I said no. She looked at me as if to say "why" and I said he isn't always interested in eating. His main meal is dinner and he enjoys his toast in the morning when he's not teething. She went on to ask if he wakes in the night and I said yes he does 2 times. She said I need to feed him up more over the day to fill him and he won't wake at night.*
Breastfeeding at night	*The Child Health Nurse I saw for baby's check-up at 8 months told me I needed to stop breastfeeding him at night as he didn't need it. He was just waking up out of habit and to just give him water to make him sleep.*

Issue	Inaccurate Advice
Breastfeeding at night	*A GP recently told me my daughter 5.5 months old doesn't need to feed at night and to give her water in a Sippy cup instead.*
Breastfeeding is not natural	*I was told by a GP (11 days post-partum) that I should go out and buy a good pump because breastfeeding isn't natural and then told me her son almost bit her nipple off. She then went on to say "the midwives want you to think that it's natural, but it's so not! It's horrible!"*
Colostrum too thick	*I was told colostrum is too thick so couldn't use an electric pump to try and bring my milk in while my daughter was in SCN, to "just wait" until my milk came in. I did source a pump on day 3 and surprisingly got 50 ml of that "too thick to pump" milk.*
Duration of breastfeeding	*I have been told multiple times over my almost 14 years as a parent (6.5 years feeding total) that feeding past 12 months isn't necessary by GPs and health nurses.*
Formula top-ups	*My baby was born at 36 weeks but weighed 7 lbs. I was told I would need to supplement to make sure his sugars didn't drop and so he didn't lose too much weight. My breast milk would not be enough to maintain his weight.*
Formula top-ups	*Paediatrician said breastfeeding causes jaundice. He said baby has lost 14% of his body weight and we had to do formula top-ups. Gave a sheet with how much to top-up (was a ridiculous amount). We didn't do top-ups, and went back to next day to see a lactation consultant and my son had somehow put on over 200 grams in 19 hours. If I hadn't done my own research prior and believed in myself, I would have listened to him.*
Formula top-ups	*Baby is a slow weight gainer so child nurses pushed for formula top-ups… initially finger feeding (resulting in stress for mum) then referred to a paediatrician. Despite there being no issues with baby, paediatrician insisted on 3-hourly feeds, 20 minutes on each breast then 75 ml formula top-up 8 times a day. I did 4 in the first day and my milk supply was affected.*
Formula top-ups	*My personal experience was just being repeatedly suggested formula top-ups by maternal and child health nurses because my child went from 40th to 5th weight percentiles in 5 weeks. What I needed was to rule out latch issues with a LC, eat more, do less and do a week of power pumping. After that, my baby's weight has slowly crept up from the 5th to the 65th weight percentile (no formula). I believe the advice to top-up would have entirely sabotaged my already compromised supply.*
Formula top-ups	*When my daughter was a newborn, we had trouble with feeding. She was a very 'sleepy baby' and would struggle to remain latched on (terrible latch, it hurt!) and eventually after continually slipping off she would just go to sleep. At three days I was told she had lost too much weight and I needed to do formula top. I was offered donor milk and asked my midwives about this and they told me not to take it and to use formula, as it was too risky. I regret not using the donor milk. We started on formula top-ups immediately.*
Formula top-ups	*When my 1st was born (3 years ago) I had never heard of cluster feeding. My bub was up the whole night on night 2 feeding. I was stressed that she wasn't getting enough milk and buzzed the midwives for help and advice. They never mentioned that it was cluster feeding or that it was completely normal, they agreed that she was hungry and bought me a bottle of formula "so you can both get a rest".*

Issue	Inaccurate Advice
Formula top-ups	*My ECHN told me I should start giving formula at the 6 week check because my son was short. When I said no he was gaining weight well, she said that I should get him checked for kidney disease by a paediatrician because kidney disease makes babies short.*
Formula top-ups	*Youngest was hospitalised at 9 months for further investigation of neurological issues. I was told to start giving him formula feeds at night so that he would sleep through and I wouldn't need to co-sleep anymore. When I pointed out that I was an IBCLC and that I didn't need breastfeeding advice and that his recommendations were in breach of BFHI he simply replied that "formula would fix all our issues". Apparently formula can fix neurological things now.*
Formula top-ups	*At my 6 week check up with my GP my baby had put on 1.5 kg since birth and grown 5cm. I was told because he is in the 15th percentile (2.9kg at birth) I would need to do formula top-ups. I didn't do formula top-up, he got weighed at 12 weeks and has doubled his weight and grew another 5 cm and is in the 50th percentile.*
Formula top-ups	*Went for breastfeeding support at CFH instantly got told to use top-ups just to check if Bub is getting enough and to stretch my boy to fourth hourly at 2 months! Paediatrician told me breast milk isn't beneficial after 6 months. Paediatrician told me my only option was to switch to formula as my son is CMPA has allergy to egg and other intolerances. When I asked why I couldn't remove these instead from my own diet he said it was too hard. Dietician told me top-ups would 100% not decrease my supply. I have seen countless health professionals and all of them have tried to convince me not to BF for stupid reasons one was he didn't think it was safe for me to be waking every two hours. Got told tongue ties are a fad and don't affect BF.*
Formula top-ups	*I mentioned to my doctor that my 4 month old baby was only having 3 wet nappies a day and that I was feeding him hourly overnight, which I assumed was because he was trying to boost my supply in the warmer weather. The doctor said I'm not concerned about the lack of wet nappies I'm concerned about your supply. Try giving him a bottle of formula after breastfeeding and if he drinks it, then you know. You might want to, you know, go onto formula.*
Frequency of feeds	*Baby is being fed too often on demand and I should wait until she was crying and hungry so that she would take both breasts.*
Introduction of solids	*I should introduce solids earlier because of her size (baby's growth tracked along at 15th percentile).*
Introduction of solids	*My GP advised me to start solids at 8 weeks old because breastfeeding is "obviously not giving him enough".*
Lip and tongue tie	*My daughter had an undiagnosed lip and tongue tie and didn't gain weight for months. Thankfully she got revised. I saw an IBCLC and informed myself. But not before seeing a GP who recommended formula and gave me a free tin -- threw it out. Sadly, you can't trust all health care workers, there's so much misinformation out there. Best we can do is not give up and seek valid, accurate information!*

Issue	Inaccurate Advice
Lip and tongue tie	*After 5 day hospital stay post cx left with torn, bleeding nipples. "Latch looks great" from many hospital midwives and LCs. The paediatrician review prior to discharge never assessed oral structures despite the nipple damage. At home I cried through every feed for the next 24 hours before I started pumping exclusively to give my nipples a break. LC's home visit 2 days later assisted with a better position and advised me to rest more so I wasn't so upset (I was crying as all I wanted to do was breastfeed my baby!). The LC never looked in my baby's mouth to identify the very clear anterior tongue tie. I battled for weeks with sore nipples, thrush, constant feeding, horrible 'colic', average weight gain. MCHN told me to keep on keeping on and he was just getting distracted when constantly pulling off the breast feeding. I stumbled across a post from milk meg about tongue ties and luckily found a great osteo who pointed me towards Dr K for laser revision.*
Lip and tongue tie	*I had two babies with ties and I had terrific support but when I brought it up with our paediatrician, she told me it was a fad. When she actually looked in baby's mouth, she was like "uh actually maybe get that looked at". We were in the PAC clinic at the hospital and they were actually turning new mothers away with tongue tie concerns telling them it was a fad.*
Lip and tongue tie	*A GP told me tongue ties are just a fad, and that they didn't exist "back in the day."*
Lip and tongue tie	*My daughter had trouble latching at birth. No one seemed concerned. I had 3 MCHNs, 2 GPs, 2 Paeds, an LC and ENT and a speech therapist all tell me my daughter didn't have any ties. One of the paediatricians told me that I had no choice but to bottle feed. He was not impressed when I said I was continuing to breastfeed, my daughter couldn't even latch onto a bottle at this point. Finally after 4 months, I managed to find an IBCLC who had some tie knowledge and she referred my daughter to a tie provider. My daughter ended up having a posterior tongue tie and an upper lip.*
Lip and tongue tie	*The MCHN said ties are a fad and accused me of child abuse for putting my son through the ties procedure and continued to accuse me of starving my son. She reported me to DHS who turned up to my house to investigate if I was neglecting my son. I was armed with all the WHO rules, medical evidence and contact details of all the medical professionals involved in my son's tongue/lip tie journey. So they eventually closed the case. However due to the horrific experience I have absolutely no trust in hospitals or MCHNs.*

