Australian Breastfeeding Association

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Select Committee on reproductive, maternal and paediatric health services in Tasmania
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Hobart TASMANIA 7000
By email: rmphs@parliament.tas.gov.au

Re: Submission to the Select Committee on reproductive, maternal and paediatric health services in Tasmania

The Australian Breastfeeding Association (ABA) Tasmania Branch welcomes the invitation to provide information for the Select Committee on reproductive, maternal and paediatric health services in Tasmania.

ABA is Australia's peak body for breastfeeding support, information, education and advocacy. It is ABA's vision that breastfeeding is recognised as important by all Australians and is culturally normal. ABA supports, educates and advocates for a breastfeeding inclusive society. The National Breastfeeding Helpline and web-based LiveChat service, staffed by ABA's Certificate IV-qualified volunteer breastfeeding counsellors and educators, support more than 70,000 mums, parents and families each year with 24/7 support and evidence-based information. ABA provides all its services free of commercial and political influence.

Through the collective experience and expertise of ABA's breastfeeding counsellors and educators, ABA Tasmania Branch is uniquely placed to identify problems and suggest solutions to improve reproductive, maternal and paediatric health services in Tasmania. We know that supporting Tasmanian women to breastfeed their babies will have immediate, short-term benefits: reducing the risk of respiratory, gastrointestinal and ear infections in babies and children, meaning fewer doctor's appointments and hospital admissions, improving their health and putting less pressure on the health care system.

Improvements can be made to breastfeeding support in the Tasmanian health system in the following areas:

1) Health professional education and continuing professional development.
2) Delivery of antenatal breastfeeding education to families.
3) Provision of adequate and effective postnatal breastfeeding support services.
4) More effective recognition of, support for, and referral to peer-support services.
5) Creation of breastfeeding-friendly environments across Tasmania.

The Tasmanian Government has an obligation to act on the recommendations of this review, and those previously identified in *The Australian National Breastfeeding Strategy: 2019 and beyond*, to ensure breastfeeding education and support are embedded at all levels of Tasmania's reproductive, maternal and paediatric health services.

Kind Regards,

Ms Charlotte Fielding
Assistant Branch President
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Australian Breastfeeding Association

Breastfeeding in Tasmania

ABA's Code of Ethics: To adhere to ABA's Code of Ethics (breastfeeding.asn.au/code-ethics), the following submission will focus on general concerns and deficiencies in the Tasmanian health system regarding breastfeeding, and not individual health facilities or practitioners.

Case history: A recent case history from a Tasmanian mother is included as an appendix to this submission. This is just one mother's story, told in her own words, but similar experiences have been reported to our volunteers by many others over the years. Identifying information has been removed to protect her privacy and to meet the requirements of the ABA Code of Ethics, but her story is otherwise unaltered. Her experiences are sadly not unusual in all regions of the state.

The importance of breastfeeding

The Australian Government's National Health and Medical Research Council and the World Health Organization (WHO) both recommend exclusive breastfeeding (i.e. no other food or drinks) for the first six months of life and continued breastfeeding for at least the first year of life, and longer if desired.[1,2] *The Australian National Breastfeeding Strategy: 2019 and Beyond*[3] (ANBS) was released in 2019 and endorsed by all Australian Health Ministers: Federal, state and territory. The Strategy was developed by the Federal Department of Health after many years of consultation, including with ABA. It sets out what is required to enable Australian mothers to breastfeed and to see the benefits of breastfeeding at both the individual and the population level.

Australian mothers want to breastfeed their babies. On average across the nation, 96% start to breastfeed. However, most mothers need to be supported to breastfeed; they cannot do it alone. The fact that Australia has such low ongoing breastfeeding rates shows mothers aren't being adequately supported.

