# Submission to the Senate Select Committee on Women's Health

# Breastfeeding is postpartum care: putting mothers' goals and wellbeing at the centre.

The Australian Breastfeeding Association is Australia's peak body for breastfeeding information, education and support. In the last 12 months, ABA volunteers have supported almost 60,000 helpline calls and web-based chats through the National Breastfeeding Helpline and LiveChat services. More than 2.5 million users have accessed ABA's website for breastfeeding and parenting information. ABA's 650-plus volunteer breastfeeding counsellors and educators also run free local peer support groups, Breastfeeding Education Classes and provide breastfeeding support at community events across Australia. We also provide nationally accredited education, bite-sized learning e-modules and membership for health professionals.

## Submission summary

Our submission contends that postpartum care in Australia should focus on support for mothers' transition to motherhood, with breastfeeding supports actively integrated.

We highlight that many mothers do not achieve their breastfeeding goals because of inadequate support, which can negatively affect their wellbeing, confidence and mental health as they embark on their motherhood journey.

ABA recommends a strong commitment to providing antenatal breastfeeding education for all mothers and mothers-to-be and improved postnatal breastfeeding support.

It is crucial that all health professionals have at least basic knowledge about breastfeeding and that professionals who work directly with breastfeeding mothers and babies have access to specialised education and skills competency for their practice context. These professionals must have capacity to integrate

effective management and support of breastfeeding into their broader clinical practice.

Postpartum care in the home and community should be normalised and valued for its capacity to provide humanistic and holistic support for an important life transition. Maternal, family and child health services are integral for ongoing mother and child health, prevention and wellbeing.

ABA also calls for better regulation of formula marketing, sustainable funding for breastfeeding support services, and nationally consistent postpartum care models.

A key theme here is equity: mothers facing complex pregnancies, financial barriers, limited support networks or difficulties accessing appropriate services often have poorer breastfeeding outcomes.

Our submission also demonstrates the need for Australia to invest in reliable national breastfeeding data, including regular national infant feeding surveys and stronger monitoring systems to guide policy and evaluate progress, as recommended in the *Australian National Breastfeeding Strategy: 2019 and beyond* (ANBS).

Overall, we advocate for a coordinated national approach that treats breastfeeding support as a core component of postpartum healthcare and maternal wellbeing.

## A. Best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss

### Key messages

- Postpartum care is poorly defined and has consistently received lower satisfaction levels than other episodes of maternity care in Australia.
- Many women in Australia enter motherhood unprepared, with little practical knowledge of breastfeeding.
- Mothers want reassurance, individualised care, readiness for discharge and links to community support.
- Breastfeeding is closely tied to many women's sense of becoming a mother.
- Many Australian mothers don't reach their own breastfeeding goals due to lack of effective support. Unplanned stopping is linked to grief and loss of maternal identity.
- Breastfeeding problems, as well as cessation, are associated with poorer maternal mood, and risks rise as problems accumulate.
- These risks are modifiable: timely, respectful support that honours women's intentions can protect maternal wellbeing.

### Recommendations

1. **Define and redesign postnatal care around the transition to motherhood.** Postnatal care should be recognised as more than a medical checkpoint, with breastfeeding support built in as a core part of best-practice postpartum care.
2. **Integrate breastfeeding support with physical and mental health care.** Breastfeeding problems should be recognised as a modifiable risk factor for maternal mood, with early identification, treatment and support for breastfeeding difficulties included in postpartum mental health pathways.

3. **Respect women's breastfeeding goals and extend support into the community.** Care approaches should honour each mother's own intentions and connect women with ongoing community-based breastfeeding support, both antenatally and after discharge.

*What is postnatal care?*

Postnatal care is multifactorial but not well defined in high-income countries.

The nature of postnatal care differs from care after a medical procedure or illness but also generally takes place in a medical hospital setting. This shapes the way care is given.

Lived experience research shows us clearly what women value from their postnatal care. A survey of UK mothers (Alderdice et al., 2020) about their postnatal care found that while they valued the checks on health that they and their baby received, they ideally wanted information and reassurance about breastfeeding and care for their baby and that what was happening was normal. Themes included their need for respect, compassion and individualised care at a vulnerable time, the need to feel ready for discharge from hospital and help to find support in the community.

In another study, the timing of discharge for first-time mothers was contrasted with mothers who had other children regarding doubts and anxiety about their confidence with breastfeeding and more general mothering (Lindblad et al., 2022). Both studies highlighted the need for individualised approaches to care.

*Breastfeeding and becoming a mother*

Alternatively, the focus of postpartum care could be on supporting the transition to motherhood, or *matrescence.* This would also position breastfeeding support as critical within this life transition through shaping the early relationship of mother and baby.

Lina Palmér's hermeneutic studies (Palmér et al., 2010, 2012, 2014, 2015) frame breastfeeding as an existential activity for the mother: a critical aspect of becoming a mother. The studies describe how the challenges in the early days and weeks involve breastfeeding moving from a physical activity to 'an embodied relationship with the infant and oneself as a mother'. Breastfeeding is described

as a way for mother and baby to connect with each other and to drive mother's care responses to her baby. The breastfed baby can be seen as an active participant in the relationship and even as guiding their mother.

In a 2012 study Palmér explores the experiences of mothers who have had breastfeeding difficulties. The study demonstrates that mothers with severe breastfeeding difficulties may feel alone and exposed because of their suffering and this can be described as being 'lost in motherhood'. The authors urge midwives and other health professionals to care for breastfeeding mothers by supporting them to gain confidence to trust their own ability to breastfeed their baby. This in turn fosters closeness between mother and baby.

Many Australian mothers do not reach their own breastfeeding goals. Research also indicates that breastfeeding difficulties and unplanned cessation can impact negatively on maternal mental health, including their sense of themself as a mother.

A recent study that has looked at women's experiences of early unplanned cessation of breastfeeding has also shown the existential outcomes from not being able to continue breastfeeding in alignment with planned goals (Mahon et al., 2026). In other words, breastfeeding can be intertwined with the mother's own breastfeeding goals and with their sense of becoming a mother. Palmér's work is also mentioned in this paper with regard to the premise that breastfeeding difficulties can potentially create an existential rupture for the mother who then may ask herself the question: 'Who am I now that I cannot do the thing that makes me a mother?'.