Issue	Inaccurate Advice
Lip and tongue tie	*My children were both born, two years apart, with tongue, buccal and lip ties. Breastfeeding was very painful for me, I saw 4 Paeds, 3 GPs, 3 LCs, 2 IBCLCs, countless midwives and MCHNs. At least 21 professionals and not a single one indicated that the ties were bad enough to contribute to the pain and that the lips on my areola latch was fine. Skinned nipples, feeding with shields (which I had to ask four different midwives for), crying and dreading my children waking therefore feeding, late on set supply issues, PND triggered by supply issues, hours of pumping daily. I had seen someone nearly every week to help his latch before I started top-ups. My second child I had diagnosed at 5 weeks, at her 6 week paed appointment I mentioned it and along with the feeding pain and poor weight gain. Her departing words were "you are both doing great; I won't need to see you again". She didn't believe in ties. So I organised the revision, and I couldn't even feel the next feed! It was amazing to not feel that toe curling pain every time. Still feeding and have nearly beat my son's mix feeding age without a worry about supply.*
Lip and tongue tie	*With my first baby, I was told by a GP to get in my car and drive around to help with my son's apparent colic. When I returned a week later to see a different GP, I was told to see a Physio for attachment issues....it wasn't until I found an LC shortly after who looked in my son's mouth and diagnosed oral thrush (he was only a few weeks old and had IVABs for ?sepsis after his delivery). He was later diagnosed with lip and tongue tie....I changed practices after that experience. Successfully breastfeed beyond a year while I was pregnant with No.2.*
Low milk supply	*I went to my GP about low milk supply. He claimed that I should supplement my 4 month old with boiled water. Not formula. Just bottles of boiled water. He also told me that my milk was drying out because my body was failing me and that not all women can breast feed; some can breastfeed for a week some for 4 months. When I questioned him on giving my baby water and when I told him that the ABA did not support this he got very mad with me and claimed to be a lactation consultant. He told me I was clearly ignorant and was not going to listen to him anyway. I put in a complaint to the practice manager about how rude he was to me and I ended up seeing another doctor who prescribed me domperidone.*
Mastitis	*I went to see my GP to get antibiotics for mastitis. I knew what I needed as my home visit midwives ad assessed and told me and it was also not the first time. We had tried to clear the blockage with heat and massage but it hadn't worked and was infected. As midwives however they could not write a prescription. The GP I saw seemed rather panicked when I said I had a lump in my breast. I did explain about the mastitis and that I was breastfeeding a newborn and had been engorged but he started looking things up on his computer and then told me he wanted to refer me to the Emergency Department. He seemed very inexperienced with breastfeeding and did not seem to understand lactation at all from the way he spoke to me. I did not get antibiotics from him. I had to go and see another doctor who prescribed them for me.*

Issue	Inaccurate Advice
Mastitis	*When bub was 6 weeks old, I got Mastitis for the 3rd time in as many weeks. After almost 4 days of antibiotics it was getting worse and spreading so my GP sent me to hospital suggesting for them to give me an IV. At the hospital I waited for approx. 3 hours in the ED on my own with a 6wk old surrounded by seriously sick adults, vomiting, passing out, bleeding etc. I had high temps was extremely painful to feed and felt faint walking bub around. Other patients were checked on, but never me. Once in to see a doctor it became apparent they had no clue about mastitis. They didn't seem to know what to check for, encouraged me to pump to remove the blockage and closed curtains on me many times when feeding. They were asking each other what mastitis was and calling the maternity ward. After a few more hours, I was changed to a short stay room. This room had not been cleaned since previous patient, with rubbish everywhere, sheets unchanged and sick bags. I refused to sit down and mentioned twice for someone to clean the room - they were too busy. I was taken for an ultrasound to check for an abscess and a nurse told me she needs to hold my baby in the room while I leave and get the ultrasound - I refused to leave my newborn with someone I did not know, in a ward that was too busy and in an unhygienic place. After the ultrasound the doctor told me there was no abscess and told me to go home. In total, I spent 7 hours at the hospital. Their lack of knowledge for breastfeeding difficulties could have lost me my breastfeeding journey had I not been better informed and determined. No one took my temperature and I took my own Panadol to treat my symptoms. I had a panic attack at staying and felt extremely anxious. I was dismissed worse off than when I came. I walked out, went across the road to the private hospital and was admitted within 20 minutes and given a drip for 24 hrs which cleared the infection and provided with breastfeeding support to help make my journey successful. It is disgusting that our public system can be run like that and that a mother who is clearly struggling to successfully feed a 6 week old, which depends completely on me, is left as a low priority.*
Oversupply	*A girlfriend's 6 week-old was screeching the house down, frothy explosive poo and nappy rash. I told her I suspected lactose oversupply. The GP at her clinic diagnosed the baby lactose intolerant and suggested he immediately be put on lactose free formula. She had a long phone chat with an ABA counsellor, I came over and we talked about block feeding, she also cut dairy and within 3 days all the baby's digestive issues were sorted. From what I've read, there's little evidence to prove that a completely lactose free diet is safe for babies. So I'm certain there's a deficit of medical knowledge surrounding infant and maternal lactose issues.*
Painful breastfeeding	*I would cry from pain the entire feed my toes would be clenched tight. I'd squeeze a stress ball in my free hand and bite down on something if I could to help with the pain. I was told by midwives that breastfeeding always hurts and at the home visit to sun my nipples.*

Issue	Inaccurate Advice
Reflux	*When my baby was 6 weeks old she developed reflux symptoms. From 6 weeks to 4 months old, we dealt with reflux, breast refusal (I pumped these feeds), a dip in her weight gain and a very unsettled baby. On the advice of a paediatrician, we supplemented with 1 bottle of formula a day for a few months (she often would only have 60 ml). The GP suggested it would be easier to treat a bottle fed reflux baby because we could just keep switching formulas until we found one that works. Being a strong advocate for breastfeeding, it really frustrated me that he suggested this. In my opinion, reflux is not a valid reason to put a baby on a bottle.*
Safe sleeping	*I was told separately by an IBCLC, GP and child health nurse to prop up my baby's mattress for 'reflux' (turned out to be tongue tie). Thank goodness for an ABA counsellor on the helpline who told me this contradicted SIDS and safe sleeping information.*
Weaning	*Was told by the GP that as my son was 5 months old I've done my part and should just wean (to start medication for anxiety). Didn't ask me what my goals are or anything. Is this just the way they all are or are there GPs hiding there that actually care about breastfeeding goals rather than being dismissive. When I asked for another domperidone script with my first I was given the whole "you're not a bad mum if you use formula" spiel. I know that but I don't want to! Aaargh! That's my rant.*
Weaning	*I told my GP I was feeling exhausted all the time hoping it wasn't something like iron issues as I've had before. Her immediate advice was to wean my 8 month old.*
Weaning	*I suffer from anxiety and got to a point I was having attacks every day. My daughter was one at the time and cmpa and egg allergy so I controlled my diet. I went to my doctor to discuss anti-anxiety medication and was told nothing was safe unless I weaned her. I was also told that at 12 months old my milk no longer contains any nutrition. Six months later I was pregnant with #4 and was told by the same GP to wean due to the fact my milk is not providing her with any nutrition and is essentially taking away from my unborn baby. I changed doctor.*
Weaning	*With regards to breastfeeding older babies, when seeing a GP and discussing constant night wakings I was told "there is research to suggest there are no benefits to breastfeeding beyond 12 months". I really believe GPs should be encouraging the WHO standard of 2 years and beyond. This GP went on to say if I wean him he will sleep through the night. She also couldn't give me reference to any specific research.*

Table 4: Examples of inaccurate advice from health professionals on breastfeeding issues