Breastfeeding is a preventative health measure: improving health and reducing health care costs

- Breastfeeding reduces the risk of infections[4-6] and SIDS[7] in babies, and the incidence of overweight and obesity (even in young children aged 1 to 9 years).[8]
- Breastfeeding reduces the costs of hospitalisation related to gastrointestinal and respiratory illness, ear infections (which can lead to hearing loss), eczema, and necrotising enterocolitis in babies.[9-11]
- Breastfeeding reduces the risk of breast cancer,[12,13] ovarian cancer,[12,14,15] cardiovascular disease[16] and diabetes[17,] in women.
- Breastfeeding improves the mental health of children and adolescents and the mental health of mothers including reducing post-partum depression.[18,19]

Breastfeeding is a human right

- Babies and children have the right to the highest attainable standard of health through optimal nutrition, including breastfeeding.[20,21]
- Women have the right to access health services for optimal care in pregnancy and postnatal care, including information and support for breastfeeding, maternity protection and adequate public spaces for breastfeeding.[22,23]

The problem in Tasmania

Most mothers of babies born in Tasmania initiate breastfeeding, but many stop earlier than planned.[24] Around 85% of Tasmanian mothers leave hospital intending to breastfeed, but in the following weeks and months there is a substantial decline, and low exclusive breastfeeding rates are seen. The best data we have, from 2010, revealed that only 15 per cent of Australian babies were being exclusively breastfed at about 6 months.[25] There is no current breastfeeding data publicly available in Tasmania.

The reasons that mothers do not continue breastfeeding are highly complex, with a number of societal and cultural barriers known to contribute. However, the most common reasons given by Australian mothers for not continuing breastfeeding, as described in the ANBS,[3] relate to challenges that can typically be overcome with accurate information and skilled support: 1) perceived low breastmilk supply; 2) child not attaching properly; 3) unsettled baby; and 4) pain during breastfeeding.

The ANBS also identifies enablers of breastfeeding that need to be in place to support mothers to breastfeed:

Individual enablers

- Universal breastfeeding education, support and information services
- Breastfeeding support for priority groups

Settings that enable breastfeeding

- Baby Friendly Health Initiative
- Health professional education and training
- Breastfeeding-friendly environments

The free ABA-staffed National Breastfeeding Helpline sees the consequences of mothers not being supported to breastfeed. They call the Helpline in large numbers, tens of thousands every year, looking for basic information and support that should have been available from the health professionals working with them.

Data from the Helpline evaluation shows that mothers are calling for the same reasons, repeatedly, year in and year out. They need reassurance and help with breastfeeding basics: sore breasts or nipples, positioning and attachment, concerns with low milk supply, and information on breastfeeding patterns.

ABA volunteers on the Helpline were able to help them. After calling the Helpline, most callers felt: reassured, less stressed and less worried, more confident and knowledgeable about breastfeeding and more determined to continue breastfeeding. They also agreed that the support they received helped them to resolve their issues and encouraged them to continue breastfeeding.[26]

But the reality is, these mothers should never have had to call the Helpline – they should have had access to timely, local support from a trusted health professional. The Helpline receives approximately 800 calls a year from Tasmania. This is evidence that parents in Tasmania are unable to get the support they need locally.

A study designed to explore and understand the experiences of women who receive antenatal, birthing, and postnatal care from an integrated maternity services model in a regional area in Tasmania found women cited mostly negative experiences from a poorly implemented and fragmented service.[27] These experiences included feelings of isolation, frustration over receiving conflicting advice, feeling ignored, and minimal to no continuity of care.

Many women in the study reflected on how they felt anxious about feeding, describing how they wanted reassurance relating to breastfeeding. While on the ward, women discussed their requests for help and the desire to have reassurance with breastfeeding. All women discussed breastfeeding in their experiences relating to their maternity care. Women felt their requests for help with breastfeeding were not met. Breastfeeding advice was inconsistent and confusing depending on who provided care. This inconsistency was most prominent in regard to breastfeeding experiences on the hospital ward, suggesting that women struggled to comprehend the advice provided to them.

Women in this study all received extended care midwifery (ECM) once discharged from the maternity hospital. Women spoke highly of this service as it offered breastfeeding support and postnatal care to women and their babies in their homes. All women described how caring and knowledgeable the ECM midwives were.

This study reflects the experiences shared in confidence with ABA breastfeeding counsellors by many mothers in Tasmania. They describe difficulties accessing the accurate information and support they seek to breastfeed exclusively for the first six months, or to continue breastfeeding for as long as they desire. Many report that they stopped breastfeeding earlier than they wanted to, due to lack of support. The information they report having received from health professionals is often not aligned with current research and national health policies.

