Submission No 66

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

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WARRA WARRA LEGAL SERVICE SUBMISSION

INQUIRY INTO SUPPORT FOR NEW PARENTS AND BABIES IN NSW

The Warra Warra Legal Service (**WWLS**) is a community legal service based in Broken Hill NSW. WWLS was established in 2009 and provides a range of services for Aboriginal and Torres Strait Islanders. In particular, services are provided to those who are victims of family violence or sexual assault. WWLS also assists clients in a range of family law and child protection matters, as well as victims of crime compensation applications and apprehended violence orders.

WWLS plays a key role in assisting and advocating for Aboriginal and Torres Strait Islander communities in far west NSW. In particular, WWLS, in collaboration with Knowmore Legal Service, led four projects focusing on the Royal Commission into Institutional Responses to Child Sexual Abuse in 2012/13. The projects involved the provision of legal advice about engaging with the Royal Commission as well as a focus on traditional healing practices.

WWLS has extensive experience in family law and child protection matters and welcomes this opportunity to make submissions to the Committee on Community Services' inquiry into support for new parents and babies in NSW (the **Inquiry**).

This submission outlines recommendations that focus on prioritising the relationship and physical connection between new born children and their mothers. WWLS suggests an increased focus on support services for "at-risk" mothers, particularly those dealing with drug addiction, rather than pre-emptive removal of newborns.

WWLS will address the following terms of reference:

1. the adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies;

2. changes to current services and structures that could improve physical health, mental health and child protection outcomes;

3. specific areas of disadvantage or challenge in relation to health outcomes for babies; and

4. models of support provided in other jurisdictions to support new parents and promote the health of babies.

LEGISLATIVE FRAMEWORK

Background

Section 36 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (the **Act**) provides the principles to which FACS must have regard when considering a report concerning a child or young person. Section 36 is expressed as follows (emphasis added):

> **36 Principles of intervention**
>
> (1) In deciding the appropriate response to a report concerning a **child or young person**, the Director-General must have regard to the following principles:
>
> (a) The immediate safety, welfare and well-being of the child or young person, and of other children or young persons in the usual residential setting of the child or young person, must be given paramount consideration.
>
> (b) Subject to paragraph (a), any action must be appropriate to the age of the child or young person, any disability the child, young person or his or her family members have, and the circumstances, language, religion and cultural background of the family.
>
> (c) **Removal of the child or young person from his or her usual caregiver may occur only where it is necessary to protect the child or young person from the risk of serious harm**.

We draw particular attention to the following:

1. section 36 applies to reports concerning "a child or young person", which includes children up to the age of 18; and

2. subsection 36(1)(c) provides that a child or young person may only be removed from their caregiver where it is necessary to protect the child or young person from the "risk of

serious harm". Noting that risk of serious harm can arise as a result of sexual abuse, physical abuse, psychological harm, neglect of basic physical needs, domestic violence and homelessness.

Issues

WWLS submits that the generality of section 36 of the Act does not adequately address reports concerning prenatal infants or newborn babies

WWLS is concerned that, in the context of newborn babies, when breastfeeding is critical to the health, growth and development of a new born child, and where it has also been shown to benefit mothers in their caregiving, there appears to be a pre-emptive approach to the question of risk of serious harm and the removal of a newborn is readily used as a preventative measure. .

WWLS submits that steps should be taken to alleviate the risk by providing multi services support and assistance to the mother and newborn.

SUGGESTED REFORMS

WWLS submits that new provisions should be inserted into the Act which deal specifically with prenatal infants and newborn babies. In particular, WWLS submits that these new provisions address the following:

1. The adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies.

WWLS submits that the preservation of the newborn and parent relationship should be the first priority in an assessment considering removal of the baby. The assessment should prioritise the fostering of interactions and relationships between babies and parents.

If removing the baby is considered a necessary option, there should be weighted assessments aimed at balancing the risk of the harm created by removing the baby from their mother's care (absence of breastfeeding and bonding) against the risk of continuing to have the baby remain in the mother's care. WWLS recommends that the mother is supported to breastfeed immediately after birth and remain with the child unless removal is recommended by a medical professional.

WWLS recommends incorporating mechanisms of support prior to birth. WWLS believes that directly supporting parents to promote and ensure early relationships between parent and child is preferable to any forced removal.

WWLS submits that legislation needs to specifically provide a timeframe during which babies are not to be removed without medical recommendation . This will require that necessary supports be

in place for the mother during this critical period (see further below) WWLS also submits that, if a child is removed from their mother's care we must ensure that:

(a) frequent contact between mother and child is facilitated, during which time breastfeeding is encouraged; and

(b) lactation is maintained while the mother and child are separated. The mother should be provided the equipment and support to continue lactation.

2. Changes made to current services and structures that could improve physical health, mental health, and child protection outcomes

WWLS submits that clarity around what amounts to "risk of serious harm for newborns" is required. There must also be clearer expectations of the evidence needed to establish the risk.

The current methods of responding to safety, welfare and well-being concerns of newborns is heavily dependent on a reactive regime which relies on reporting and identification of risk factors during pregnancy. This often results in the unfair targeting of disadvantaged parents.

In circumstances where a risk of serious harm has been established, all reasonable efforts to provide support services to the mother and baby should be implemented to alleviate the risk. Organisations such as the Supporting Families Early Maternal and Child Health Primary Health Care should be involved. Resources which alleviate the risk of harm to babies whose mother are suffering from drug addiction should also be implemented.