Examples of lack of support in hospital for breastfeeding

Theme	Example of lack of support
Birth complications and initiation of breastfeeding	*My first night on the ward after the birth of my daughter, I couldn't get out of bed to get her because I'd had a caesarean. Immediately after the birth, my daughter breastfed quite well and I was keen to try again. I buzzed the midwife and asked her to give the baby to me so I could feed her. Midwife asked if I had any expressed colostrum, which I did. Midwife said she would give the baby the colostrum so that I could sleep. I would have preferred to breastfeed her but was told by the nurse that if I wanted to do it, that we would wait until the sun rose, because babies needed to learn to wake with the sun (which wasn't due to rise until several hours later). She was a very strict, old school midwife and I was vulnerable, as I wasn't able to move, so I didn't push the issue any further. The next morning when I tried to breastfeed, my daughter no longer remembered how to breastfeed. I then had to express and finger feed her for a week before she slowly relearnt how to breastfeed. It took over 11 days before she started to exclusively breastfeed. I wonder if I'd been able to establish that relationship in the hours after birth whether she would have continued to breastfeed and not forgotten how.*
Birth complications and initiation of breastfeeding	*My experience as a first time mum. My baby was born via emergency C-section after a really long labour. When he was born he was laid on my chest for about 30 seconds before being taken to the resuscitation table, and then to the special care unit. When I saw him, around 6 hours later he was in the humidicrib and connected to a lot of machines, I wasn't able to hold him at this time. I was taken back to special care at midnight (after the 6am birth), and was able to hold my baby. I was encouraged to take off my nightgown and hold him on my chest, and I also requested that the overhead fluoro lights be turned off, and the nurses did that. My baby was really drowsy and not interested in latching, but the nurses kindly encouraged me, asking permission to touch me or him, and advising me how to shape my breast for easier latching. I was taken back to the special care unit at 4am and was encouraged and cared for by the same nurses. The following day I went to the special care unit (very excited to spend the day with my baby), he had been upgraded to an open crib, not needing the humidicrib any longer, he was still on fluids and had the observation wires stuck to him. I was surprised that the radio was on quite loudly and the lights very bright for all of these sick babies, and the two nurses on (different to the night nurses) were speaking very loudly. A nurse handed me my baby, and I was slowly undoing my top to place him on my chest. She said "stop doing that, you need to breast feed him now'. I kept up what I was doing, just being with him on my skin, she came back and said 'have you breastfed him yet? You need to do that now!' I said something like 'were just getting to know each other'. Another nurse came by and said 'his nappy needs changing' and I said 'great, I can do that" and her reply was 'no, you sit there, I will do it. When she handed him back to me he began crying, and the nurse came and said 'He's hungry, you need to feed him, may I help you?' I said yes, thinking that it would be the same supportive help from the evening before, the nurse grabbed my breast firmly, and grabbed the back of my baby's head and forced him on, he started screaming, I started crying, the nurse said 'you're*

Theme	Example of lack of support
	making him distressed, you should go back to your room'. Then the other nurse came and said 'he needs to calm down' and took him from me and laid him in the crib, and gave him a hospital issue dummy, and then she said 'he prefers the dummy to you'. I was really crying by this stage. After some time I stopped crying and they handed him back to me, and I was able to latch him on to my breast. After a time, the nurse came back and said "how long have you been breastfeeding him?" I said "I don't know' she said 'well how long has it been? You must know?!!!" and I said "I didn't check the time when we started' and she said 'well how long roughly has it been?" I said "I don't know, 5 minutes?" and she said 'right, you should go back to your room now'. I said that I was staying. After about 10 minutes someone I hadn't seen before came to me and said she was checking my epidural wound, and then she told me I should go and have lunch and a rest in my room. I was so distraught, I asked her to call a wheel chair for me, and a student midwife came to pick me up. When I got back to the ward, I was so upset that the midwives took me to the bereavement room so I could have some space to cry. When my husband arrived (he had gone home to collect clothes etc.) he went straight to the special care unit before seeing me or knowing what had happened, and he said the two nurses had been really defensive with him, and saying that I was causing trouble and refusing help from them. My husband spoke to the midwife on duty, and somehow, she went down to special care unit and brought our baby up to us. We were able to spend that night in the family room together. The midwife in charge of the ward (who got our baby to us), as well as 3 other midwives all independently spoke of "those two" down in the special care unit, and how horrible they are and how they don't like the mothers being in there so they belittle them and are nasty to them. It was as if everyone knew this about them, and yet it continued...
Forced to give formula	*First time mother here and straight after bub was born they put her on me. I had many 3rd degree tears and had to be rolled into surgery for an operation, so the midwives hand expressed colostrum from me and took the baby away while I was in the theatre. 3 hours later I came to the maternity ward with my legs not working due to a spinal. So it was hard for me to pick baby from the cot and feed. Baby was asleep for 5 hours straight where I had visitors come and go. When my husband left he put the baby back in the cot and she still hadn't been fed from my breasts still. A midwife came at night and started telling me all these things that bub is hungry and my milk hasn't come in and the bub hasn't had anything to eat since birth and came in with a blood sugar test and said her levels were extremely low. Now there was no one with me and I never attended any prenatal birth classes or paid attention to breastfeeding so had no idea that colostrum is way better than the actual milk. She told me if I don't sign the consent form to give her formula, I will starve her and something bad would happen. I was in tears and signed the form and they wheeled the baby to special care. I was crying the whole night when eventually another nurse came and said they will take me down to SCN and let me breastfeed baby. By that time she had been given a bottle 3 times and colostrum through a syringe at birth. She never had the breast so she cried and refused when I got there. They kept us in the hospital for 7 days and no one helped me or gave me info that my bub actually had tongue tie. I went home with no actual help from a LC. I had to get formula because bub just wouldn't latch on. Finally when the 2nd*

Theme	Example of lack of support
	CHN came at home, she said my bub had PTT and made me an appointment with the Tongue tie clinic. After 10 weeks and so much pain for bub and myself we had some answers. So heartbreaking that my bub missed out on so much bf goodness. I wish I knew from before. I feel so sorry that I forced my bubs head and mouth on my boobs so hard that she has dents in her head from my fingers pushing too hard cause that's what the nurses at the hospital advised.
Forced to give formula	*My child had trouble latching on and I was advised by the midwives that she had "a lazy latch". They tried to latch her on by grabbing my breast and shoving them in her mouth. I felt disempowered by this. I had no control. Tongue tie or other challenges were not investigated and "lazy latch" was the official diagnosis. I was SO determined to breastfeed that any time formula was mentioned (and it was a few times) I said No I want to breastfeed my child. It reached a point where a doctor was called in. I never met this guy before. A total stranger. He said my baby was at risk of starvation and jaundice. He said things like "if we don't get something into this baby they might starve". How does that make a new mum feel? So I agreed... the worst thing I would want is my baby to starve or get jaundice. So they gave her formula. We then worked again on latching her on. I was in hospital for 5 days!!! I wanted to leave but I wasn't allowed to be discharged as I was having "feeding complications". I was referred to the hospital LC who gave me not much info but a feeding plan to latch baby on and then once she comes off the breast, I would top her up with formula. I agreed and I was then allowed to go home. I never got any follow-up support or any referral to support groups or other supports. Without realising it yet, I was in the early days of PND as well. I was also given a nipple shield to use and the brand name of the formula the hospital used as my baby would have been used to it by now. We attempted breastfeeding for 2 months and then due to many reasons I gave up and went formula feeding full time. I would also add that at 4 months, I was advised by the early childhood nurse that I could start solids.*
Forced to give formula top-ups	*I was told in the first 24 hours of my son's birth that I had low milk supply so was forced to give my son formula top-ups. When I say forced I mean the hospital refused to let me take my son home unless I gave him formula. I learned that this was false information as milk supply doesn't come until a few days after birth. Then for the months that followed the MCHN still kept pushing formula as I stopped formula after learning it was affecting my milk supply and the health risks of formula. She told me my son wasn't putting on enough weight as my breast milk wasn't nutritional enough for him. I then did my own research, saw an ICBLC and found out my son had tongue and lip ties which we then had corrected. I found out from a midwife at the hospital that they have a special arrangement with S26Gold to promote their products to all mums and babies. So they don't care about what's right for the babies, only about their special deal with a formula company for rewards!*