The impact

- As stated in the ANBS, nutrition in the first 1000 days is one of the most significant influences on child health and development. For the child not being breastfed, or being breastfed for shorter lengths of time, the risk of SIDS, gastrointestinal infections, respiratory infections, ear infections, necrotising enterocolitis (NEC) in premature babies, sepsis in premature babies, dental malocclusions, overweight and obesity, lower IQ and leukemia is increased.[4-11]
- For the mother, not breastfeeding increases the risk of breast cancer,[12,13] ovarian cancer,[12,14,15] cardiovascular disease[16] and diabetes.[17]
- There is a significant financial burden on households who need to purchase expensive infant formula.
- Formula-fed infants are more vulnerable in emergency situations because power outages and water contamination can make safe preparation of infant formula impossible. Formula-feeding families may be unable to reliably purchase infant formula in the event of supply chain disruptions.
- Costs to the community of babies not being exclusively breastfed to six months include the increased need for healthcare for hospitalised/sick babies and young children[9-11] and the cost of workforce absenteeism of parents to care for their sick babies.[28]
- Pregnant women and breastfeeding mothers who have been infected with, or vaccinated against, COVID-19 produce antibodies that are passed onto their babies via the placenta and through their breastmilk.[29] This protection against COVID-19 is vital for all babies and young children, but especially for babies under 6 months who cannot be vaccinated against COVID-19.

The solution

ABA Tasmania Branch makes the following observations in response to the Terms of Reference:

(a) to assess the adequacy, accessibility and safety of the following services for Tasmanian parents and their children in relation to:

(i) reproductive health services:

- Breastfeeding is the last stage of the reproductive cycle and the best possible start for the health of mothers and babies following birth. The hormones involved in breastfeeding help the uterus to expel the placenta and return to its pre-pregnant state, minimising the risk of postpartum haemorrhage.[30] It is therefore important that this information is included in all education for parents and professionals.
- Exclusive breastfeeding suppresses ovulation in a breastfeeding woman and supports appropriate birth spacing. The Lactational Amenorrhea Method (LAM) is listed by the World Health Organization as an accepted and effective temporary method of contraception.[31]
- It is vital that mothers receive timely and accurate advice about medications and contraceptives that are compatible with breastfeeding. Safe medication options are available for the vast majority of common medical conditions, however medicine use is a reason often cited by mothers who cease breastfeeding earlier than intended.

(ii) maternal health services:

- Antenatal and postnatal education and support are critical in assisting mums, parents and families with breastfeeding. Qualitative studies of mothers' values and preferences show they felt that infant feeding was not discussed enough during the antenatal period and that antenatal education about breastfeeding could be improved.[32]
- Evidence indicates that a mix of professional and peer support is more effective in increasing breastfeeding than health professional support alone.[32] The role of peer support needs to be recognised and valued as an important and cost-effective part of the health system.
- Training of health practitioners (e.g. midwives, nurses, pharmacists, dietitians etc.) on the importance of breastfeeding and providing support for mothers who choose to breastfeed is an important evidence-based strategy to improve outcomes for women and children.
- Providing access and support for staff to attend regular professional development on breastfeeding is an important way to ensure safe and adequate services, and to ensure mothers receive information that is accurate and up to date. Mothers often report confidentially to ABA breastfeeding counsellors in Tasmania that they have received out-of-date information.
- Tasmanian families deserve access to the right care at the right place at the right time. Accessible, adequate and safe breastfeeding education and support is crucial during the perinatal period when infants and mothers are particularly vulnerable.
- Breastfeeding takes time to learn. Many mothers report that it takes several weeks before they feel fully confident breastfeeding. Mothers need easy access to skilled support for the full duration of lactation, not just while they are establishing breastfeeding. Mothers also require support prior to introducing solids at six months, in the event of teething, during weaning, when babies are unwell, in relation to contraception, and when returning to work.