3. Alleviating specific areas of disadvantage in relation to health outcomes for babies.

"Risk of serious harm" is often raised where a mother has a diagnosed drug addiction. Considering the link between drug addiction and homelessness, WWLS submits that mothers should be given adequate support services by way of residential care or supervised accommodation after giving birth. This would enable the alcohol and drug addiction to be addressed *in situ*, whereas the current policy requires the mother to detox as a pre-condition for entry into the support residential accommodation programmes, jeopardising the bonding for the mother and baby and halting breastfeeding. Further, delays in court processes of up to 6 months results in the baby becoming settled in care which is used against returning the baby to the mother.

WWLS submit that priority should be given to help such women stabilise their lives to enable planning for the future. This ought to take the form of complementary follow-up procedures to provide support for both parents and newborns, including securing permanent housing.

4. Models of support provided in other jurisdictions to support new parents and promote the health of babies.

WWLS submits that the South Australian guidelines for the management of drug use during pregnancy, birth and early development may provide a model for the equivalent framework in NSW.

The South Australian regime provides for written discharge plans which take into account parenting ability, stability and psychosocial issues, mental health, environmental issues and child protection. It also ensures follow-up measures post discharge, which includes:

(a) inpatient services (i.e. for appointments, transport and finances);

(b) community services through ensuring active and engaged services in safeguarding the wellbeing of the mother and child);

(c) home visiting; and

(d) adherence to early intervention programs.

WWLS submits that the South Australian model is an appropriate guide in developing procedure and policies on new legislative provisions, that could be implemented in all hospitals.

Additional considerations of rights of the child

The United Nations Human Rights Convention (**UNHRC**) promotes the importance of parents in the care and protection of children.

WWLS notes the UNHRC highlights rights of the child to enjoyment of the highest attainable standard of health (art 21(1)) and requires states to "combat disease and malnutrition"(art 24(2c)). In particular, there is an arguable right to be breastfed (*see Annexure 1: "BreastMilk is a Human Right", Olivia Ball, Australian Breastfeeding Association 2010*). Premature cessation of breastfeeding causes infants to be at increased risk of infection and leads to impeded development.

WWLS submits that supporting breastfeeding enables maternal sensitivity and improves the mother-child attachment. Hormones released in the mother in response the breast feeding act on the central nervous system to promote maternal behaviour and reduces a woman's response to physical and emotional stress.

The removal of newborns from their mother's care denies them access to the benefits of breastfeeding, and should be avoided when other options, as discussed above, have not yet been exhausted.

Dated this 19th day of December 2017
Warra Warra Legal Service

Breastmilk is a human right

Olivia Ball MA (Human Rights)

ABSTRACT

All babies have a human right to breastmilk, based on the right to life, to adequate nutrition and to the highest attainable standard of health, and based on women's rights, which include the right to breastfeed, to breastfeeding education and to paid maternity leave. This article examines international human rights law as it applies to breastfeeding, with particular reference to the Australian context. It also lays out the rights obligations of organisations such as the Australian Breastfeeding Association, their relations with government and the merits of such organisations adopting a rights-based approach to advocacy.

Key words: human rights; right to health; right to food; rights of the child; maternity protection

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Human rights constitute the moral discourse of our time. Their claim to universality offers a bridge between diverse cultural, religious and philosophical worldviews (Ball & Gready 2009). Human rights exist in law, but precede law, demanding legal recognition. In this article, I will argue that a baby's right to breastmilk (related to but distinct from a woman's right to breastfeed) is unequivocally protected in international law.

To explain briefly the status of international law: international law exists in treaties and sometimes customary practice agreed between nations. In broad terms, it is not enforceable in the same way national laws can be enforced. International law is binding, but the cords that bind nations to comply are, by and large, political and moral.

Once a nation has ratified a human rights treaty, it is expected to make those rights explicit in national ('domestic') laws so as to make them enforceable 'on the ground' (ICCPR 1966: Art. 2(2); Committee on Economic, Social and Cultural Rights 1999: para.29). Australia has been slow to enshrine human rights in domestic law, as will be discussed below.

The right to breastmilk exists within three human rights that are well established and developed at the international level. They are the right to food, the right to health and the right to life. The right to breastmilk is further elucidated in international law with respect to three specific groups of rights-holders: children, women and workers. Any one of these bases is a sufficient foundation for the right to breastmilk, and yet we have multiple, mutually reinforcing pillars of human rights undergirding every baby's entitlement to breastmilk. I will briefly discuss each in turn, relying on international law.

THE RIGHT TO FOOD

Breastmilk's most obvious function is as a baby's food. Food is a human right, but this right is specified as 'adequate food', with the term having special meaning in human rights law. The United

Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR), the highest authority on the interpretation of the International Convention on Economic, Social and Cultural Rights (ICESCR), defines 'adequate' in human rights terms, and states that an infant's food must satisfy (at least) these six criteria:

Quality

Babies' food must be of sufficient quality to satisfy their dietary needs (CESCR 1999: para. 8). Breastmilk is certainly adequate — the World Health Organization (WHO) recognises that breastmilk is a complete food and recommends that babies be fed nothing but breastmilk ('exclusive breastfeeding') for the first 6 months of life. Complementary foods may then be introduced, with breastfeeding continuing up to and beyond 2 years of age.

Artificial baby milks lack the nutrients necessary for normal growth (Berry & Gribble 2008) and brain development (Kramer et al 2008). Thus, artificial baby milks fail the first test of adequacy necessary to meet a child's human right to food.