Cooklin et al., (2018) carried out a prospective study of first-time mothers with a focus on the relationship between physical problems from birth and breastfeeding difficulties. They asked whether breastfeeding problems could play a role in increased depressive symptoms.

They then found that a high burden of breastfeeding problems (nipple pain, mastitis, low supply or frequent expressing) alone or with other physical problems was significantly associated with poorer maternal mood at 8 weeks. Breastfeeding problems were seen to multiply in a gradient fashion to increase risk of mood symptoms. This was the first study to indicate that *breastfeeding problems*, rather than only *the cessation of breastfeeding* could affect maternal mood, and this had important implications for clinical care. Breastfeeding

difficulties, as we know, are readily able to be ameliorated with appropriate and effective identification, treatment and support.

Research has provided us with arguments for taking a humanistic and holistic approach to postpartum care that acknowledges the importance of breastfeeding to mothers and of the need for positive support from healthcare professionals to strengthen mother and baby connection.

## B. Women's experiences in the postpartum period, including the physical, psychological, emotional and economic impacts of birth

**Key messages from surveyed mothers**

- Breast and nipple pain is the most common reason mothers contact ABA's National Breastfeeding Helpline (32%), followed by information on feeding patterns and general reassurance.
- Compassionate listening matters: 90% of callers felt reassured, and many felt less alone, more confident and more determined to keep breastfeeding.
- Many mothers lack a 'village' and struggle to navigate health services, sometimes delaying care.
- Specialist breastfeeding support is costly. Cost-free services such as ABA's National Breastfeeding Helpline and LiveChat services are essential for equity.
- Formula promotion, including in health settings, can undermine mothers' confidence and complicate gaps in timely, independent support.

**Recommendations**

1. **Fund cost-free and accessible breastfeeding support as part of postpartum care to help mothers know when and where to seek care.** This includes sustaining community services such as ABA's National Breastfeeding Helpline and LiveChat, and making timely specialist lactation care available through Medicare.
2. **Strengthen navigation, referral, and professional education.** Health professionals need training in breastfeeding and in the growth of breastfed babies. See further response to this in section H.
3. **Legislate the full scope of the WHO Code.**

   Formula marketing should be regulated nationally, including toddler and follow-on milks and promotion in healthcare settings.

ABA lived experience from ABA's National Breastfeeding Helpline users (breastfeeding and postnatal mums) is shared here.

There are many reasons for mothers and others to ring the National Breastfeeding Helpline or access LiveChat, and our 2026 annual user survey indicated that they value:

- talking to a real person
- the kindness and understanding given by ABA volunteer counsellors
- the accessibility of the service.

The reasons for calling vary widely but nipple and breast pain are the most common, followed by concerns about their baby's feeding patterns and finally seeking general reassurance.

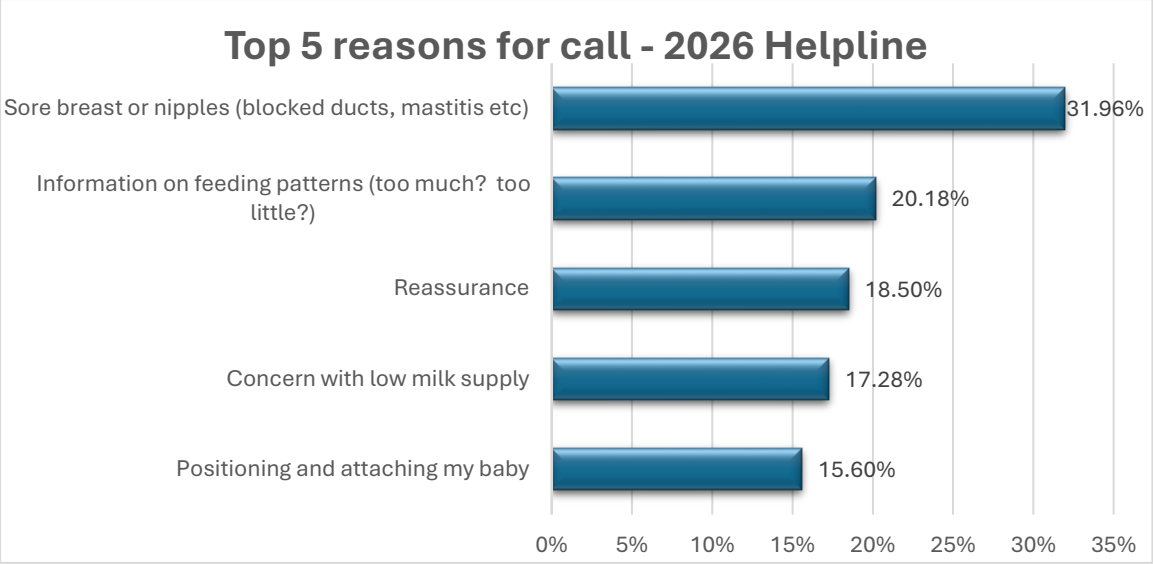
Responses to an ABA consumer survey about lived experience of marketing of infant formula in Australia are also included.

*National Breastfeeding Helpline 2026 survey of users*

National Breastfeeding Helpline users are surveyed every year about their reasons for calling and the experience they had with the National Breastfeeding Helpline service.

This ABA service (along with LiveChat) offers support from breastfeeding counsellors who are trained volunteers and provide individual breastfeeding support to mothers. ABA's National Breastfeeding Helpline is available 24/7 to support mums on their breastfeeding journey.

This feedback provides a reliable source for understanding what mothers value about breastfeeding support, their motivations for seeking support, and their broader needs in the postpartum period.




Breast and nipple pain are the most common reasons for mums to ring ABA's National Breastfeeding Helpline (31.96%; LiveChat ranked this first also) and way ahead of the next most common reasons, which were information about feeding patterns (20.18%; LiveChat ranked equal second) and general reassurance (18.5%; LiveChat ranked equal second).