(iii) birth trauma:

- A traumatic or premature birth can sometimes make it more difficult to establish breastfeeding and mothers may require additional skilled support. Mothers report to ABA volunteers in Tasmania that they have sometimes been discouraged from trying to establish breastfeeding after a traumatic birth. Reasons given have included that it will add to their stress and potentially to their feelings of disappointment if it does not go well, or that using infant formula will allow others to feed the baby so the mother can rest. These reasons are not evidence based. Research actually shows that, with the right information and support, breastfeeding can be very healing.[33] One mother reported that, after a difficult birth, breastfeeding was the only thing she could 'do right'. She felt empowered through breastfeeding and resolved her feelings of failure regarding the delivery of the baby. However, she still received comments and pressure from professionals to discontinue breastfeeding. These comments were not in line with government recommendations.

(iv) workforce shortages:

- Many mothers (in all areas of Tasmania) report that the midwives in hospital do not have adequate time to spend with them to help them establish breastfeeding. Increasing the number of midwives and International Board Certified Lactation Consultants (IBCLCs) in hospitals would provide more support for mothers in hospital.
- There is often a gap of several days between discharge and the first CHAPS appointment. Establishing breastfeeding takes many weeks, and challenges are very common in the early days. New mothers require information, support and reassurance during this time. If a mother is facing breastfeeding challenges, it can be hard for her to get support in a timely manner.
- In broader terms, creating a supportive culture for women's participation in the workforce may help address healthcare workforce shortages. Women are subject to various forms of discrimination during pregnancy, parental leave, and when returning to work. Providing breastfeeding-friendly workplaces, including the right support for women to continue breastfeeding when they return to work, is fundamental to increasing breastfeeding rates and the duration of breastfeeding in Tasmania.

(v) midwife professional Indemnity Insurance:

- Out of scope

(vi) perinatal mental health services:

- ABA volunteers in Tasmania are mothers themselves who have breastfed their own children and have completed a Certificate IV in Breastfeeding Education. Peer support, such as that offered at ABA local groups, can play an important protective role alongside formal perinatal mental health services. ABA local group activities facilitate connection between local mums and other parents who are qualified breastfeeding counsellors. The role of qualified peer support needs to be recognised and valued as an important part of the health system.[34]

(vii) paediatric services for children aged 0-5 years:

- The knowledge, skills and attitudes towards breastfeeding beyond 12 months vary significantly amongst health professionals.[35] Training of all health practitioners (general practitioners, midwives, nurses, pharmacists, dietitians, dentists, anesthetists etc.) on the importance of breastfeeding for young children and providing support for mothers who choose to breastfeed for longer durations is an important evidence-based strategy to improve outcomes for women and children.
- Access and support for staff to attend regular, ongoing professional development to ensure competency in breastfeeding management is vital for the provision of safe and adequate paediatric services.

(viii) the Child Health and Parenting Service (CHaPS):

- Training of child health nurses on the importance and management of breastfeeding and providing support for mothers who choose to breastfeed is an important evidence-based strategy to improve breastfeeding rates.
- Providing access and support for CHaPS staff to attend regular professional development on breastfeeding is an important way to ensure safe and adequate services.

(b) to examine disparities in the availability of services, staffing and outcomes between:

(i) Tasmania and other Australian states and territories

(ii) Tasmanians living in rural, regional and metropolitan areas

(iii) Tasmanians experiencing socio-economic disadvantage.

- The National Breastfeeding Helpline (funded by the Australian Government since 2008) provides access to qualified breastfeeding counsellors 24 hours a day, 7 days a week. Sixteen trained Tasmanian breastfeeding counsellors contribute to this service, taking calls in their homes. This peer support service needs to be recognised and valued as an important part of the Tasmanian health system, delivering equitable access to adequate and safe breastfeeding education and support.
- In all other states and territories, ABA receives reliable ongoing funding to support the provision of their free services. This is not the case in Tasmania. A small amount of funding was allocated to ABA in Tasmania in the May 2023 budget, but it was not received until 18 December 2023. Increased, guaranteed funding is required if ABA Tasmania Branch is to continue to offer its services free of charge to families.

(c) to make recommendations on actions that can be taken by the State Government to ensure reproductive, maternal and paediatric health and perinatal mental health services meet the needs of Tasmanian parents, families and children:

1) Recognise and value the important contribution that organisations such as the Australian Breastfeeding Association make to the Tasmanian health system. Maintain viability of ABA services in Tasmania by:
    a. supporting breastfeeding counsellors and educators in Tasmania to maintain their knowledge

and skills

b. assisting ABA Tasmania Branch to attract new volunteers to these roles

c. guaranteeing adequate and ongoing funding for ABA Tasmania Branch to deliver services to Tasmania's families.