Quantity

Food must be available in a quantity sufficient for the baby's needs. There are circumstances in which breastfeeding and artificial feeding may fail to meet the quantity criterion. Breastmilk production is unique, however, in being regulated by the individual infant according to their needs (Daly, Owens & Hartmann 1993). Breastfeeding according to need will usually satisfy the quantity criterion (barring biological or behavioural impediments), even in water-sparse environments where mothers are chronically dehydrated (Vitzthum & Aguayo 1998).

Babies fed artificial baby milk may receive sufficient quantity in wealthy families (indeed, they may be overfed). In impoverished families, however, the costs involved in artificial feeding may mean it is not given in sufficient quantity or concentration.

Safety

To be adequate in human rights terms, food must be safe. Every baby's food must be uncontaminated, meaning 'free from adverse substances' (CESCR 1999: para. 8).

Artificial baby milks may be contaminated in several ways. Most powdered artificial baby milks consist predominantly of dried cows' milk. Many countries, such as Australia, have regulations to ensure that milk products are free from hormone and antibiotic residues, but studies have suggested that milk-based powdered formula from other countries may be contaminated (see for example Mishra, Johnson and Vankar 2002). Artificial baby milks based instead on soy beans could contain levels of phyto-oestrogens that can disrupt a baby's natural hormones, with particular dangers to the reproductive system. The risks associated with genetically modified soy (or any other crop used in artificial baby milks) apply no less to soy-based formula (Linnecar 1997: 477).

Of major concern is contamination of artificial baby milks with heavy metals or toxic chemicals, as seen in an outbreak of melamine poisonings in China (Thomas 2006, WHO 2008). Artificial baby milks can be contaminated with harmful bacteria (24% of samples in one study by Oonaka et al 2010). Further, pathogens may be introduced to powdered artificial baby milks via water used either in reconstitution or in washing feeding implements. Ingesting artificial baby milks or other substitutes may also alter the environment of the intestine and facilitate infections (Gribble 2007), leading to concerns about safety.

Breastmilk, too, may be contaminated if the mother ingests toxins, either voluntarily or involuntarily. For this and other reasons, pollution of air, soil and water are human rights issues (eg *Convention on the Rights of the Child* (CRC) 1989: Art. 24(2)(c)), as is chemical-intensive agriculture; and governments have a responsibility towards the health of mothers who may be substance-addicted, and their babies.

In terms of contaminants in breastmilk, there is a small risk — in Australia, less than 1% — of an HIV-positive breastfeeding mother transmitting the infection to her child through breastmilk (WHO 2010). The risks associated with artificial baby milks may equal or exceed the risk of HIV transmission, depending on the circumstances (Latham 1999). Exclusive breastfeeding appears to lessen the risk of HIV transmission, compared with mixed feeding. The 'gut mucosal injury and disruption of immune barriers' (Sachs et al 2000) caused by artificial feeding increases the risk of transmission of the virus into the bloodstream. Thus, even for HIV-positive mothers, breastfeeding as recommended may be in 'the best interests of the child' (CRC 1989: Art. 3).

Accessibility

Whatever a baby is fed must be physically and economically accessible to the child and their family. This aspect of the right to breastmilk has implications in the workplace: babies have a right of access to their mother and/or her breastmilk if she re-enters paid employment. Greiner (2007) argues that a baby's right of access to their mother is best protected by paid maternity leave, a subject discussed further below.

To be adequate, food must also be affordable, which means the cost to the household of feeding a baby should not threaten or compromise other basic needs (CESCR 1999: para. 13). Breastfeeding costs little but artificial baby milks can be expensive and, in impoverished contexts, artificial feeding means less money is available for other essentials. The right to food should not be exercised in a way that interferes with other rights (CESCR 1999: para. 8). All children in the family suffer the consequences of the high cost of artificial feeding (Linnecar 1997).

Acceptability

A baby's food must be acceptable within the child's culture (CESCR 1999: para. 8). All cultures have traditions that support breastfeeding, but most cultures are now influenced by marketing of artificial baby milks. Given the fluidity of culture, and diversity within cultures, it can be difficult to agree what is or is not culturally acceptable in a given context at a given time.

Sustainability

To fulfil the right to food, infants' food must be sustainable (CESCR 1999: para. 7). Breastmilk is a sustainable, secure food source, for this and future generations (Connolly 2004; Gupta & Rohde 1993). It does not contribute to deforestation, climate change or landfill. Artificial baby milks are unsustainable and therefore inadequate.

THE RIGHT TO HEALTH

The right to breastmilk is also supported by the right to health, which is broader than just nutrition (ICESCR, 1966, Art. 12). Breastmilk and breastfeeding play a part in mother and infant health beyond the baby's dietary requirements.

Breastmilk is a 'live substance, containing immunological and anti-infective properties' (Margulies 1997:420) and is sometimes dubbed a baby's first vaccination. It has other constituents 'not normally considered of dietary importance but of great importance to the health of the infant' (Latham 1997:398).

Mounting medical research demonstrates a large number of immediate and long-term health risks — in addition to the food hygiene risks already mentioned — for babies not breastfed as recommended. These risks are not limited to physical maladies. When we speak of the right to health, it is shorthand for 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (ICESCR 1966: Art. 12(1)). Breastfeeding is 'very important for infant development, including mental development' (Latham 1997:398), mental health (eg Oddy 2006), emotional development and mother-child bonding (NHMRC 1996; Gribble 2006; Strathearn et al 2009).