Theme	Example of lack of support
Forced to give formula top-ups	*My bub was born 4 weeks early and had lost weight when we were supposed to be leaving and they insisted he stay another night and be given formula top-ups. I had to promise to give him the top-ups and they gave me pre-mixed formula so I could start immediately. This was all only 2 days after he was born, so my milk hadn't even come in. I just fed him without top-ups at home and milk came in the next day. It was appalling they would only let me leave if I promised to use formula.*
Forced to give formula top-ups	*I got told on day 2 by hospital Paediatrician, obstetrician and midwife to give formula top-ups while my milk come in and told by all three that it would not in any way affect my supply cause little man had lost 9% of his birth weight - he was born 4 weeks early and was doing so well and was very settled bub. I "agreed" to give him formula top-ups at home so they would discharge us. If I didn't agree they wouldn't have discharged us. I didn't give formula top-ups, my milk came in the next morning and by a week old my little guy had already passed his birth weight... the private LC I had hired was so mad at the advice I was given.*
Formula offered	*Formula offered regularly from XXX Hospital. Formula and a teat brought in placed on my table, without me asking for it. Nurse gave my friend (taking me home) 3 bottles of XXX Formula to take with us for the trip. Zero help getting baby to attach. No skin-to-skin at all in birth suite. No help at all.*
Formula recommended	*My baby was big and didn't breathe when she came out. Midwifery team were awesome. Baby sent to special care for tests and precautions. Basically Doctors told me every time to use formula. I had hardly had a chance to start breastfeeding. Second baby so I was brave and said I'd prefer she didn't have any formula. They almost tried to scare me that she would improve and be home quicker if she had formula. I pumped and fed as much as I could and stuck to my guns and not one drop was given. I refused but I wonder how many other mothers just went along with them and said ok???*
Formula top-ups	*The lactation consultant at the hospital told me to continue formula top-ups of 60 ml via bottle when baby was less than 2 weeks old. It wrecked my supply and he developed breast refusal. Took me months to fix and this was their so called lactation consultant. I feel like I am breastfeeding in spite of them not because of them!*
Formula top-ups	*No one at the hospital taught me how to get baby to latch. They told me to feed my 5 day old 90 mls of expressed breast milk!*

Theme	Example of lack of support
Lip and tongue tie	*I was told 2 days after birth I MUST supplement. The LC in the hospital said he had no tongue tie. The 3 midwives who visited at home said he didn't. I took my 3 day old son back to the emergency room after him screaming and passing unusual stools. The doctor in charge told me that it was both a foremilk/hind milk imbalance and straight afterwards that my milk hadn't come in because my boobs weren't big enough to indicate it. I had his tongue tie identified and snipped but was told to increase his formula top-ups (even though I had pumped BM) "if he will take 120mls, give it to him". I then started a top-up weaning plan and was fully breastfed at 3.5mths. He lost weight when the formula was stopped (as expected when he was having 8 x 120ml bottles in 13 hrs after each breast feed). Was told by MCHN to get him to the hospital. Despite heavily wet nappies, advanced development and sleeping through the night happily. At the hospital I was booked into a dietitian and told to give him formula again to increase his weight. I didn't, (he would vomit it all up and spend the day screaming when he was given them. When ebf he was happy and content). He gained no weight but lost none in 4 weeks. The dietitian at the hospital told me I MUST start solids (at 4mths!!) because the WHO recommendations were "out of date". If he didn't gain within two weeks, they would admit him and feed him formula themselves. Not one single person who saw him noticed he had a lip tie, buccal ties and a high palate.*
Lip and tongue tie	*I noticed on day 1 a tongue tie, Paediatrician dismissed it immediately. Feeding became painful, and she was cluster feeding. I and still so confident we would get through it. I was completely bullied to give formula top-ups by both the head Paediatrician and my Obstetrician. I resisted and was told they may not discharge me unless bub puts on a certain amount of weight as she lost more than 10% of her birth weight. They refused to factor in my Caesar/fluids, the tie, milk was not even in yet and feeding was not yet established properly. I was made to feel absolutely awful for my want to persist and only breastfeed. I was told "formula is exactly the same as breast milk" and "It wouldn't be right to starve my baby" "they won't discharge you". I was only able to be discharged on the provision that I come back in 2 days for bub to be weighed. 7mths on and I'm still so upset by how I was treated and undermined. I told the paediatrician I was confident and knew a lot about breastfeeding after my experience with my 1st daughter. On day 7 we had our tie released and the feeding continued to improve her weight gain was great and we are still breastfeeding.*
Oversupply	*Baby was born premature and spent almost 7 weeks in hospital NICU/SCN. I found the lactation advice with regards to pumping to bring milk was useful but there was no one-on-one lactation support to avoid an oversupply. Luckily one of the nurses noticed how much milk I was getting and suggested I reduce pumping. When we were sent home the hospital lactation consultant did two visits with me (the first time she sat with me). I asked her what she recommended in terms of cutting back on pumping. She didn't seem to want to offer any advice and just said for me to do whatever I thought was best (I had no idea being a first time mum!). We ended up having a bub who was really windy and unsettled due to oversupply so the hospital LC was making the problem worse!*

Theme	Example of lack of support
Time between feeds	*My first night in hospital - there was the worst midwife on the ward. She kept telling all the new mums that they needed to sleep, and to ignore their babies, so they would sleep too -- cuz babies "don't really need to eat for 9 hours after their first feed at birth!"*

Table 5: Examples of lack of support in hospital for breastfeeding

Returning to work and its impact on breastfeeding

Issue	Example
Baby feeds only at night	*I went back to work when baby was 9 months and she refuses milk any other way than from the breast so would go without milk all day till I got home. The extra few months till she was 12 months would have made it easier for us and a lot less stress. Financially, I didn't have a choice but to go back as I had pushed it too far already.*
Breastfeeding is priority	*Not going back to work because I am still breastfeeding. Because of this, we are financially struggling but this is our family's priority right now.*
Breastfeeding is priority	*I was originally only going to take just over the 18 weeks paid leave... as in, my payments stopped mid Dec and I was going to go back to work mid Jan. When that time came though, I just wasn't ready to leave my baby in childcare full time (as we have no family close enough to help) he couldn't self-settle, still EBF and I knew I wouldn't have time to pump at work and the stress would definitely have dried my milk up anyway. I had 2 stressful periods where my milk production had almost stopped, I was back cluster feeding all day and night like the newborn days and those two times of stress were not nearly as stressful as my job before his birth. My breastfeeding journey would have been shortened had I not chosen to stay home unpaid with my son.*
Breastfeeding is priority	*I'm not returning to work so I can still feed full time. I'm a teacher and it's too hard to find time to pump at lunch as I use that time for class preparation and colleague communication time (no time during the day as we are all teaching then). I only got the government PPL as I'm on contract so losing out a lot by not working.*
Breastfeeding is priority	*I delayed returning to work for a whole year (so 2 years total) to continue our feeding journey but we are financially unstable for doing so.*

Issue	Example
Breastfeeding is priority	*I chose to return to studying (change of career) purely to stay at home with my daughter. I wasn't prepared to put her in care [at all] until she is school age. I would have had to return to work, financially, if I didn't go to study. I study from home full time, and still have 3.5 years left. My daughter is now 13m and still EBF (hardly any solids) and definitely wouldn't cope with a bottle or ebm out of a cup (we've tried...and failed). Which means I can't go anywhere for more than 4 hours at a time. But that's ok. I didn't want to stop my BF journey and so glad I get to stay home with my girl.*
Breastfeeding is priority	*I refused to go back before 12mths. Now I'm on unpaid extended maternity leave for 15mths. My main reason to breastfeed my son who is 13mths. It's been a struggle financially but we have made it work.*
Flexible work arrangements	*I'm desperately pumping at work, we are 6 months EBF! I have her on a schedule that works for us and I start work later so I am only pumping for two feeds. And I also do home-based work as much as I can. But I don't get enough - and use my haakaa pump during the week, save it up and top off the bottles. I'm so proud of myself, we had ties and dairy/soy allergies too. If I didn't have flexible work arrangements it wouldn't work. I'm in Defence and we are ABA accredited. I wouldn't need 12 months paid but I do need a FWA.*
Lack of facilities to express	*Had to return at 5 months casually due to being in financial dire straits. It was an absolute pain in the rear to pump at work. Still feeding mornings and nights at 15 months but no longer pumping due to lack of facilities.*
Lactation breaks	*I'm a teacher and barely get time to pee once a day. I doubt there will be time to pump.*
Mental health and wellbeing	*Yes breastfeeding journey was shortened/interrupted. Matched with having to negotiate expressing in the workplace. A very stressful time which also impacted my milk supply. Went back at 8 months, but always trying to express enough for the next day's feed.*
Mental health and wellbeing	*Returning to work early didn't alter my breastfeeding journey, but I believe it affected my mental health greatly. The guilt of leaving my son made it impossible to find a healthy balance in my life because I was always overcompensating for the missed time with him.*
Mental health and wellbeing	*Dreading return to work in a few weeks, but the truth is, we need my income so I have no choice. I will express but it's really not the same and all too soon my milk will be gone. I believe this happens not only because bub doesn't directly latch during the day, but also the stress, guilt and anxiety of going back to work.*