When we take a broader look at reasons for the call being made, we find 23 different 'main reasons' from 2026 feedback (anything from teething to tips on returning to work) and under 'other' there were 90 different reasons self-identified by callers.

What meaning do we attach to these responses? Most of the callers to ABA's National Breastfeeding Helpline have babies aged from 1 week to 4 months. Their concerns could be seen to come under a heading of 'early challenges' and might be said to be like speaking to a 'support village'. But also important is that callers define their own reasons for calling ABA's National Breastfeeding Helpline, and most have their needs met.

*Feedback from ABA's National Breastfeeding Helpline callers*

A strong theme was the vulnerability of mothers in the postnatal period. Many respondents expressed shame, self-doubt, and reduced confidence during the postnatal period.

> *I was stressed because it had just reached 24 hours with no wet nappies.*

*Almost always in tears from exhaustion and overwhelmed.*

Negative experiences often involved feeling dismissed, judged, rushed or unheard, which clearly demonstrates what is important to mothers when seeking support.

Many women described lacking family support, community support or trusted individuals to turn to during the postnatal period. Several mothers referred to support services as being part of their 'village'.

Mothers frequently reported feeling uncertain when trying to navigate medical services to get care, including when to seek medical support, who to contact and whether symptoms required urgent intervention.

And mothers were also concerned about the implications of delays in medical assessment and treatment.

The importance of compassionate listening emerged consistently. Positive experiences were strongly associated with being heard, reassured, validated and treated with empathy:

*The volunteer was kind and understanding.*

*The volunteer made me feel very heard and reassured.*

*The information provided was so reassuring and made me feel like what I was experiencing was common and manageable.*

*The counsellor was compassionate and comprehensive in her explanation, suggestions and overall support.*

Women repeatedly highlighted the benefit of speaking with a *real person* during periods of distress, particularly overnight when caring for newborns and many responses described feeling less alone after receiving support.

The responses indicate that mothers felt ‘less worried’, ‘less stressed’, ‘more confident’, overwhelmingly reassured (90%), and importantly, more knowledgeable about breastfeeding and more determined to continue breastfeeding.

> *I went from crying and having a breakdown to calling and feeling so much better.*
>
> (Counsellor name) *made me feel empowered and informed about my rights to breastfeed and how to best support my child.*

When women were appropriately referred to emergency departments, GPs, lactation consultants or specialist services, they often reported improved outcomes and reduced anxiety.

Mothers mentioned the cost of accessing breastfeeding support and some reported spending significant amounts of money on specialist breastfeeding support including lactation consultants, breastfeeding physicians, breast pumps and healthcare appointments. One mother reported spending approximately $3000 in order to access breastfeeding support.

Free support services were repeatedly identified as essential. Respondents frequently expressed concerns that many women may not otherwise be able to access effective support.

*Responses from ABA consumer survey about marketing of infant formula*

Guidance from the World Health Organization (WHO & UNICEF, 2022) and *The Lancet* Series on Breastfeeding showed that formula marketing is one of the strongest hidden barriers to breastfeeding (Rollins et al, 2023). This is not just the ads seen on television or Instagram. It's the wording on the tin, the free samples in the hospital bag, the app that asks the pregnant woman to 'track your baby's development' and then recommends a formula product, and the conference sponsored by a formula company that healthcare providers attend.

Formula milk is a $55 billion global industry. Companies also spend billions each year on marketing strategies designed to create doubt about breastfeeding and position formula as the confident, scientific, modern choice.

The Australian Government has committed to creating new laws to restrict infant formula marketing in Australia. A large public consultation about what the new laws should cover finished in April 2026. The most comprehensive option proposed (Option 3) would put in place the broadest set of protections for families. This includes protection of clinical decision-making and mothers' feeding choices from commercial influence by excluding formula-industry

promotion, representatives, sponsorship, branded materials, samples and gifts from healthcare settings.

However, only legislation that is fully aligned with the WHO International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions (the WHO Code), will achieve the stated policy goals of increasing breastfeeding rates and enabling parents to make informed infant feeding decisions free from commercial influence.

Part of ABA's work towards advocating for national adoption of the full scope of the WHO Code included surveying consumers about their own lived experience of being marketed to.

Some respondents described marketing as raising doubt, undermining confidence or making families question whether breastfeeding was sufficient.

> *No but I feel like it made my husband question why we weren't shifting to formula if it was better.*

> *We are a strongly supported breastfeeding family and it still raised the question if we are doing the right thing or if formula could add something more – this is misleading for families struggling.*

> *I think the marketing and packaging of formula poorly directs mums to believe that formula is the better source of food for young babies. I firmly stand behind the ethos of 'fed is best' because breastfeeding is a stressful journey, but bombardment of products can make mums question the importance of breastfeeding.*

Respondents raised concerns that toddler milk and follow-on milk marketing can utilise brand recognition, blur product distinctions and make formula appear normal or beneficial.

> *I can't remember the brand but clearly remember when I was breastfeeding my first child, the range of formulas on the shelves and the fact that they were promoting 2-year-old/3-year-old formula.*

> *Being new to breastfeeding, it definitely confused me and made me question if I needed to start giving formula after 12 months of age.*

Several respondents referred to formula promotion, recommendation or distribution in healthcare settings, including health professional advice, hospitals and samples.

> *I found that it was our paediatrician who pushed it the most. I'd like to see more regulation of formula companies marketing to paediatricians, as well as more government funding for breastfeeding education for doctors.*

Respondents linked the influence of marketing with gaps in timely, independent breastfeeding support and health professional knowledge.

> *Better access to breastfeeding support – better availability, more timely and covered by Medicare. I had to wait over a week for support, which felt like forever with a newborn feeding 10 to 12 times per day during that time.*

> *I think this* [regulation] *will go part of the way, and needs to be done alongside other strategies including better breastfeeding support. My experience is that breastfeeding support is being removed from the hospital system at the same time as formula is becoming more normalised, particularly online which is where so many mums are spending their time.*

> *Yes* [regulation is needed] *but we also need to ensure health professionals are trained to understand breastfeeding and growth in breastfed babies and infants.*

The mothers who responded to this survey were aware of the negative influence of the marketing of breastmilk substitutes on mothers' confidence to keep breastfeeding, often learning this through their own early experience. They ask here for better controls on industry advertising and promotion, having seen how this disrupts mothers' closely held breastfeeding intentions.