In the context of the right to health, breastfeeding can be an effective form of contraception (most effective when the child is fed frequently according to need, around the clock). Not only is the Lactational Amenorrhoea Method free and readily available to impoverished women, unopposed by religious or social custom and largely within a woman's control, spacing births with the aid of breastfeeding 'improves the health and wellbeing of all children in the family, and the health of their mother' (Linnecar 1997:475).

The right to health requires, in part, that governments take steps to:

- reduce the rate of infant mortality (CRC 1989: Art. 24(2)a)
- provide for 'the healthy development' of all children (ICESCR 1966: Art. 12(2)a)
- prevent, treat and control disease.

All these obligations may be furthered by promoting and protecting breastfeeding. Even in countries such as Australia, where infant mortality is low, artificially fed infants nonetheless require hospital treatment up to five times more often than those who are fully or partly breastfed' (*Lancet* editorial 1994; National Breastfeeding Working Group 1995; Bachrach, Schwarz & Bachrach 2003; Paricio Talayero et al 2006). From the purely pragmatic perspective of government budgets and public policy, raising breastfeeding rates would produce 'immense savings' in health spending (Smith, Ingham & Dunstone 1998:33).

THE RIGHT TO LIFE

The most basic of all rights is the right to life (ICESCR 1966: Art. 6). The highest international legal authority on this treaty encourages a broad interpretation of this right (Human Rights Committee 1982: para. 1) which, I submit, must include the life-protecting powers of breastmilk as an aspect of the right to life.

UNICEF estimates that 1.5 million babies die each year for want of 6 months' exclusive breastfeeding (O'Brien 2006). Most of those millions of babies are dying in impoverished countries, where 'artificially fed infants are at least 14 times more likely to die from diarrhoea than are breastfed children and four times more likely to die from pneumonia'(*Lancet* editorial 1994).

Closer to home, a concern for many Australian parents is 'cot death' (Sudden Infant Death Syndrome). Compared with a breastfed baby, an artificially fed baby is more likely to die from SIDS (Ford et al 1993; Smith, Ingham & Dunstone 1998:19; McVea, Turner & Peppler 2000), and twice as likely to die from any cause in the first 6 weeks (Thomas 2006).

Wherever you are, if your government has ratified the *International Covenant on Civil and Political Rights* (ICCPR), it must 'take all possible measures to reduce infant mortality' (Human Rights Committee 1982: para. 5). Cutting the global under-five mortality rate by two-thirds is one of the UN Millennium Development Goals, thought to be achievable by 2015 (MacInnis 2007). Jones et al (2003) argue that, of all the interventions that could be implemented to prevent under-five deaths, enabling exclusive and continued breastfeeding would be the most effective.

THE RIGHTS OF THE CHILD

As well as expressing the content of rights belonging to all humanity, international law sets out rights of vulnerable groups such as ethnic minorities, people with disabilities, migrant workers and, for our purposes, women and children. A third area of law I draw upon is labour rights, as they pertain to the right to breastfeed.

In 1989, UN member states adopted the *Convention on the Rights of the Child*, which remains the most widely ratified of all human rights treaties (UN 2010). Article 24 of that Convention addresses children's right to health.

A joint meeting in 1990 of two specialised agencies of the United Nations, the WHO and UNICEF (held at the historic foundling hospital *Ospedale Degli Innocenti* in Florence) made clear their total support for breastfeeding by issuing the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.*[1] The *Innocenti Declaration* emphasises, among other things, the Ten Steps to Successful Breastfeeding (UNICEF 1990) and full implementation of the *International Code of Marketing of Breastmilk Substitutes* and associated World Health Assembly resolutions.

The *Convention on the Rights of the Child* further emphasises the obligation on governments to combat disease and malnutrition

[1] *The Innocenti Declaration is a statement of best practice, rather than a binding legal treaty. It has, since 1991, been the "basis of UNICEF policies and actions in support of infant and young child feeding" (Resolution 1991/22 of the UNICEF Executive Board).*

and reduce infant and child mortality (CRC 1989 Art. 24(2)). It also protects prenatal and postnatal health care for mothers and makes particular mention of breastfeeding education. Governments must take 'appropriate measures':

> *…to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of … the advantages of breastfeeding…(CRC 1989: Art. 24(2)e)*

Breastfeeding education is an important component of the right to breastmilk, which brings us to the rights of women.

THE HUMAN RIGHTS OF WOMEN

Women have a right to full and accurate information on which to base decisions affecting their health and their children's health. Many would not be aware that not breastfeeding after birth increases their risk of:

- excessive postpartum bleeding (Marchant et al 2006)
- anaemia (WHO 2001)
- heart attack (Stuebe et al 2006)
- breast, cervical, ovarian and endometrial cancer (eg Boyd Eaton et al 1994; Smith, Ingham and Dunstone 1998:21)
- obesity (Rooney & Schauberger 2002; Kac et al 2004)
- osteoporosis (Cummings et al 1985)
- rheumatoid arthritis (Karlson et al 2004)
- stress and anxiety (Mezzacappa & Katkin 2002)
- diabetes (Metzger et al 2007).

The right of parents to be informed of the risks of artificial feeding is enshrined in the *Convention on the Rights of the Child*, as we have seen, building on the WHO's earlier, non-binding *International Code of Marketing of Breastmilk Substitutes*, and prior to that, two other major, binding treaties: the *International Covenant on Economic, Social and Cultural Rights* and the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW). Governments are obliged by law to disseminate 'knowledge of the principles of nutrition' (ICESCR 1966: Art. 11(2)a), recognising women's right to 'specific educational information to help to ensure the health and wellbeing of families' (CEDAW 1979: Art. 10(h)).