2) Provide an enabling and empowering environment that protects, promotes, supports and values breastfeeding in Tasmania by implementing actions from the Australian National Breastfeeding Strategy: 2019 and beyond.[3]

3) Provide and facilitate access to education and training in breastfeeding for all health professionals who care for mothers and children, including midwives, child health nurses, paediatricians, speech pathologists, dieticians, dentists etc. Successful breastfeeding requires timely, affordable and accessible support at many levels. ABA provides educational opportunities for all health professionals.

4) Include reasonable paid leave for health professionals to attend regular professional development to ensure they are always up-to-date with the latest research and best practice in breastfeeding management.

5) Ensure all mothers receive antenatal education about the importance of breastfeeding for their babies and themselves, and accurate information about establishing and maintaining breastfeeding. ABA provides accessible online Breastfeeding Preparation Sessions and Newborn Virtual Village, a series of five live educational sessions covering key topics.

6) Provide breastfeeding education for a mother's primary support network, including partners and grandmothers. ABA encourages a mother's support people to access information and support through our comprehensive website and network of local trained volunteers.

7) Strengthen programs that provide mother-to-mother support and peer counselling. ABA delivers the National Breastfeeding Helpline and provides free local face-to-face breastfeeding counselling at local get-togethers. Qualified peer support such as this is widely known to have a positive impact on breastfeeding experiences and outcomes.[36,37]

8) Enhance postnatal breastfeeding support:

   a. increase the frequency of CHaPS visits and ensure that all mothers receive contact from a CHaPS nurse immediately after discharge from hospital

   b. extend the radius from major centres for eligibility for skilled post-natal breastfeeding support at home

   c. extend the timeframe for eligibility for skilled post-natal breastfeeding support at home so that every mother is supported to fully establish breastfeeding, no matter how long that takes.

9) Employ more International Board Certified Lactation Consultants (IBCLCs) in the community so mothers can access specialised breastfeeding support quickly and easily.

10) Increase the number of breastfeeding-friendly settings/environments across Tasmania, including baby-friendly health services, workplaces, early childhood education and care services, and public spaces. ABA delivers Breastfeeding-Friendly Workplace accreditation, Breastfeeding-Friendly Early Childhood Education and Care Recognition, Breastfeeding Welcome Everywhere program and Baby Care Room Recognition.

Australian Breastfeeding Association

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Australian Breastfeeding Association

One Tasmanian mother's story

I delivered both my babies in the public system in NW Tasmania. Both were full term, uncomplicated, unmedicated vaginal births. I am 29 years old, I am married, and I have a tertiary education and a permanent government job. I am Caucasian. Statistically my demographics mean I am most likely to initiate breastfeeding and breastfeed for longer. However, I nearly didn't breastfeed at all.

I prepared to breastfeed my first daughter. I attended antenatal classes provided by the hospital, I attended a breastfeeding education class run by the Australian Breastfeeding Association, I read several books, a heap of online information and I quizzed mothers I knew that had breastfed.

After delivering my daughter, I requested 3 hours of uninterrupted skin to skin time to allow the best chance for the initiation of breastfeeding. However, during the first hour, the midwife wanted to measure and weigh the baby and do their APGAR score. I was told this couldn't be done on my chest. I protested but was told it would only take a few minutes and that they needed to get me over to the ward to free up beds. My daughter had not yet latched and was very sleepy. Her removal from my chest for tests made her very distressed and difficult to calm down. I was trying to get her to self-latch, however the midwife told me she was too sleepy to self-latch and tried to assist in bringing her to my breast. This involved holding her head and jaw and just made her more distressed and frustrated. After about 2hrs she finally latched and had a very long time at the breast - I assumed she was feeding. It was painful and I told the midwife this. They assured me that she had *'the perfect latch'* and my nipples would toughen up in the next few days and it was normal. They told me they worked with an obstetrician years ago who recommended mothers scrub their nipples with dry terry towelling nappy material to tough them. When I unlatched my daughter after about 45minutes my nipple had a white blanched line on it and was misshapen.