Issue	Example
Mental health and wellbeing	*I think this is one of the key factors putting me off having a second child. I took 10 months off with my son. Was good as only needed 1-2 bottles whilst at work. Took me 3-4 sessions pumping to get this. With the proposed changes to the Paid Parental Leave, I wouldn't be able to take the same time off work and would have to return at 3-4 months. I had such a long and stressful feeding/pumping, top-up journey with my son. Although happy to pump, my body hates it. It would cause too much stress but I wouldn't consider formula now either (now I know about milk sharing) but not being able to pump well will stuff supply too. Too much stress from all corners of the debate.*
Mental health and wellbeing	*I am preparing to go back to work in about 10 weeks and am really concerned that it may mean the end for our breastfeeding journey. Our journey so far has been a strong one and I feel that if I wasn't going back that the journey would definitely continue for a long time yet. It is a huge trigger for my anxiety at the moment and it is a major factor in me absolutely dreading going back to work.*
Milk supply - reduced	*I went back to work when baby was 10 months and tried to get baby on bottle of expressed milk. She wouldn't take the bottle, my supply did drop and she cluster feeds when I'm with her. Although I work 3 days a week and got close to 12 months off. If I had to return to work sooner than I did it would have affected our breastfeeding journey a lot more. I feel that working mums should be allowed to get maternity pay from both employer and government for 12 months. They can have in the agreement that mums need to return back to work within 3 years for at least 12 months to help employers with staffing if that helps them. I got a bonus pay for coming back to work provided I stay working for the next 12 months on return.*
Milk supply - reduced	*Returned after 6 months off work, bub was just over 5.5 months. It wasn't until then we had ties revised and our bf journey had already been disrupted. I couldn't pump as frequently at work to increase supply enough to not supplement with formula - not because work restricted breaks but because I would pump for an hour and still get next to nothing. We have been using a sns ever since. I had the opportunity of 12 months mat leave but financially couldn't do it as it would have been all unpaid (Apart from government paid mat leave of 18 weeks which is a great bonus don't get me wrong but is not anywhere near my usual wage) he's now almost 14 months and we're still feeding morning and night but I always wonder what would have happened had ties been diagnosed earlier and I had been able to concentrate more on building supply after they were revised.*

Issue	Example
Milk supply - reduced	*My breastfeeding journey ended abruptly at 10 months with my daughter when I returned to work. As a teacher, despite legally being allowed to express, our duty of care and/or timetables mean we have to be in the classroom all day. In our 2 x 30-min lunch breaks we then have to somehow eat, toilet, communicate with other staff, assist students who need extra support, prepare for next classes, several times a week do playground supervision, and for some teachers there are extra duties with students that undertake sports or other extracurricular activities. That's all before expressing happens. Which means, you guessed it, expressing doesn't happen.* *It took a mere week of that for my supply to drop off to the point I had to switch to formula, when prior to that I actually had an oversupply where I could give my daughter a full feed and still express off an extra feed straight after. Besides, why should we be forced to forgo our break to do this when we are legally entitled to an allotted time specifically for expressing?*
Milk supply - reduced	*For a colleague, her son went on a nursing strike that was prolonged due to her working full time around 6 months when she had to return to work. Her supply decreased, her son only accepted bottles and not breast and he weaned at around 6 months. She was devastated. He ended up 2 months later in hospital with pneumonia - decreased immune system from no longer receiving breast milk?*
Milk supply - reduced	*I had 5 1/2 months before I went back part time 2 1/2 days and I remember and still feel guilt ridden when I don't pump a lot of milk. I almost resent the fact that I'm not breastfeeding solely and have felt pressure to supplement with formula (10 1/2months and still only breast milk). I feel miserable waking many times a night for bub to reverse cycle feed and wish I had more time off with just me and bub so I wouldn't doubt myself and my milk supply. Maybe the pressure to wean him would be less intense but economic reasons saw me back at work (I returned full time on Monday which was my 12months off).*
Negative attitudes in workplace	*Absolutely, I think for a lot of mums it's not just the feasibility of being able to pump at work, it's how acceptable it is. I think that because mothers are still not adequately represented in workplace practice and policy that there isn't enough openness about the reality of breastfeeding and therefore workplaces don't make room for it naturally. It challenges a lot of mums to have to broach the topic themselves which can also be daunting.*
Negative attitudes in workplace	*With my first child yes. Went back to work when he was 5mths and he was in day care fulltime. He pretty much weaned a few weeks later. Work was not supportive in pumping. Fast forward 4 years, planning on going back to work part time (same company) with bub no.2 (8mths old) and they are more accommodating with pumping. Couldn't afford to stay at home with no money coming in with both kids so unfortunately breastfeeding is impacted.*

Issue	Example
Negative attitudes to expressing at work	*I return to work next week and I am terrified I will lose my milk supply because I know for a fact that I will receive negative attitudes for needing time to express. People will openly harass me for needing to express and for returning to work. While I was pregnant I received a lot of harassment for taking extra toilet breaks (I ended up with UTI's every 2nd week). I was told mothers should stay at home and not work if they choose to have children and I was harassed for taking my lunch break because I needed to eat. Apparently I was always eating (I never actually took my lunch break and would eat my lunch at the desk). I made a lot of trips to HR and on one occasion my GP even spoke to HR. So now I am getting stressed just thinking what people will say when I need to express. I had planned to return to work 5 days a week but now will only 2 days a week. Oh and I have already been told that they would rather keep my maternity full in than have me back as they won't get as good work quality from a new mum. So probably going to start looking at a new job anyway.*
Negative attitudes to lactation breaks	*With my first child, I returned to work at 8 months. Work weren't happy giving me breaks to pump and were always questioning me as to how long I was going to continue. In-laws didn't feel comfortable giving expressed breast milk. I also struggled to pump as much as I needed. Second time round I've decided to stay home with bubs and toddler and plan to feed until natural weaning.*
No lactation breaks	*I'm at 5.5 months now after returning to work at 4.5 months. We supplement with 2 bottles of formula a day because I can't express enough and my work doesn't pay for expressing breaks so it comes out of my lunch time or I have to make up the time (meaning I usually have 20 minutes for lunch in a 9.5 hour day with no tea breaks etc. either). So I can only afford 1 break to pump a day and never get what bubs needs out. I was feeling sick, down and sore today and have been diagnosed with mastitis and I'm almost ready to give up. It's just so hard. I wasn't ready to return to work after a horrendous pregnancy and emergency C-section then post natal depression with a high needs baby. I wish I could take extra time off but finances necessitate me working after 2 redundancies during my pregnancy.* *I even worked to 39 weeks despite being very ill at the time, because work has no obligation for paid maternity leave and I had used all my annual and sick leave during pregnancy. So bare minimum time off 18 weeks for me.*
Not eligible for maternity leave	*I'm taking 12 months unpaid. I don't qualify for any maternity leave due to a loop hole whereby PhD research doesn't qualify because our income is a scholarship.*

Issue	Example
Not eligible for maternity leave	*I had to return to work at 7 weeks post-partum as I had been off work the previous 2 years looking after my 28 week old who was tube fed until 1y 9m old. I started work again right after her 2nd birthday and also fell pregnant then unknown to me. Because I was off work for 2 years I was not entitled to paid parental leave from Centrelink even though I had worked the required hours. My due date was also 15 days short of 10 months' work. Because I had not been at my new job for 12 months I was not entitled to paid maternity leave. I had to use all my accumulated paid leave (except sick leave) to take as much time off as I could. My paid time off fell just short of 7 weeks pp. I left work at 31 weeks due to threatened preterm labour, had bub at 36 weeks and returned when he was 7 weeks old.* *Because my shift is short (total of 4 hours out of home) and a feed time falls in the middle, I am not always able to take that break in the middle to express resulting in bub having to take part or all formula for his feed while I am at work.* *He is 8 months old now and we still breastfeed. I wish I had been able to take more time off but finances did not allow.*
PPL supported breastfeeding	*I'm one of those lucky "double dippers" where I was paid maternity leave from my employer (I took half pay for 28 weeks) and then PPL for 18. Bub is one on Thursday and tomorrow is officially my last day of PPL. I can, without a doubt, say that were it not for this there is no way I would have continued breastfeeding as long as I did. Although I can pump quite a lot and my boy takes a bottle, it is not consistent and he sometimes goes all day without milk when he is in the care of others or refuses a night bottle. I am extremely fortunate to have been in the position I'm in.*
Pumping - difficulties	*I tried pumping prior to returning. It was not working for me. I tried keeping evening/night feeds and weekends but as soon as I stopped through the day my supply disappeared. I don't work in an office or in a building. My work site changes daily. Pumping on the side of the road in a pop-up tent with a manual pump just wasn't really going to work for me.*
Pumping - difficulties	*For my first bub I took 12 months off and was unpaid for some of that time. Hubby and I struggled a lot financially during that time. For our next bub, I don't think I will get the 12 months off again and I am already dreading the fact that I don't want to formula feed and I am a crap pumper (not even pregnant yet either, and I'm already worrying!). 12 months paid maternity leave would be amazing for a lot of people I think.*
Pumping - difficulties	*My journey has definitely been impacted. I am still breast feeding but after being back at work for 3 months I had to introduce formula during the day as I was physically not able to pump enough and live in a remote location where donor milk is also not available.*
Pumping - difficulties	*I had to pump when I returned to work at 7 months post partem but the pump couldn't extract enough to fully feed my daughter. I resented having to go back and not being able to feed her myself, which would have fed her much more than the pump could.*