This urgent, life-saving right to information is poorly implemented, 'even' in rich countries. In the UK, a survey by the Department of Health found that:

> *…a fifth of women under 24 thought that breastfeeding would ruin their bodies. Women greatly overestimated the difficulties of producing milk. But perhaps most significantly, 34% believe that infant formula milks are 'very similar' or 'the same' as breastmilk (Monbiot 2007; also UK Department of Health 2004).*

Another recent British poll found almost one-third of women believed infant formula was 'as good as' breastmilk, and 6% thought it was better (Faircloth 2006). It is not just that the public health messages are not getting through, women are being actively deceived by corporate interests. As the Australian Panel on Marketing of Artificial Infant Formulas (APMAIF) concedes: 'Industry promotion has contributed to the belief held by many *health professionals* that infant formula resembles breastmilk so closely that it does not really matter which is used' (APMAIF 1994, emphasis added).

Clearly, a baby's right to breastmilk is intimately linked with women's rights. In part, this is because babies are unable to assert their own rights. (They are distinct, however, in that a baby can be fed breastmilk in the absence of his or her mother.) The right to breastmilk extends into the workplace, and thus I turn to labour rights.

THE RIGHTS OF WORKERS

Women have a right to paid maternity leave and babies have a right to breastmilk. Given the first supports fulfilment of the latter, mandating paid leave is a tangible way governments can support women to breastfeed.

Human rights scarcely rate a mention in the decades-old debate about paid maternity leave in Australia. The right of working women to maternity leave and the right to continue breastfeeding after returning to (paid) work exist in a number of UN treaties including the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW 1979) and the *Maternity Protection Convention* (ILO 2000a). Women have a right to a minimum of 14 weeks' paid maternity leave (paid by the government or their employer) and should not lose their job, their seniority at work or any other benefits they have accrued (ILO 2000a, Art. 4). Governments must promote the establishment of child-care facilities and 'impose sanctions' on employers that sack women who are pregnant or on maternity leave (CEDAW, Art. 11(2)).

The *Maternity Protection Convention 2000* — which Australia has not yet signed — enshrines women's right to paid lactation breaks during the working day (ILO 2000a: Art. 10). The ILO (International Labour Organization) further recommends that employers provide suitable facilities for women to breastfeed or express breastmilk (ILO 2000b: Art. 9).

International labour law provides a compulsory minimum standard that in some societies can, and should, be surpassed in order to fulfil human rights. In Norway, for instance, all women are entitled by law to a year's maternity leave on 80% pay (or 10 months at 100%). And look at the results: 80% of Norwegian babies are still breastfed at 6 months of age (Monbiot 2007), compared with 49% of Australian babies at the same age.[2]

Australian women are presently entitled to 52 weeks' unpaid maternity leave; the average leave taken is only 34 weeks (Egan & Gough 2008). The one in every three working women with access to paid leave typically get no more than 6 weeks (Dubecki 2008;

[2] *The National Health and Medical Research Council (2003) contends Australia should aim to attain the same rates as Norway. This 2001 figure (49%) includes both partially and exclusively breastfed babies. It is recommended that a breastfed child is not given solids or other fluids until after the age of 6 months. Only 18.4% of Australian babies fit this narrower criterion (Australian Breastfeeding Association 2008).*

Egan & Gough 2008). Least likely to have paid maternity leave are women on lower incomes (Millar 2008), and these women are also significantly more likely to wean prematurely (Donath & Amir 2000).

In 2008, the Rudd Government ratified the Optional Protocol to CEDAW (OP-CEDAW 1999), but did not withdraw the Hawke Government's reservation to CEDAW exempting Australia from the Covenant's provision guaranteeing paid maternity leave (Broderick 2008). In 2010, however, the Parliament passed legislation creating Australia's first national paid parental leave scheme, covering all working parents, including casual and contract staff and the self-employed. Effective from 1 January 2011, a new parent can take 18 weeks' leave paid at the federal minimum wage of around $544 a week (FaHCSIA 2010) — a human rights win for Australian parents.

WHAT ABOUT WOMEN WHO CHOOSE NOT TO BREASTFEED?

Every human right has corresponding duties and duty-bearers. Given that babies have a right to breastmilk, who bears the duty to fulfil that right? A contentious but obvious question arises: do mothers have an obligation to breastfeed?

Vitzthum and Aguayo (1998) recognise that women have 'multiple roles and obligations, including a responsibility for their own wellbeing as well as that of their children'. The 1995 Beijing World Conference on Women asserted women's right to 'determine the course of their reproductive lives and health' (cited in Latham 1997:404) — a right to choose, if you will. We all have a right to control our own body (CESCR 2000, para. 8).

It must be acknowledged that a small minority of women are incapable of breastfeeding (this discussion does not pertain to such women, who will be discussed in the next section). Many more lack the information or support necessary to overcome difficulties breastfeeding — they are deprived of choice in the matter. Conversely, only a minority of privileged women may decline to breastfeed and have their baby survive (Morrison 2008), so the idea of choice for most women is illusory.

If breastfeeding is constructed as a choice — part of a woman's right to choose — a conflict with a baby's right to breastmilk emerges. To give an example of how this conflict could play out, Papua New Guinea has a law prohibiting the purchase of baby bottles except by a doctor's prescription (Latham 1997). Such resolute action in defence of breastfeeding could be seen as a violation of a woman's right to choose.[3]

This sort of conundrum — baby's rights versus mother's rights — is not in itself unusual. Most human rights are not absolute[4] and may conflict with one another. My right to freedom of expression, for instance, is limited by your right not to be sexually harassed or racially vilified.