We were then taken over to the ward. It was about 8pm. My midwife was called up to emergency to address a staffing shortage. They promised to come back and show me around. They didn't come back.

Another midwife arrived about 9.30 and asked my husband to go home as is policy. They asked me if I'd breastfed yet and I said *'yes, but it was painful'*. They told me someone would be around to help in the night if I needed and to get some rest. I had a set of observations about 10pm, and because my baby was asleep, I soon fell asleep.

I woke up at 6am. No one had woken me in the night; my baby had slept all night. I was immediately worried that she hadn't breastfed for more than 10hrs. I called the nurse. She told me that it was fine, my baby was probably tired and to try and feed again. My baby just wouldn't wake up properly and was falling asleep after a few sucks, even when undressed. When she did suck it was painful and she fussed. I was anxious to be discharged so I didn't have to go another night without my husband.

A young female registrar thought my daughter looked jaundiced, her supervising male senior obstetrician dismissed her concerns and said it was just the lighting. We were discharged and told to see a lactation consultant if I had any other worries. But we decided to stay in the hospital units as where we live, we cannot get home visits from the extended care midwives. The radius is 50km from Burnie and we are 53km away.

That night I woke up every 3 hrs to try and feed my baby. Again, she wouldn't really wake up and kept falling asleep at the breast. My nipples were beginning to be red and chaffed.

The next morning the Extended Care Midwife arrived. She declared that my daughter had lost too much weight and was dehydrated and jaundiced. She commanded me to breastfeed immediately. I couldn't get my daughter to latch and without asking she came over and tried to 'milk' me like a dairy cow to get a let down. It all happened so fast I felt I couldn't ask her to stop. I had engorgement and it was painful. I still

couldn't get my daughter to latch and was at the point of tears. The LC told me that my stress was the reason baby would not latch and I needed to give her to my husband and calm down. She told me I had three hours to express 90ml of colostrum for my baby, or she would bring some formula to rehydrate her. I got given a leaflet on hand expressing. After she left, I realised I had forgotten I had lots of expressed colostrum in the freezer. My husband reminded me. We syringe fed my daughter my antenatally expressed colostrum.

When the LC returned, she checked my daughters bilirubin levels and said we had a day to get them down, or be re-admitted for photo therapy. She told me to triple feed and had brought over a hospital breast pump and told me I had to purchase a flange kit for it. I wasn't shown or told how to use it. Just given an instruction booklet and told to express every three hours.

It took us until day three to get my daughter latched. I sought help from the ABA helpline and also video chatted with my aunt who is a retired midwife and child health nurse. By the end of a one hour video chat with my aunt, my daughter was latching. But it was still painful. My aunt, and the breastfeeding counsellor advised me to get a second opinion on a tongue tie, as two obstetricians and a registrar (is that what you call a resident doctor before they specialise?) had checked her mouth before discharge.

The LC looked in my daughter's mouth on day three and said she didn't have a tongue tie. On day 5 we saw a different LC who also said she didn't have a tongue tie. My daughter still wasn't gaining weight, but wasn't dramatically losing weight either. We decided to take her home.

Breastfeeding was still painful and my nipples would be blanched and a strange shape after every feed. Feeds took up to an hour if I kept my daughter awake. If I didn't undress her and put a wet flannel on her she would fall asleep after only a minute or two of feeding. Feedings were frequent, nearly every 1 to 2 hrs morning and night. My daughter would vomit and spit up very frequently.

At her two week check my daughter had not regained her birth weight. The child health nurse advised I try to feed her more and suggested I may have low supply and to express some milk and cup feed my daughter. The child health nurse was very dismissive of my nipple pain as she said my daughter had the perfect latch. She just advised some other feeding positions which did nothing to help. I also struggled with block breast ducts which constantly needed massaging and pumping to remove. I was expressing and giving my daughter one bottle per day, which she drank quite well. I believe this is what enabled her to gain enough weight to be 'over the line'.