Current work by the federal Department of Health, Disability and Ageing (DOHDA) to create legislation that regulates the marketing of breastmilk substitutes should ensure that it reflects the full scope of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions (the WHO Code) in order to support the protection of breastfeeding in Australia.

## C. Best practice pregnancy and postpartum care models to support long-term maternal physical and mental health

**Key messages**

- Breastfeeding provides lifelong protection of maternal health, by reducing risk of breast and reproductive cancers, cardiovascular disease and metabolic syndrome.
- While mothers with complex pregnancies gain significant health benefits from breastfeeding, they also have poorer breastfeeding outcomes.
- Shorter postpartum hospital stays have become embedded permanently in most health systems.
- Home visiting models are highly variable and the rationale behind decisions about the number and timing of visits is opaque. Linking mothers on to community supports after discharge from home visiting is inconsistent.
- Mothers value midwife home visits, which better meet their social and emotional needs.
- Child and family health services vary significantly across jurisdictions; families need accessible, non-judgmental, universal support.

**Recommendations**

1. **Build breastfeeding support into care for complex pregnancies.** Women with gestational diabetes, hypertension, metabolic syndrome or other complexities need care models that support their breastfeeding goals alongside their medical needs.
2. **Individualise discharge and improve postnatal home visiting.** Discharge planning and the number of home visits should reflect each mother's needs. Midwives working in home visiting should be skilled in providing ongoing breastfeeding and infant care and have capacity to link families to community support.
3. **Establish a universal child and family health service.** It should be nationally consistent, with tiered additional support for families who need it, as Price et al. (2025) proposed. These services should provide funded ongoing community-based breastfeeding support for all mothers with a focus on access and equity.

*Complex maternal health problems and breastfeeding*

Optimal breastfeeding contributes to the disruption of inter-generational cycles of disease for mothers *and their offspring*. Models of care that support breastfeeding also support lifetime maternal health.

While evidence for lifelong health benefits for breastfed infants is already well-established, and there is clear evidence for breastfeeding conferring protection for mothers against reproductive cancers (Tawia, 2022), more recent research further explores the benefits of breastfeeding for those mothers whose pregnancies had been complicated by diabetes, hypertension or what comes under the term 'metabolic syndrome'. Much of this research has been undertaken in Australia. Duration of breastfeeding has been shown to decrease the acuity of these conditions, prevent worsening or stop its recurrence (e.g. gestational diabetes in future pregnancies).

These health benefits give weight to the necessity of providing support and removing barriers for mothers to reach their breastfeeding goals. When mothers meet or exceed their breastfeeding goals, all of society benefits.

A recent systematic review and meta-analysis (Mohebi et al., 2025) found that about one fifth of pregnant women globally have metabolic syndrome (MetS) which is defined as a cluster of risk factors that increase the risk of cardiometabolic diseases.
Another recent study of the association between breastfeeding and prevalence of metabolic syndrome in women with a previous major pregnancy complication found that breastfeeding is protective against metabolic syndrome (Pathirana et al., 2026).
In a qualitative study looking at women's knowledge of breastfeeding benefits for mothers who had a major complication of pregnancy, all of the mothers in the study were aware of the protective effects of breastfeeding on heart disease risk factors more generally but not for themselves (women who had experienced major complications in pregnancy). These mothers asked for more access to non-judgmental early breastfeeding support so that mothers like them could have a better chance of reaching their breastfeeding goals (Pathirana et al., 2025).
Melov et al. (2023) showed that intensity of breastfeeding decreases the risk of an abnormal fasting glucose in a subsequent pregnancy. Another recent study

compared a cohort of women with polycystic ovarian syndrome (PCOS) and a cohort without a diagnosis and found that exclusive breastfeeding was a potent independent factor associated with a significantly lower risk of cardiometabolic impairment (Palomba et al., 2026).

Breastfeeding improves the health outcomes of mothers with complex pregnancies, but their breastfeeding outcomes are worse. We need models of care that prioritise support for breastfeeding goals as well as their medical needs.

*Postpartum length of stay and breastfeeding*

Length of postpartum hospital stay has decreased incrementally over the last 50 years, with little evidence about satisfaction or health outcomes. Short postpartum stays may shape the care that new mothers receive but the outcomes for maternal and infant wellbeing and breastfeeding are not clear and there is limited research about models of postpartum care in the home (Jones et al., 2021).

Lindblad (2022) found that a cohort of Danish first-time mothers were at greater risk of feeling doubtful of their ability to breastfeed, and of feeling anxious and depressed. They were more likely to perceive that their discharge was too early, indicating that standardising postpartum length of stay may have limitations.

An Australian study examined the relationship between short length of postpartum hospital stays and later presentations at the emergency department. They found a statistically significant increase in presentations of infants and mothers after short stays, but no increase in re-admissions in the study period, indicating a lack of readily available community support for new mothers (Francis et al., 2025).

While there is limited research about models of postpartum care in the home and many different iterations of this care, there are a few studies that have shown that mothers are more satisfied with their midwife care from home visits compared to their care in hospital (Walker et al., 2019; Schmied et al., 2024). The mothers in these studies felt they were more likely to receive care that met their social and emotional needs when it occurred in their own home.

Midwives who provide postpartum home care should have the appropriate skills for ongoing support for breastfeeding and infant care, which is somewhat different to providing support in the hospital during the first 2 days after birth. Clinical need should drive the number of visits at home rather than vague guidelines based mostly on the need to provide task-based care such as weighing the infant or assumed need. Visits should not be planned on task-based care but on more general need and mothers should be encouraged to state their own needs for visits and support.

Models of maternal, child and family health vary significantly across Australian jurisdictions in terms of structures, principles of care and universal access. These services can provide crucial assessment and screening for infants and children in the important early years, when key health patterns and potential vulnerabilities can be identified and supported.