How is this particular tension to be resolved? The World Alliance for Breastfeeding Action has opted to argue that a baby's right to breastmilk 'shall in no way be understood or perceived as the mother having a duty to breastfeed' (cited in Latham 1997). Kent (2001, 2006) prefers to think of babies as having a right to breastmilk 'in the sense that no-one may interfere with their mother's right to breastfeed them'.

Perhaps, in addition to a shared right, there is a shared duty. It is not unfamiliar to think of parents as having moral obligations to their children. So, too, they have legal duties corresponding to their children's rights. As expressed in the *Convention on the Rights of the Child*:

> *States Parties[5] undertake to ensure the child such protection and care as is necessary for his or her wellbeing, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her . . . (Art. 3(2)).*
>
> *[P]arent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development (Art. 27(2)).*

Parents have an obligation to do what they can to fulfil their children's right to education, for example, a duty which is shared with the state and other non-state parties. Logic seems to dictate that parents have a shared duty to do what they can to breastfeed: a duty shared with family, health workers, public and private hospitals, employers, government, business and so on.

Just as different rights need to be balanced (baby's right to breastmilk with a woman's right to choose), so duties may compete with rights (parents' duties to their children may constrain their freedom of choice). Moreover, violations of rights can lead to failures of duties. Many factors that bear on a woman's decision not to breastfeed (such as inadequate paid maternity leave, 'baby-unfriendly' hospitals and workplaces, inadequate breastfeeding education or failure to suppress misinformation) are violations of the rights of mother and baby. The 'circumstances which lead to the choice not to breastfeed', argues Latham (1997:416), 'must be altered'.

The framing of a duty may, in fact, be an asset to mothers. Some women may feel more comfortable asserting their duty to breastfeed (in public, at work, etc.) rather than their right to breastfeed; third parties may be more receptive to the notion of breastfeeding mothers fulfilling their duty.

Oftentimes, rights-based approaches focus on building the capacity of duty-bearers to fulfil their obligations. If breastfeeding is framed as a mother's duty — a duty shared with communities, organisations and governments obliged to support them — the strategic question is how can women be educated, supported

[3] A similar proposal for Australia (limiting the supply of artificial baby milk, rather than bottles) recently met with a cacophony of protest, from hundreds of online readers of the Herald Sun, and the Australian Medical Association and others (Butler 2010).

[4] Excluding three rights which apply in all circumstances without exception, namely: freedom from slavery, torture and capital punishment. All other human rights are deemed relative.

[5] States are 'party to' a treaty – and legally bound to implement it – once they have ratified it and the treaty has 'entered into force' on an agreed date marking the simultaneous commencement of the obligation on all parties.

and enabled to breastfeed, and protected from obstacles to breastfeeding, in order to fulfil their duty?

WHAT ABOUT WOMEN WHO CAN'T BREASTFEED?

A minority of women cannot breastfeed, for reasons physical, psychological and practical. It is for this reason we might conceive of babies having a right to breast*milk* rather than to breastfeed. Suckling at their mother's breast is ideal, but not always possible. Given the risks associated with artificial feeding, it would seem that babies have a right to breastmilk, however they might come by it. Where it cannot be directly from their mother's breast, alternatives such as expressed breastmilk, wet-nursing and milk banking are still preferable to artificial baby milk.[6]

IS THE RIGHT TO BREASTMILK PROTECTED IN AUSTRALIA?

As mentioned at the outset, international human rights treaties impose clear obligations on participating governments, but governments only implement those commitments if there is political or other advantage in doing so. That means we have to know our rights and hold our governments to account.

Human rights protection in Australian law is poor. Even though our governments are obliged, by ratifying these international treaties, to enact them in domestic law, most often they have not. Australia is alone among all comparable democracies worldwide in not having a constitutional or legislative bill of rights.

Only recently have the ACT and Victoria introduced statutory bills of human rights (the *Human Rights Act 2004* and the *Charter of Human Rights and Responsibilities Act 2006*, respectively). Neither of these protects economic rights such as food and health.

All Australian jurisdictions, however, have laws against discrimination. In Victoria, for instance, it is unlawful to discriminate on the basis of breastfeeding (*Equal Opportunity (Breastfeeding) Act 2000*), whether it be in employment, education, the provision of services or participation in sport, etc. This is not the same, however, as mandating lactation breaks in the workplace, for instance, as provided for in international law (and discussed above).

Importantly, the *International Code of Marketing of Breastmilk Substitutes* is poorly protected in Australian law.

The International Code of Marketing of Breastmilk Substitutes

The UN CESCR has stated that:

> *Violations of the right to food [and health and life] can occur through the direct action of States or other entities insufficiently regulated by States...*
>
> *While only States are parties to [international human rights treaties] and are thus ultimately accountable for compliance with [them], all members of society – individuals, families, local communities, non-governmental organizations, civil society organizations, as well as the private business sector – have responsibilities in the realization of [the rights to food, life and health]. The State should provide an environment that facilitates implementation of these responsibilities. The private business sector – national and transnational – should pursue its activities within the framework of a code of conduct conducive to respect of the right to adequate food, agreed upon jointly with the Government and civil society (CESCR 1999: paras 19 & 20; see also CESCR 2000: paras 42 & 48).*

Happily, we have such an agreement regulating the business sector: the *International Code of Marketing of Breastmilk Substitutes* (often called 'the WHO Code' and referred to here as the Code).