Issue	Example
Pumping - difficulties	*I believe I was only able to feed past 1yr as I was able to have a year off of work. I could never pump a significant amount so expressing at work would not have been enough.*
Pumping - difficulties	*Not the first time as I was lucky to have quite a bit of time off. But this second bub will be a different story as will have to go back a lot sooner. If this feeding journey is anything like my first I will have to use formula as I can't seem to pump enough for a day of feeds.*
Pumping - dislike	*Pumping right now at work and hating it. Contemplating formula for while I'm at work because I dislike pumping so much. She is 9 months old.*
Refused bottled expressed milk	*My son refused pumped milk from a bottle at day care whilst I was at work. He was still 7-8 months old and so he still needed breast milk during the day. He would go all day without any milk. Also having to go back to work financially, meant that my baby was in day care early, when his immune system was very immature. I may as well not have been working with the sick leave (and unpaid sick leave!) I had to take!*
Stopped feeding earlier than planned	*I stopped feeding earlier than I would have if I had been able to stay home a bit longer. 2nd lot of maternity leave starting in 10 weeks and again I will be forced to return to work and stop feeding sooner than I'd like to.*
Supportive workplace - Lactation breaks	*What I had instead (have) is a supportive workplace. I take lactation breaks and walk across the road to child care to feed.* *My first I wasn't able to do that (long commute at the time) so I expressed but he never drank from a bottle. I know if I had been able to have him across the road from my work as well then he would have fed more often (although no longer).*
Supportive workplace - Lactation breaks	*I think the answer partly lies in how supportive the work place is of pumping mums on return to work. I managed to continue to exclusively breastfeed til 6 months (returned to work at 4.5 months) and then breast milk and some solids since. I continued to pump at work 3 then 2 times a day up until my son was 12 months. By then he was showing that he would rather wait til I got home and made it through the day on food and water. In saying all that I'm conscious of the fact that pumping is not so easy for some, and my sons day time carers had their share of him refusing the expressed breast milk bottle! Almost two years on however we still feed before and after work.* *I will however look forward to being able to take a total of 12 months paid leave with No.2.*

Table 6: Returning to work and its impact on breastfeeding

Appendix D: Stakeholder consultation participants – workshops and written submissions

Workshop participants

Stakeholder	Attendee	Position	Workshop Location
Aboriginal Family Birthing Program	Deanna Stuart-Butler	Manager	Adelaide
Child and Family Health Services-Women's and Children's Health Network	Lynne Kurtzer	Advanced Nurse Unit Manager	Adelaide
Child and Family Health Services, Women's and Children's Health Network	Mary Schneider	Associate Clinical Services Coordinator	Adelaide
Clinical Nursing Services, Child and Family Health Service	Nghi Huynh	Clinical Nurse	Adelaide
Country Health SA Local Health Network (CHSALHN), South East Region	Rachael Yates	Midwife Management Facilitator	Adelaide
Flinders Medical Centre, Southern Adelaide Health Centre	Tracey McPhee	Midwifery Unit Manager	Adelaide
Healthy Mothers, Babies & Children SAHMRI	Dr Merryn Netting	Research Fellow	Adelaide
Lactation Consultant, Midwife and Baby Friendly Health Initiative (BFHI) Assessor, Member of BFHI Advisory Committee, Member SA BFHI Reference Group	Marianne Sturm	Lactation Consultant, Midwife (also BFHI Assessor), Member of BFHI Advisory Committee, Member SA BFHI Reference Group	Adelaide
Medela Australia Pty Ltd	Jarrod Percy	Managing Director	Adelaide
Nursing and Midwifery Office, SA Health	Paula Medway	Midwifery Project Officer	Adelaide
Nutrition & Dietetics, Flinders University	Jacqui Miller	Senior Lecturer	Adelaide
Port Broughton and Crystal Brook	Elizabeth Traeger	Multi Campus EO/ DONM,	Adelaide
Postnatal Service, Women's and Children's Health Network and BJOG member for SA	Belinda Biddle	Clinical Service Coordinator	Adelaide

Stakeholder	Attendee	Position	Workshop Location
SA Health- Health Informatics, Performance, Planning & Outcomes (HIPPO) Unit Women's and Children's Health Network	Nareen Carter	Manager Child Health Strategy and Chair of the Statewide Breastfeeding Policy Working Group	Adelaide
Women's and Children's Health Network	Kathy Mattner	CM BFHI Coordinator	Adelaide
Alice Springs Hospital, Central Australia Health Service	Diana Baseley	Clinical Midwifery Manager	Alice Springs
ASH Paediatric Liaison, Outreach Central Australian Health Service	Lynne Little	Child Health Nurse, Clinical Nurse Specialist	Alice Springs
Birth and Beyond	Kirsty Robertson	Manager	Alice Springs
Central Australian Aboriginal Congress	Lisa Charmer	Alukura Maternity Services Coordinator	Alice Springs
Central Australian Aboriginal Congress	Stacey de Grave		Alice Springs
Charles Darwin University	Angela Bull	Bachelor of Midwifery Course Coordinator	Alice Springs
Nganampa Health Council	Carmel Hattch	Child Health	Alice Springs
NT Government	Amanda Hill	Dietitian (outreach)	Alice Springs
NT Government	Ann Hallett		Alice Springs
NT Government	Annie Godwin		Alice Springs
NT Government	Jenny Kenna		Alice Springs
NT Government	Robyn Wallace		Alice Springs
NT Government	Ruth Primrose		Alice Springs
NT Government	Sandy McElligott		Alice Springs
Access Community Service	Jess Chang	Care worker	Brisbane
Apunipima Cape York Health Council	Kirby Murtha	Community Nutritionist	Brisbane
Australian Breastfeeding Association	Naomi Hull	Queensland Branch President, Lactation Consultant	Brisbane
Centre for Children's Health Research, Queensland University of Technology (QUT)	Dr Rebecca Byrne	Accredited Practising Dietitian, Research Fellow	Brisbane
Children's Health Queensland	Dr Melinda White	Acting Director, Dietetics and Food Services, Children's Health	Brisbane

Stakeholder	Attendee	Position	Workshop Location
Children's Nutrition Research Centre, UQ Child Health Research Centre	Dr Wendy Brodribb	GP, academic, researcher, immediate past president of the Academy of Breastfeeding Medicine, clinical lead for the Queensland BF guideline	Brisbane
Eight Mile Plains Community Health South East Queensland Breastfeeding Coalition	Simone Johnston	Senior Community Nutritionist	Brisbane
Ethnic Communities' Council of Queensland	Hong Do	Program Manager, Chronic Disease Program	Brisbane
Gold Coast University Hospital	Lyn Ahearn	Lactation Consultant and Baby Friendly Health Initiative (BFHI) Coordinator	Brisbane
Independent participant	Emily Dickson	Volunteer Breastfeeding Counsellor	Brisbane
Lactation Consultants of Australia and NZ	Colleen Hickey	Regional Coordinator – Brisbane	Brisbane
Lactation Service, Division of Medicine, Lady Cilento Children's Hospital	Judith Cunningham	Lactation Consultant	Brisbane
Lactation Service, Division of Medicine, Lady Cilento Children's Hospital	Suzanne Oram	Lactation Consultant	Brisbane
Logan Hospital	Debbie Olsen	Lactation Consultant, Special Care Nursery	Brisbane
Mater Health	Julie Germain	Breastfeeding Coordinator and International Board Certified Lactation Consultant (IBCLC)	Brisbane
NAQ Nutrition (the Qld Division of Nutrition Australia)	Aloysa Hourigan	Senior Nutritionist	Brisbane
Office of the Chief Nursing and Midwifery Officer	Lee Poole	Acting Director of Nursing	Brisbane
Queensland Department of Health	Janny Goris	Senior Public Health Nutritionist/ Dietitian	Brisbane
Queensland Department of Health	Sally Russell-Hall	Clinical Nurse Consultant/ BJOG representative	Brisbane
Queensland Department of Health	Sharon McDonald	Principal Policy Officer	Brisbane
Queensland Hospital and Health Services	Catherine Marron	Nursing Director, Ellen Barron Family Centre/ Child Health Sub-network Chair	Brisbane