Hesson et al. (2017) asked families about their experiences with child and family health services and found that many were 'lost and confused' in their efforts to navigate their parenting journey. They indicated that they needed accessible, timely and non-judgmental interactions with health professionals. Price et al. (2025) have published about the importance of universal services in this area to ensure equitable health outcomes for Australian children. They proposed a universal service for all children with two levels of increased support for those who require it.

D. The cost and accessibility of postpartum healthcare, including:

- infant feeding supports

**Key messages**

- Current high-level evidence indicates that breastfeeding-specific support is likely to be associated with increased breastfeeding duration and exclusivity, may reduce cessation of breastfeeding at 3 to 4 months and has most benefit through four to eight contacts. Peer, professional or combined support was found to be effective face-to-face, by phone or via digital technologies.
- Mothers report that breastfeeding peer support builds their self-efficacy by offering respect, reassurance and companionship. Authentic peer support fosters maternal autonomy rather than dependency.
- The approach to existential caring that informs breastfeeding peer support may also enrich professional care, where structural limits often affect breastfeeding support.
- Lactation care should be recognised as a specialty within health care and be supported through accredited Australian competency-based qualifications.

**Recommendations**

1. **Fund universal, ongoing peer breastfeeding support models.** It should be part of postpartum care, offered across face-to-face, phone and digital channels, and continue beyond the early weeks.
2. **Build skilled breastfeeding support across mainstream health services.** This means health professional education, informed by what makes peer support effective: respect, listening and building confidence.
3. **Recognise lactation care as a healthcare specialty.** It needs accredited education pathways and must ensure equitable access to specialist support for women who need it.

The most recent update of the Cochrane Review of support for healthy breastfeeding mothers with healthy term babies (Gavine et al., 2022) found that specific breastfeeding support was likely to have a positive effect on increasing breastfeeding duration and, importantly, exclusivity. This review examined types and outcomes of breastfeeding support for healthy mums and babies as well as features such as:

- was there other support involved?
- effect of type of support
- intensity of support
- the person who delivered the support
- any variation in outcomes between high income countries and low-middle income countries.

The review covered 116 trials from 42 countries involving almost 100,000 mother–infant pairs, with 55% of these coming from high-income countries, 37% from middle-income countries and 8% from low-income countries.

Primary outcomes focused on breastfeeding rates at specific time points.

Other outcomes included mothers' satisfaction with care and feeding method, infant morbidity and maternal mental health, and were described as having 'no consistent findings'.

*Breastfeeding peer support*

Another recent study that was part of a larger randomised controlled trial examined women's experiences of peer breastfeeding support in Hong Kong (Ho et al., 2026). Mothers described the peer support they received as a 'lighthouse' and a 'shelter'. Their choices were respected and emotional reassurance was provided, which mothers described as 'heartwarming'. Mothers appreciated the positive outcome expectations from their peer supporters and felt that their concerns were listened to and understood. Another theme named the peer support as 'a cheer team in the same boat' that provided companionship and helped mothers feel less alone. The mothers were motivated by knowing that other breastfeeding mothers had faced similar challenges and still met their own breastfeeding goals.

The study authors produced a blueprint for effective support programs:

1. Explicitly target holistic support to foster self-efficacy in breastfeeding mothers – prioritise building confidence over disseminating information.
2. Involve/include peer supporters who have breastfed – 'their lived experience provides a powerful source of observational learning'.
3. Focus on environmental facilitation to remove barriers to access.

The 2025 paper by Lina Palmér et al. also deepens our understanding of the meaning of breastfeeding peer support from the perspective of breastfeeding peer supporter mothers who described their work as 'an embodied and existential presence'.

The peer support mothers in the study belonged to the Swedish breastfeeding support organisation Amningshjälpen, which was formed in the 1970s in response to low breastfeeding rates and an increasing prevalence of medicalisation of breastfeeding. This was also an effort to recognise women's right to breastfeeding knowledge and a valuing of woman-to-woman support.

The study reported carers being aware of tendencies to own the care they give, in a way that threatens the breastfeeding mother's autonomy and that may create a dependency on the caregiver. Another, more positive outcome of care was described when the caregiver leads the breastfeeding mother toward her own autonomy and their own individual sense of purpose and meaning in their life, also known in Heideggerian terms as 'authentic care'.

Breastfeeding peer support offered in this way acknowledges that breastfeeding has existential dimensions too. In the end, the mother is supported to make decisions that align with her own wellbeing. This was contrasted in the article with what is known about care in professional contexts that can be described as inflexible, instrumental and disciplined and more likely to objectify the patient by presenting as 'expert'.

*The case for expert breastfeeding support*

A recent scoping review examining the impact of International Board Certified Lactation Consultant (IBCLC) care on breastfeeding rates found only four studies to review (Lunny et al., 2026). The authors noted some increases in rates and

duration of breastfeeding associated with care from IBCLCs, but that access issues were significant, casting doubt on the sustainability of the IBCLC model.

The system reduces the need for specialist care by ensuring that mainstream services provide skilled and effective breastfeeding support. This aligns with the World Breastfeeding Trends initiative (WBTi) Indicator no. 5 outcomes and with the Australian National Breastfeeding Strategy's Action Area 2.2 to increase education for all Australian health professionals. [See more in section H.]

The Australian Breastfeeding Association delivers the Australian-accredited competency-based *11451 NAT Diploma in Breastfeeding Management* that is readily available for health professionals. ABA is held in high regard for setting the 'international gold standard for health worker education'.

The UK Baby Friendly Initiative has recently published a policy paper about infant feeding education in England that includes a section about specialist clinical lactation training. They stated that one third of respondents to their stakeholder survey had completed preparation for IBCLC certification, which is not a recognised or registerable healthcare qualification in the UK (or in Australia). The access to this training and uptake of IBCLC certification was seen as inequitable, demonstrating a gap in education options and career opportunities available in the UK health system.

The policy paper recommendations support better recognition of infant feeding and lactation care as a specialty within the healthcare system, with the development of a career structure and access to recognised education that can be accessed within the workplace.