The Code is a world standard prohibiting, among other things, advertising of any 'breastmilk substitute' plus bottles and teats. Since its adoption in 1981, it has been supplemented and clarified by a number of resolutions of equal standing to the original Code.[7]

The Code is not a treaty, and thus has no signatories and is not legally binding. It is a form of 'soft law'. That is, the Code represents highly authoritative guidelines that we can all draw upon to call governments and industry to account.

A leading children's rights non-government organisation, Save the Children, argues that compliance with the Code should be a measure of countries' progress in implementing the *Convention on the Rights of the Child* (Moorhead 2007). At present, Australia falls short of the WHO requirement that all countries implement the Code and related World Health Assembly resolutions in national legislation. That is, advertising of breastmilk substitutes and baby bottles should be prohibited by Australian law, but it is not. Instead of binding domestic law, we have a watered-down 'Agreement' in Australia and a toothless 'Advisory Panel'. The Code itself is 'a compromise agreement . . . the very minimum needed to address a small part of a large problem' (Latham 1997: 410). Australia is failing to meet that bare minimum.

An independent study of Code compliance conducted in 1997 found that manufacturers of artificial baby milk were violating the Code 'in a systematic rather than one-off manner':

> *[C]ompany information not in compliance with the Code was given to mothers and health facilities; mothers and health workers received free samples; company personnel visited health facilities in ways that contravened Code restrictions; and, posters and products were improperly displayed (Interagency Group on Breastfeeding Monitoring 1997[8]).*

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[6] Greiner (2007) promotes 'breastfeeding as breastfeeding, not as the provision of breastmilk'. While 'pumping is for many the best solution, it should be seen as a short-term approach to cope with a situation where mothers' and infants' rights are not being respected'. He argues that 'babies have not only a need but a right to be with their mothers during [at least] the first [six] months of life', and makes a strong case for universal, government-mandated, paid maternity leave (a position I endorse, as discussed above). He warns: 'If all you want is the biochemical benefits of breastmilk', infant formula companies are already attempting to modify mice genetically to produce human milk.

[7] "The International Code and subsequent relevant resolutions," as they are known collectively (e.g., World Health Assembly Resolutions 34.22, 39.28, 47.5 and 49.15), have the same legal status under Article 23 of the WHO Constitution and must be read in conjunction

Improperly displayed posters may at first glance seem a minor infraction, but one-and-a-half million avoidable infant deaths every year is as grave a human rights issue as any other, and poorly regulated, unethical advertising is how it happens, at least in part. To quote Stephen Lewis, former Deputy Executive Director of UNICEF:

> *Those who make claims about infant formula that intentionally undermine women's confidence in breastfeeding, are not to be regarded as clever entrepreneurs just doing their job, but as human rights violators of the worst kind (UNICEF 1999).*

'Only through joint and sustained efforts' by non-government organisations such as the Australian Breastfeeding Association, working with governments 'can transnational companies be restrained' (Margulies 1997:437).

WHAT DOES ALL THIS MEAN IN PRACTICE?

Rights such as food and health have minimum core content — aspects that must be realised immediately by governments bound by the relevant treaties — and additional aspects, no less important, which cannot be achieved instantly but must be realised progressively. Governments must 'move as expeditiously as possible' towards full enjoyment of these rights by everyone (CESCR 1999: para. 14). The minimum core content of the right to food, for instance, in broad terms, means ensuring no-one is chronically hungry, while the full extent of the right means everyone has secure access to 'adequate food' which, as we have seen, points unambiguously to breastmilk.

Further, all human rights impose a three-fold obligation on governments. They must:

Respect

Refrain from violating the right to breastmilk by any legislation, policy or practice of government; such things form part of the 'minimum core obligations' which can be implemented straight away.

Protect

Governments must prevent any third party from violating the right to breastmilk; for example, by regulating the private sector to ensure rights compliance by non-state actors (such as manufacturers of artificial baby milk). The Code is designed to protect breastfeeding in this way.

Promote

Take positive action to achieve universal breastfeeding (or else access to breastmilk) as rapidly as possible, by appropriate legislative, administrative, budgetary and other positive means.

We could conclude that any avoidable obstacle to breastfeeding — its initiation, exclusivity (in the first 6 months) and duration — is a violation of the right to breastmilk. Moreover, failure to take positive action to achieve progressively near-universal breastfeeding (an act of omission) is also a rights violation.

IS AUSTRALIA OBLIGED TO SUPPORT BREASTFEEDING IN POORER COUNTRIES?

Universal human rights and corresponding obligations do not stop at national borders. The right to breastmilk is 'inseparable from social justice, requiring the adoption of appropriate economic, environmental and social policies, at both the national and international levels, oriented to the eradication of poverty and the fulfilment of all human rights for all' (CESCR 1999: para. 4; see also CESCR 2000: para. 38).

International co-operation is essential to protect the right to breastmilk in all countries. This may mean development aid from rich countries to poor countries, but can mean much more. For example, the ACT/Southern NSW branch of the Australian Breastfeeding Association raised funds to send dolls to Timor-Leste for use in breastfeeding education. Further, individuals and organisations must monitor and pressure formula companies operating in poor countries to respect human rights, wherever they operate:

> *States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means (CESCR 2000: para. 39).*

WHAT CAN A RIGHTS-BASED APPROACH CONTRIBUTE TO THE WORK OF BREASTFEEDING SUPPORT ORGANISATIONS SUCH AS THE AUSTRALIAN BREASTFEEDING ASSOCIATION?