Stakeholder	Attendee	Position	Workshop Location
Queensland Hospital and Health Services	Kristina Palmer-Field	Clinical Nurse – Lactation Consultant, Women's and Newborn Services	Brisbane
Queensland Hospital and Health Services	Robyn Penny	Clinical Nurse Consultant, Children's Health	Brisbane
Queensland Hospital and Health Services	Tracey Button	Clinical Nurse Consultant, Children's Health	Brisbane
Redland Hospital	Ruth Cantrill	Lactation Consultant and Baby Friendly Health Initiative (BFHI) Project Coordinator	Brisbane
Royal Brisbane and Women's Hospital	Jeanette Tyler	Clinical Nurse Consultant/ Clinical Midwifery Consultant	Brisbane
South East Queensland Breastfeeding Coalition	Simone Braithwaite	Prevention Division, Department of Health	Brisbane
University of Queensland	Michelle Harrison	Researcher	Brisbane
ABA – ACT Regional Office	Megan Fox		Canberra
ACT Health	Ann Burgess		Canberra
ACT Health	Mary Ellen Youseman		Canberra
ACT Health	Pip Golley		Canberra
ACT Health	Raelene Garrett-Rumba		Canberra
Australian Healthcare & Hospitals Association	Kylie Woolcock	Policy Manager	Canberra
Belconnen MACH Team, ACT Health	Sally Campbell	Clinical Nurse Manager	Canberra
Centenary Hospital for Women and Children	Donna Solari	Lactation Consultant,	Canberra
Child and Family Health Section, IHD, Department of Health	Alicia Roff	Assistant Director	Canberra
Child and Family Health Section, Indigenous Health Division, Department of Health	Nick Pascual	Director	Canberra
Dietitians Association of Australia	Ms Gabrielle O'Kane		Canberra

Stakeholder	Attendee	Position	Workshop Location
Division of Women Youth and Children ACT Health	Cathy O'Neill	Assistant Director of Nursing	Canberra
Early Childhood and Youth Branch, Education, Community Safety and Health Division, Department of the Prime Minister and Cabinet	Vanessa Beck	Acting Assistant Secretary	Canberra
Food and Nutrition Section, Department of Health	Belinda Turk		Canberra
Infant Nutrition Council	Jan Carey	CEO	Canberra
Maternal Health, Children, Youth and Families Unit AIHW/ Breastfeeding ERG	Conan Liu	Head	Canberra
Migrant and Refugee Settlement Services of the ACT (MARSS)	Nelofar Jadeer		Canberra
Migrant and Refugee Women's Health Partnership	Gulnara Abbasova	Executive Officer	Canberra
NCEPH, ANU & HPSD Branch, IHD, Department of Health	Alex Marmor	MAE Scholar	Canberra
Nutrition Australia ACT	Leanne Elliston	Program Manager	Canberra
Policy Unit, Australian College of Midwives	Sarah Stewart	Midwifery Adviser	Canberra
Prevention and Health Policy Branch, Department of Health	Elizabeth Flynn	Assistant Secretary	Canberra
Primary Healthcare Branch, Department of Health	Anita Soar	Departmental Officer	Canberra
Primary Healthcare Branch, Department of Health	Samantha Diplock	Assistant Director	Canberra
Public Health Evidence Advice and Governance, NHMRC/ Breastfeeding ERG	Emma Breen	Assistant Director	Canberra
Regulatory Institutions Network, ANU	Libby Salmon		Canberra
University of Canberra, Australian College of Midwives (ACM)/ ERG member	Marjorie Atchan	Assistant Professor in Midwifery (Clinical)	Canberra
ABA	Mary Peterson		Darwin

Stakeholder	Attendee	Position	Workshop Location
AMSANT	Karrina Demasi		Darwin
NT Government	Alexander Wetten		Darwin
NT Government	Carmel Rankin		Darwin
NT Government	Janice Finlayson		Darwin
NT Government	Jenelle Craggs		Darwin
NT Government	Karen Burke		Darwin
NT Government	Maggi Richardson		Darwin
NT Government	Terri Dunn		Darwin
NT Government	Virginia Skinner		Darwin
Australian Breastfeeding Association (ABA), Tasmania	Charlotte Fielding	Branch President	Hobart
Australian College of Midwives (ACM)	Lou Klug		Hobart
Breastfeeding Coalition Tasmania	Ali Graham	Secretariat	Hobart
Breastfeeding Coalition Tasmania	Ros Escott	Co-convener	Hobart
Child Health Association Tasmania	Emma Rowell	Family Food Patch Program Manager	Hobart
Child Health Association Tasmania	Liz Crane	State Executive Officer	Hobart
Chronic Conditions Prevention, DHHS, Public Health Services	Julie Williams	Manager	Hobart
Curriculum, Child and Family Centres, Department of Education, Tasmania	M'Lynda Stubbs	Project Manager	Hobart
Department of Health and Human Services (DHHS), Public Health Services – Breastfeeding Jurisdictional Officers Group	Judy Seal	Principal Public Health Nutritionist	Hobart
Health State Network (HSN), Department of Health	Carole McQueeney		Hobart
Lactation Consultants Australia New Zealand, Tasmanian Branch	Christina Galloway	Lactation Consultant	Hobart

Stakeholder	Attendee	Position	Workshop Location
Nursing, Midwifery & Allied Health Professionals, Tasmanian Health Services	Susan Gannon	Executive Director	Hobart
Tasmanian Aboriginal Centre	June Sculthorpe	Manager, Policy and Planning	Hobart
Tasmanian Aboriginal Centre	Rose Romeo		Hobart
Tasmanian Health Service (THS)	Dominica Kelly		Hobart
University of Tasmania	Dr Jennifer Ayton	Senior Clinical Lecturer, Researcher	Hobart
Australian Breastfeeding Association (ABA)	Rebecca Naylor	CEO	Melbourne
Australian Breastfeeding Association (ABA)	Susan Tawia	Manager, Breastfeeding Information and Research	Melbourne
Australian College of Midwives	Jen Hocking		Melbourne
Australian College of Midwives	Judith Russell		Melbourne
Bayside City Council	Robyn Corser	Maternal and Child Health Nurse	Melbourne
Breastfeeding Support Centre Mercy Hospital for Women	Constance Banks	Registered Nurse, RM, IBCLC, Acting NUM	Melbourne
City of Boroondara	Teresa Murphy	MCHN, IBCLC	Melbourne
Department of Education and Training/BJOG	Dr Jenny Proimos	Principal Medical Adviser	Melbourne
Department of Education and Training/BJOG	Megan Leuenberger	Principal Maternal Child Health Nurse Adviser	Melbourne
Family Children and Young People City of Whittlesea	Leanne Taylor	Maternal and Child Health Coordinator	Melbourne
Family Health Family Services, Community Services, City Communities, City of Melbourne	Patti Reilly	Assistant Coordinator	Melbourne
Family, Youth and Children Services	Christine Cooper		Melbourne
Hume City Council	Ann McNair	MCHN Coordinator	Melbourne