At three months old my supply dropped dramatically over a few weeks and my daughter became very fussy at the breast. She was still not gaining well and was the 5th percentile. I was encouraged to increase feedings again, offer both breasts, before and after a nap, and put her back to the breast if she unlatched. I was asked about my feelings with supplementing formula and I declined. This fussiness only got worse as I tried to increase feedings. It developed into a breastfeeding and oral aversion.

By my daughters 6-month CHaPS check I was a mess. My daughter was waking up to 10 times per night to feed and feeding every 2 hrs during the day. She would not sleep lying down, and I wore her in the baby carrier nearly all day. At night she would sleep no more than 15 minutes in her cot and much of the night was spent trying to get her back in the cot or feeding and changing her. I was surviving on micro sleeps while sitting holding her. And on a few hours each night where my husband would bottle feed her expressed milk while I slept.

I had seen 5 or 6 different GPS, who all dismissed my concerns as 'colic' and told me inaccurate information. They told me my daughter did not require night feeds, to night wean her, to let her cry, that she was manipulating me, and that I was spoiling her.

The child health nurse took a gentler tone, but at this stage was also suggesting 'gentle' sleep training and night weaning. My daughter struggled to gain weight until she was 6 months old. Cutting out night feeds would have halved her milk intake. All the ABA counsellors I spoke to advised against this.

The CHaPS service did not suggest my daughter had any medical problems. They thought it was behavioural. At this time, I requested a referral to a speech pathologist as my daughter was having trouble drinking from a straw and sippy cup and was getting food stuck in her high palate. She was still difficult to breastfeed. She had all the signs of oral aversion. I couldn't feed her in public or even in my lounge room. She would only feed in total dark and quiet when very tired. She would get dehydrated and scream until exhaustion on days where I had to be out of the house all day. Eventually I was able to put blankets over the windows in my car and feed in the back seat. I was beginning to suspect her lip tie was an issue. I still did not think she had a tongue tie as she had been checked multiple times. I was nearly ready to stop breastfeeding, however my daughter was also rejecting bottles.

The CHaPS service was not able to refer me to a speech pathologist at this time. I had to visit several GPs until I finally secured a referral. My daughter was 6.5 months old. The speech pathologist diagnosed her with an oral aversion and a lip and tongue tie. She suspects the aversion was due to the forced bottle and breastfeeding in attempts to improve weight gain. She also said silent acid reflux was a factor. I spent the next 6 months doing desensitisation on advice from the speech pathologist and was able to cure my daughters aversion.

Unfortunately, by the time we were able to see a dentist to get her tongue tie released she was 8.5 months old, and the provider does not operate on babies older than 6 months except in extreme cases.

I persevered with painful breastfeeding, low supply, and recurrent blocked ducts until she was 15 months old, because of the health and emotional benefits for her. She is now 2. She still gags on thin fluids from stress and cups because of her restricted tongue movement. She doesn't like to drink water because of this and is frequently dehydrated and constipated. We have to give her ice chips or homemade icy poles to get enough fluids in. She gets food stuck in her high palate frequently. She has dental crowding and will require extensive dental work later in life. She still doesn't sleep all night and breathes noisily through her mouth. Had we been appropriately referred by the hospital and CHaPS service, she would have had her ties released in the weeks following birth and been relieved of all her issues.

With my second baby, I immediately knew she had oral ties when breastfeeding was painful and causing a blanched ridge on my nipple. I asked for a referral at the hospital. The obstetrician told me *'I know what a tongue tie looks like, she doesn't have one'*. I persisted and said I wasn't leaving without a referral. The hospital LC this time around left me alone, when I explained about my first daughter and showed her my gigantic stash of expressed colostrum. I had to do a little syringe supplementing.

The CHaPS service tried to talk me out of going to the speech path because she *'had the perfect latch'* and looked happy. The same nurse still didn't believe me about the oral ties even though it was my second baby with the issue. There was a 3 month wait for speech path, but I phoned up and explained my situation and was bumped up the list. She was diagnosed by the speech path at 2 weeks old and had her ties revised at 3 weeks. She was like a different baby afterwards. My breastfeeding is pain free and easy. She sleeps all night and rarely cries.

My only hope is that the maternity services and CHaPS stop pushing harmful sleep training advice and outdated breastfeeding information and takes mothers concerns more seriously.