At its heart, a rights-based approach re-frames policy debates from perceived need, private charity or governmental largesse, to one of entitlement. A needs-based approach alleviates symptoms; a rights-based approach addresses causes, operationalises solutions, apportions responsibility and monitors outcomes.

Under the Code, individuals and non-government organisations such as the Australian Breastfeeding Association and its members have the responsibility 'of drawing the attention of manufacturers or distributors to activities incompatible with the principles and aim of [the] Code so that appropriate action can be taken. The appropriate governmental authority should also be informed' (Art. 11.4). Such organisations must also advocate strongly for full implementation of the Code in Australian law and elsewhere.

According to the UN CESCR, governments that have ratified the *International Covenant on Economic, Social and Cultural Rights* must:

[8] *The Interagency Group on Breastfeeding Monitoring (IGBM) was a UK body created 'specifically to conduct monitoring independently of Baby Milk Action and International Baby Food Action Network (IBFAN) to verify whether IBFAN's monitoring could be trusted.' Its report, Cracking the Code, found 'systematic' breaches of the Code by Nestlé and others, leading UNICEF to declare IBFAN's monitoring 'vindicated'. See IBFAN (2007) for more recent documentation of unethical marketing of infant formula, broken down by brand and manufacturer. A new edition of* Breaking the Rules: Stretching the Rules *by IBFAN is due at the end of 2010.*

...secure a representative process towards the formulation of a strategy [to realise the right to food], drawing on all available domestic expertise relevant to food and nutrition (CESCR 1999: para. 24).

Assuming that in the Australian context the Australian Breastfeeding Association is a leading expert on breastfeeding, the government is encouraged by the UN Committee to seek Australian Breastfeeding Association input into all aspects of health and social policy relevant to breastfeeding.

The UN Committee makes it clear that the government should have a strategy that addresses the marketing of breastmilk substitutes, as well as strategies for education, employment and social security (CESCR 1999: paras. 25 & 30) as they relate to breastfeeding. These government strategies must say who is responsible for what, and set a specific time-frame for implementation of policy goals so that rights obligations may be progressively and fully realised as expeditiously as possible (CESCR 1999: para. 24). Further, governments must establish 'verifiable benchmarks' to facilitate 'national and international monitoring'. Again, governments 'should actively involve civil society organizations' in setting these time-frames, targets and benchmarks (CESCR 1999: para. 29).

Beyond working with their own government, breastfeeding support organisations can contribute at the international level by ensuring violations of the right to breastmilk are documented in alternative or 'shadow' reports on their country's human rights performance which is regularly reviewed by the UN treaty committees. For instance, the Australian Government reports to the UN Committee on the Rights of the Child and the CESCR every five years. Non-government organisations often work together to compile a shadow report to give an alternate view of the situation on the ground. The experts at the UN welcome independent and authoritative assessments from civil society.[9]

And of course, in its core community work, in myriad practical ways throughout the country, the Australian Breastfeeding Association is working every day to realise the right to breastmilk.

IN CONCLUSION

There is ample support in international human rights law for the existence of a universal human right to breastmilk. It is based on every baby's right to life, to adequate nutrition and to the highest attainable standard of health, as well as provisions protecting women's, children's and workers' rights. Where breastfeeding is not possible, the right to breastmilk entitles babies to expressed breastmilk and donated milk before resorting to artificial alternatives.

As well as promoting and supporting breastfeeding, governments, employers, NGOs, the health sector and the business sector must endeavour to protect this right by minimising obstacles to breastfeeding, whether they be in the hospital, workplace, supermarket or elsewhere. The right to breastmilk should be given legal protection in Australian law and practice, reflecting our existing international obligations. We all have a role to play in realising the right to breastmilk, both in Australia and overseas. The role of organisations such as Australian Breastfeeding Association in this endeavour cannot be overstated.

[9] For example, the Committee on the Elimination of Discrimination Against Women (CERD) reviews States Parties' assessment of their own performance every four years and it 'welcomes country-specific information from non-governmental organizations, in the form of alternative or shadow reports' (UN Division for the Advancement of Women, p1). For details, see www.un.org/womenwatch/daw/cedaw/NGO_Information_note_CEDAW.pdf Accessed: 13/10/10.

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Statement of Mutual Support from the Australian Breastfeeding Association for the International Board of Lactation Consultant Examiners

The Australian Breastfeeding Association (ABA) (formerly the Nursing Mothers' Association of Australia) has been involved from the inception of the International Board of Lactation Consultant Examiners (IBLCE) because it recognised that some of the problems mothers experienced were beyond the scope of practice of the ABA counsellor. This credential was seen as providing a career option and professional recognition for those ABA counsellors who wanted to specialise in clinical lactation, ensuring their ongoing education as they built evidence-based practice.

Similarly, the IBLCE recognises the value of the ABA counsellors in providing the mother-to-mother support essential to widespread breastfeeding success in a contemporary setting. The IBLCE recognises that mother-to-mother support is the foundation on which rests the community-based public health programs in educating the public about the value of breastfeeding, advocating for breastfeeding babies, helping mothers and their families understand the normal course of breastfeeding and thereby empowering women to breastfeed.

The IBLCE recognises that the role of ABA counsellors is different from that of the IBCLC. The ABA counsellor provides ongoing support and information that is necessary to improve lactation outcomes. IBLCEs provide another layer of support and information, working cooperatively as members of the health care team by offering skilled crisis intervention and non-medical problem solving which the ABA counsellor may not wish to provide. The roles of the two designations are not duplicative but rather integrative and complementary, and mutual referrals provide optimum benefit to the mother-baby dyad.