Stakeholder	Attendee	Position	Workshop Location
Judith Lumley Centre, La Trobe University	Assoc Prof Lisa Amir	Principal Research Fellow	Melbourne
Kingston	Emma Hartridge	MCHN, IBCLC	Melbourne
Kingston	Erika Matthews	MCHN	Melbourne
Knoxfield	Cheryl Kessler	Maternal and Child Health Nurse	Melbourne
Lactation Breastfeeding Service and the Royal Women's Hospital	Helene Johns	Clinical Midwife Consultant, Lactation Breastfeeding Service and Midwife/Women's Health Nurse at the Royal Women's Hospital	Melbourne
Lactation Consultants of Australia and New Zealand	Helen Adams	President	Melbourne
Mallee District Aboriginal Services	Kate Glenie	Early Years Project Worker	Melbourne
Manningham City Council	Alice Yianni	Maternal and Child Health Coordinator	Melbourne
Maternal and Child Health Nurses Victoria Inc	Joanne Fittock	President	Melbourne
Mercy Health	Kyra Booth		Melbourne
Monash Health	William Dolan	Clinical Midwife Consultant	Melbourne
Multicultural Centre for Women's Health	Dr Regina Quiazon	Senior Research and Policy Advocate	Melbourne
Municipal Association of Victoria	Kim Howland		Melbourne
O'Connell Family Centre	Kerri McEgan	Manager/Director of Nursing	Melbourne
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	Dr Bernadette White	College Councillor	Melbourne
Royal Children's Hospital	Erin Mullane	Clinical Specialist Dietitian	Melbourne
Royal Women's Hospital	Anita Moorhead	Clinical Midwife consultant	Melbourne
Vic State Maternal and Child Health (MCH) Coordinators group	Helen Watson		Melbourne
Victorian Aboriginal Community Controlled Organisation	Simone Andy		Melbourne
Victorian Association of Maternal and Child Health Nurses	Heidi Brundell		Melbourne
West Gippsland Health Care Group	Robyn Barr		Melbourne

Stakeholder	Attendee	Position	Workshop Location
Australian Breastfeeding Association	Kirsten Tannenbaum		Perth
Australasian Society of Clinical Immunology and Allergy Limited	A/Prof Richard Loh		Perth
Australasian Society of Clinical Immunology and Allergy Limited	Sandra Vale	National Allergy Strategy Coordinator	Perth
Baby Steps Wembley	Jenny Lynn	Lactation Consultant	Perth
CACH Policy	Megan Knuckey	Policy Officer	Perth
CACH Research	Karen Forde		Perth
CDPD	Krista Coward		Perth
Child and Adolescent Community Health (CACH) CNM	Alison Senior		Perth
Curtin University – research	Prof Yvonne Hauck		Perth
King Edward Memorial Hospital	Marie Warrington	Lactation Consultant	Perth
KEMH Breastfeeding Centre	Liz Ashton	Clinical Midwifery Consultant	Perth
Kimberley Population Health Unit	Di Dobson		Perth
Kimberley Population Health Unit	Gail Freeland		Perth
King Edward Memorial Hospital	Dr Ben Hartmann	PREM Bank Manager	Perth
PMH dietetics (HoD)	Beth Martino		Perth
Royal Australian College of General Practitioners	Marnie Rowan	General Practitioner and Lactation Consultant	Perth
Research Officer at UWA Human Lactation Research Group & ABA Counsellor	Jennifer Turner	Research Officer and Counsellor	Perth
St John of God Hospital (Murdoch)	Sue Bradshaw	Deputy Director of Nursing	Perth
St John of God Subiaco Hospital	Heather Marin	Deputy Director, Obs/Gynaecology and Newborn Services and Nurse Manager	Perth

Stakeholder	Attendee	Position	Workshop Location
Telethon Kids Institute	Dr Roslyn Giglia		Perth
UWA Human Lactation Research Group	Melinda Boss		Perth
WA Country Health Service - South West;	Leanne Muir	Warren Blackwood - Community Nurse Early Childhood Intervention;	Perth
WA Primary Health Alliance	Rhonda Marriott		Perth
WACHS	Leonie Hellwig		Perth
WACHS Population Health-Central Office	Kylee Cox		Perth
WACHS, Broome	Mary Jane McNamara	Acting Community Health Nurse Manager	Perth
WACHS, Broome	Melissa Williams		Perth
Warmun and Kalumburu Communities Kimberley Population Health Unit WA Country Health Service- Kimberley	Cathy Garbin	New Directions Maternal and Child Health Nurse	Perth
Aboriginal Maternal Child & Family Health Team (AMCFH) MCYP, HSPB, MoH	Elizabeth Best	Manager	Sydney
Aboriginal Maternal Infant Health Service (AMIHS) Western NSW Local Health District, NSW Health	Linda Bootle	Clinical Midwifery Consultant	Sydney
Aboriginal Nursing and Midwifery Strategy Nursing and Midwifery Office (NaMO), MoH	Skye Parsons	Project Officer	Sydney
Australasian Association of Parenting and Child Health (AAPCH)	Robert Mills	President AAPCH and CEO Tresillian	Sydney
Australian Breastfeeding Association (ABA) NSW/ACT	Nicole Bridges	President	Sydney
Australian College of Midwives - BFHI	Michelle Simmons	Representative	Sydney
Australian College of Midwives - BFHI	Shahla Meedya		Sydney
Australian College of Neonatal Nursing	Annette Wright	Representative	Sydney
CFH, Western Sydney Local Health District, NSW Health	Jennie Mulligan	Clinical Nurse Consultant	Sydney

Stakeholder	Attendee	Position	Workshop Location
Child & Family Health (CFH) Hunter New England Local Health District, NSW Health	Helen Higgins	Clinical Nurse Consultant	Sydney
Sydney Children's Hospital, Randwick	Jessica Menzies	Paediatric Dietitian	Sydney
Sydney Children's Hospital, Randwick	Nora Crotty	Clinical Nurse Educator	Sydney
Children's Hospital at Westmead	Gabrielle Kerslake	Lactation Specialist	Sydney
Children's Hospital at Westmead	Helen Mercieca	Lactation Specialist	Sydney
Children's Hospital at Westmead	Sheridan Collins	Dietitian	Sydney
Clinical Nurse Consultant Network, Child & Family Health (CAFH)	Jenni Jones	Clinical Nurse Consultant (CNC) CAFH and SLHD Family Partnership Co-ordinator	Sydney
Clinical Nurse Consultant Network, Child & Family Health	Trudy Wynne	Secretariat	Sydney
Ethnic Communities' Council of NSW	Mary Karras	CEO	Sydney
Lactation & Parenting, Sydney Local Health District, NSW Health	Carmel Kelly	Clinical Nurse Consultant, Lactation, RPAH	Sydney
Lactation Consultants of Australia & New Zealand (LCANZ)	Yvette Sheehy	Representative	Sydney
MCYP, HSPB, MoH	Margaret Lum	Research Implementation Officer	Sydney
NaMO, MoH	Carolyn Ripper	Principal Advisor Midwifery	Sydney
Royal Hospital for Women	Shea Caplice		Sydney
Wellington Aboriginal Corporation Health Service	Emma Ramsay	Nurse Home Visitor	Sydney
Wellington Aboriginal Corporation Health Service	Francie Kelly	Aboriginal Family Partnership Worker	Sydney
Wellington Aboriginal Corporation Health Service	Jinnaya Tyson	Aboriginal Family Partnership Worker	Sydney
Wellington Aboriginal Corporation Health Service	Kenneth Pascoe	Nurse Supervisor	Sydney
Wellington Aboriginal Corporation Health Service	Lyndall Fryer	Nurse Home Visitor	Sydney
Wellington Aboriginal Corporation Health Service	Nikkita Chatfield	Aboriginal Family Partnership Worker	Sydney
Westmead Private Hospital/APHA	Annie Fleming	Lactation Consultant	Sydney

Table 7: Workshop participants

Written submissions - Individuals

Name
Dr Jennifer Ayton
Melinda Boss
Emily Dickson
Amanda Dietiker
Dr Ben Hartmann
Naomi Hull
Nicole Jameson
Jenny Lynn
Alex Marmor
Maureen Minchin
Rachel McDonald
Claire Philipps
Susanna Scurry
Kristie Welch

Table 8: Written submissions - Individuals

Written submissions - Organisations

Name
Australian Breastfeeding Association
Australian College of Midwives
Australian Healthcare and Hospitals Association
Safe Motherhood for All Inc
Medela Australia Pty Ltd
Faculty of Health, University of Tasmania
Breastfeeding Advocacy Australia Facebook Group
Child and Adolescent Community Health (WA Health)
Victorian Aboriginal Community Controlled Health Organisation

Table 9: Written submissions - Organisations