## E. Antenatal and postpartum reproductive health support and education, including contraceptive care

### Key messages

- There is evidence that antenatal preparation for breastfeeding that continues into effective and relational breastfeeding support in the postpartum period improves breastfeeding outcomes. However, it is complicated to measure education outcomes as opposed to a case of giving women standard information.
- Women face barriers to accessing personalised breastfeeding information and support that is free of conflicting information. Online antenatal breastfeeding education risks widening inequity through a digital divide.
- Women value honest, real information and individual conversations about breastfeeding that respect their autonomy and build confidence. Training midwives to provide breastfeeding conversations during antenatal care episodes enables more equitable, accessible and engaging care.

### Recommendations

1. **Embed individualised antenatal breastfeeding education in all pregnancy care.** It should replace standard information and continue into postpartum support.
2. **Ensure equitable access to antenatal breastfeeding education.** This means addressing the digital divide through e-health literacy and culturally responsive design.
3. **Train midwives and other health professionals to provide antenatal breastfeeding conversations.** These conversations should be consistent, honest and respectful of women's decisions.

*Breastfeeding education and breastfeeding rates*

A systematic review of antenatal breastfeeding education versus standard hospital information (Rohini et al., 2022) found increased exclusive breastfeeding rates, although four interventions did not result in statistically significant

differences. Importantly, the authors affirmed that the current practice of usual standard information had limited value in improving the rate of exclusive breastfeeding. The authors tackled some of the issues that throw doubt on the value of antenatal breastfeeding preparation. These include how contexts that have pre-existing structural breastfeeding supports contribute to better breastfeeding education outcomes. Sometimes the individual woman's knowledge and attitudes about breastfeeding will also influence outcomes but can't be controlled for. The authors also noted the lack of consistency in how breastfeeding outcomes are reported, which limits reliable conclusions.

*Women's experience of antenatal breastfeeding preparation/education*

A recent randomised controlled trial (RCT) examined outcomes for breastfeeding education with women either alone or attending with their mother-in-law versus a control group receiving usual care. Both education groups had much better breastfeeding outcomes than the control groups with less prelacteal feeding, more colostrum feeding, more early initiation of breastfeeding and more exclusive breastfeeding (Jena et al., 2026).

Another recent study examined mothers' experiences of barriers and facilitators of receiving breastfeeding education and getting breastfeeding support (Abbass-Dick et al., 2026). This showed that there were clear barriers to accessing personalised support that was free of conflicting information.

An integrative review of women's experiences of online antenatal education identified a marked digital divide for women accessing online antenatal education, placing vulnerable women at risk of continued inequity (Whitworth et al., 2024). The review indicated that e-health literacy frameworks need to be implemented to create genuine accessibility, comprehensibility and cultural responsiveness to best meet the needs of users. As digital health is an emerging field, there is strong evidence that online antenatal education requires further evaluation to better meet the needs of pregnant women and their support people.

Shipton et al. (2025a) reported on an Australian qualitative study of women's lived experiences of receiving antenatal breastfeeding education in either a midwife continuity of care model or standard care and found a lack of information being offered in both models of care. Breastfeeding information was either not mentioned at all in the antenatal period or only superficially and with

assumptions, or else focused on guidelines and recommendations. The study examined how women engaged with breastfeeding information and found that women sought alternative sources of information and then used midwives to factcheck this. Participants valued 'honest and real information' and were led by their own learning styles. The authors urged further development of holistic and individualised antenatal breastfeeding education.

A study carried out in Sweden developed training for midwives to have effective conversations with women about breastfeeding in the antenatal period. One article examined mothers' experiences of support when they received care from midwives who had undertaken the training program (Blixt et al., 2026). They found that continuity-based, individual antenatal breastfeeding education that was offered in clinic appointments could complement antenatal group sessions, enhance maternal satisfaction, and enable midwives to provide more equitable and accessible care for all families. This study also carefully articulated what happened for mothers in relation to breastfeeding itself. The authors concluded:

> *Mothers valued support that recognised their perspectives and strengthened their ownership of breastfeeding decisions, while negotiated partner involvement deepened shared understanding without compromising maternal autonomy. Individual dialogue grounded in each mother's lived experiences, needs, and circumstances fostered a sense of safety, reflection, and growing confidence throughout pregnancy and early motherhood.*

## F. Research, education and training on pregnancy and postpartum care for healthcare professionals working in maternal care

**Key messages**

- All health professionals likely to care for breastfeeding mothers or infants need pre-practice lactation and breastfeeding education.
- Those health professionals who work in maternity and neonatal care need more expert-level knowledge, consistent with Baby Friendly Health Initiative requirements.
- Midwifery course accreditation sets a low benchmark for postpartum care and lactation support in pre-practice curricula. Nursing staff who are increasingly staffing postpartum areas often have no formal education about lactation.
- Breastfeeding support should continue after hospital discharge, yet child and family health arrangements, knowledge and practice vary widely.
- Home visiting staff need the knowledge to provide ongoing breastfeeding support and link mothers to community services, including ABA.
- Breastfeeding research in Australia is active and has a diverse focus. It has potential to influence and inform policy and practice. However, it lacks direction and coordination.

**Recommendations**

1. **Require lactation and breastfeeding education for all relevant health professionals.** Maternity and neonatal staff should be educated to expert level, in line with BFHI requirements and the Australian National Breastfeeding Strategy.
2. **Raise midwifery accreditation standards for postpartum care and lactation support.** A national education framework, informed by current Australian research, should guide this.
3. **Ensure that health professionals have capacity to provide effective breastfeeding support for ongoing home-based postpartum care.** Child and family health staff should be required to meet consistent knowledge standards for breastfeeding information and support.

4. **Establish a national breastfeeding advisory committee** as outlined in the *Australian National Breastfeeding Strategy: 2019 and beyond* (ANBS), which should lead planning for an independent national breastfeeding research framework.

As mentioned previously, the World Breastfeeding Trends initiative (WBTi) Indicator no. 5 assesses breastfeeding education for healthcare workers and relies on the principle of all health professionals requiring basic education about lactation and breastfeeding if they are likely to care for breastfeeding mothers or infants in their everyday practice. Those working in maternity or neonatal clinical care need expert levels of knowledge that reflect standards included in BHFI education requirements as well as access to an established program of continuing professional development.

Midwives are the only registered health professionals in Australia who are required to have breastfeeding education prior to registration and practice for course accreditation, which specifies adherence to BFHI principles. Current midwife practice standards do not mention breastfeeding knowledge or skills specifically but have broad expectations for evidence-based care (Pangerl et al., 2026).

Research that examines the infant feeding support skills and knowledge of practice midwives shows mixed outcomes (Schmied et al., 2024; Shipton et al., 2022; Shipton et al., 2025b). Conflicting information, a lack of time to offer one-to-one breastfeeding support and a non-relational approach to care are consistent concerns expressed by mothers.

As mentioned in section C of this submission, postpartum home visiting by midwives is more highly regarded by mothers for the one-to-one care and the capacity for conversations about emotional and social issues (Walker et al., 2019; Schmied et al., 2024).

Maternal, child and family health nurses are not registered with the Australian regulator of health professionals, but the national professional body, Maternal Child and Family Health Nurses Association (MCaFHNA), is currently reviewing

their professional standards documents including those that cover breastfeeding support.

There is also synergy here with the ANBS Action area *2.2 Health Professionals Education and Training* that includes provision of education and training in breastfeeding for all health professionals who care for women and children, and the development of a core curriculum and competency standards.

Current research is under way reviewing Australian midwifery course curricula, researching midwives' experiences and sources of breastfeeding education and knowledge, with an aim to create a national education framework (Pangerl et al., 2024; Pangerl et al., 2026).

Systematic and scoping reviews as well as a variety of studies that investigate the breastfeeding knowledge, attitudes and practice of other health professionals beyond midwives are increasing and include general practitioners (Fitzgerald et al., 2025; Holtzman & Usherwood, 2018), obstetricians (Cher et al., 2025), paediatricians and paediatric nurses (Hookway & Brown, 2023), intensive care nurses (Zisin et al., 2025) and neonatal nurses (Li et al., 2025; Peng et al., 2026).

These studies of different health professionals showed shared themes of moderately positive or mixed attitudes towards breastfeeding, uniformly low levels of formal education about breastfeeding prior to practice as well as ongoing low levels of knowledge as practitioners. There was also a shared reliance on the clinician's own or their partner's breastfeeding experience to inform clinical practice, and a general interest in gaining more skills despite poor access to professional breastfeeding education, whether foundational or more specific to their specialty.

One systematic review needs specific mention for its examination of both clinician and parental experiences of breastfeeding support when nutrition interventions are introduced in paediatric settings (Errico et al., 2025). Understanding the needs of breastfeeding mothers and families in these settings is critical for building better breastfeeding support.

## G. Existing Commonwealth, state and territory government policies, programs and healthcare initiatives addressing postpartum care

**Key messages**

- Breastfeeding appears in several national strategies, with sound recommendations, but implementation has been patchy.
- The *Australian National Breastfeeding Strategy: 2019 and beyond* (ANBS) remains the strongest roadmap for change.
- The 2025 target of 50% exclusive breastfeeding to around 6 months is far from met, at 29%.
- The Baby Friendly Health Initiative adoption is uneven, with some state jurisdictions having fewer than 12% of facilities accredited.
- Marketing regulation aligned with the WHO Code is a current work in progress with DOHDA, with policy position on scope still unknown.
- Australian national postnatal care guidelines are currently being developed
- Regular high-quality population infant feeding data capture is not occurring.
- Community breastfeeding support, such as that offered by ABA's National Breastfeeding Helpline and LiveChat, is not sufficiently funded.

**Recommendations**

1. **Fund and implement the Australian National Breastfeeding Strategy.** This should prioritise:
    - the formation of a national breastfeeding advisory committee
    - a commitment to regular national infant feeding surveys
    - universal requirements for Baby Friendly Health Initiative accreditation for maternity health services.
2. **Ensure that new legislation to regulate marketing of breastmilk substitutes in Australia reflects the full scope of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions (the WHO Code).**

*The National Breastfeeding Strategy: 2019 and beyond* (ANBS), provides a roadmap for increasing breastfeeding rates. Breastfeeding is also referenced in several Commonwealth strategies beyond the ANBS, relevant to postpartum care, including the *National Women's Health Strategy 2020–2030,* the *National Preventive Health Strategy 2021–2030* and the *National Obesity Strategy 2022–2032*. These strategies contain recommendations that could shape better postnatal care, but delivery and implementation of recommendations is largely in early stages and has been patchy.

*The National Women's Health Strategy (2018)* commited to supporting enhanced access to maternal and perinatal health care services. One of its objectives was to support women's capacity to establish and maintain breastfeeding through improved health professional education, promotion of breastfeeding information and support programs, promotion of the NHMRC Australian Infant Feeding Guidelines and support for implementation of the Australian National Breastfeeding Strategy (pp. 25–26). These are appropriate actions, but the Strategy did not specify how they would be funded, delivered or measured.

*The National Preventive Health Strategy* recognised that, in the first 2000 days of a child's life, breastfeeding is one of the most effective preventive measures available to give a child the best start in life. Its goals for 2030 included reducing structural and environmental barriers to breastfeeding through policy action. It also set a target that at least 50% of babies be exclusively breastfed until around 6 months of age by 2025.

*The National Obesity Strategy* noted that while 96% of Australian mothers initiated breastfeeding, only 29% of babies were exclusively breastfed to 6 months (Australian Bureau of Statistics, 2018). With the 2025 target date now passed, the gap between ambition and outcome is substantial. The strategy also recognised that longer breastfeeding is associated with a lower risk of childhood overweight and obesity. It called for women to be supported to breastfeed, and to continue breastfeeding, by implementing the Australian National Breastfeeding Strategy.

*The Australian National Breastfeeding Strategy (ANBS): 2019 and beyond*

The ANBS provided a multi-perspective approach to improving breastfeeding support in Australia and remains a sound reference for where change needs to occur. Its implementation was framed as a shared responsibility across

governments and other stakeholders, not the Commonwealth alone. It set out three groups of action areas: structural actions, settings actions and individual actions.

Implementation of the ANBS has been uneven, and its commitment to evaluation has yet to be fully realised. Some actions have progressed through other means, such as the federal funding for ABA's National Breastfeeding Helpline, as well as a national network of donor milk services. Others, including a national advisory structure, regular national infant feeding data collection and universal support services require renewed commitment and dedicated funding.

*The Baby Friendly Health Initiative (BFHI)*

The ANBS called for more maternity services to achieve BFHI accreditation, or for BFHI to be integrated into national health service accreditation. Embedded requirements for staff education, including knowledge of the WHO Code mean that there would be a baseline of knowledge and interest in provision of evidence-based breastfeeding support. Importantly, BFHI requires that healthcare staff have capacity to advise mothers about access to ongoing breastfeeding support in their communities, which makes for a natural bridge between hospital and community based postnatal care. Integrating BFHI standards into national accreditation would extend consistent, evidence-based practice to every maternity service.

*Regulating the marketing of infant formula*

Preventing inappropriate marketing of breastmilk substitutes was a structural ANBS priority. Australia was an original signatory but has never adopted the full scope of the WHO Code. In 2022, Australia scored 27 out of 100 for its implementation of the WHO Code. The Government's proposal to regulate infant formula marketing is a significant opportunity. ABA encourages the Government to draft regulation aligned with the WHO Code. ABA's consumer survey (see submission B) showed that mothers' confidence about breastfeeding was undermined by formula marketing, including in healthcare settings.

*National postnatal care guidelines*

Blair et al. (2024) compared Australian postnatal care guidelines with international standards and concluded that a national approach was needed. The Living Evidence for Australian Pregnancy and Postnatal Care (LEAPP) group

has embarked on a journey of developing 'living' guidelines to guide professional care for mothers during pregnancy and after birth up to 6 weeks. This is the first effort to produce national postnatal guidelines in Australia. Breastfeeding support should be a core component of any national postnatal guidelines, with clear expectations for care after discharge and referral to community services. The guidelines are designed to be on a continual cycle of review and updating.

*Community-based support*

Government strategies consistently reference breastfeeding information and support programs. ABA's National Breastfeeding Helpline and LiveChat provide free, accessible, evidence-based support from trained volunteer counsellors and breastfeeding educators at any hour, as described in submission B. Services like these give practical effect to the ANBS commitment to universal breastfeeding support and strengthened mother-to-mother support. They should be recognised and sustainably funded as part of Australia's postnatal care system.

## H. Data collection, reporting and monitoring processes and allocation of research efforts relating to postpartum healthcare

**Key messages**

- Australia's last national infant feeding survey was in 2010, despite it being intended to serve as a baseline for future data collection and the ANBS recommending 5-yearly surveys.
- Since 2010, every collection of Australian breastfeeding data has been incomplete, unreliable and unrepresentative of diverse and marginalised populations.
- Without a national, standardised data framework, national targets and equity progress cannot be evaluated.

**Recommendations**

1. **Fund a national infant feeding survey now, to be repeated every 5 years.** This is what the ANBS recommended. The survey should use standardised, WHO-aligned indicators and be representative of Australia's population.
2. **Make breastfeeding a mandatory national health indicator.** It should sit within a national, standardised data collection framework that tracks infant feeding from birth to the toddler years and is linked to the National Preventive Health Strategy's monitoring framework.

*Why is breastfeeding data needed?*

The federal Department of Health Disability and Ageing website states that medical data are collected in Australia to ensure better healthcare and more, that data support health and medical research and discovery, and that this can have life-changing results.

When *breastfeeding* data is not collected regularly or with robust methods, we miss an opportunity to improve care and support, reduce errors and inconsistencies in practice, contribute to system planning, guide public health policy and drive medical research. Not collecting regular and comprehensive data about this aspect of maternal, child and societal health reflects a systemic lack of recognition of breastfeeding as a key health behaviour.

The Australian National Infant Feeding Survey (ANIFS) was conducted in 2010 with data from 52,008 children. The survey was well designed and used a sound methodology. However, it remains a 'snapshot' of breastfeeding behaviours as it has never been repeated.

Australian National Health Surveys (NHS) collect some breastfeeding data that can be linked to other health conditions, but changes in indicators make use of longitudinal data difficult and small sample sizes preclude meaningful generalisation of data to the whole population.

Oliveri et al.'s (2026) scoping review of current breastfeeding data in Australia found a vacuum of reliable and representative data. They stated that since 2010, Australia's reported breastfeeding rates have remained unreliable and non-representative of diverse and marginalised populations. They recommended the introduction of a national standardised breastfeeding data collection framework that will track national targets and equity progress and include breastfeeding as a mandatory national health indicator. This would allow for accurate and ongoing documentation of infant feeding from birth to toddler years so that national targets can be evaluated and improvements in equity (or not) made visible.

A published review of breastfeeding data indicators in 51 out of 82 high-income countries globally (Vaz et al., 2021) found huge variation in how data were collected (national surveys or from hospital records), the breastfeeding indicators being used (exclusive or 'any'), at what infant age breastfeeding was measured (some did not capture exclusive breastfeeding at 6 months) and the patterns of time intervals when breastfeeding data were collected (from yearly to once!). The authors urged countries to engage in stronger promotional interventions for breastfeeding and to *invest* in data collection to monitor trends with standardised methodologies.

The UK Infant Feeding Survey 2024 was repeated after a 10-year gap and found a variety of outcomes that then needed retrospective attention. This recent survey demonstrated some improvements in breastfeeding initiation and early 'any' breastfeeding but also showed lower rates of exclusive breastfeeding on discharge from hospital.

There were clear and complex differences in breastfeeding initiation and duration between specific population groups and serious issues of inequity related to

social deprivation and higher levels of early mixed feeding. The survey also found that 75% of women were not meeting their breastfeeding goals.

When breastfeeding data are not collected, there is simply no opportunity to evaluate where we are succeeding or failing to support mothers' breastfeeding goals, or to plan for future success.

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