



Dietitians Association of Australia 34th National Conference

LECTURE IN HONOUR OF SHIRLEY MURRAY

Empowerment through education

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Shirley Murray, nee Trudgeon, was born the third of nine children in Bendigo on 5th December, 1939. In 1956 she was accepted into the Diploma of Institutional Management and the Certificate of Dietetics by the Emily McPherson College, an Australian domestic science college for women, and completed her fifth year of training in the Nutrition Department of the Royal Melbourne Hospital. Unable to graduate because she had not completed year 12 English, this devastating event shaped Shirley's lifelong determination to work and study hard.

Her priority at this time was creating her own family with Kevin Murray. Their early years involved travel and overseas postings where Kevin was based with the Royal Australian Airforce (RAAF). It wasn't until 1971 when they were back in Australia, with all of their three children at school, that Shirley was able to study again. She completed English and was finally awarded her dietetic qualification. She went on to complete a Diploma of Education and started teaching science and home economics.

A few years later they moved to Wagga Wagga, in NSW, where Kevin was Chief Executive Officer of base squadron in the RAAF. Here Shirley moved back into the field of nutrition, starting

the first weight loss clinic for staff of the armed forces. Shirley was later encouraged to apply for the position of dietitian at the Wagga Wagga Base Hospital but there was strong resistance from the NSW Dietitians Association. During the 1970s there were significant differences between the training offered by Victoria and NSW, with the latter considered more comprehensive. Despite the objections of the Association, Wagga Wagga Base Hospital wanted, and needed, Shirley to work for them.

Once again, Shirley felt a failure in her chosen profession. Her way of dealing with this was to work and study extremely hard to make up for her lack of experience, and perceptions by others that her training was insufficient. She learned much from her colleagues and as a dietitian she developed an expertise in obesity and diabetes management, becoming one of the first dietitians to also train as a diabetes educator.

Shirley oscillated between working as a dietitian and a teacher for many years, including when, with Kevin, she moved to Tasmania in 1999. She started working as a dietitian at the Royal Hobart Hospital but soon left to take up a teaching position when patient education was not encouraged. It was in Tasmania Shirley met Johanna Coy who became not only a close friend but her mentor for many years. Shirley states, "Johanna was my rock. She encouraged me to shake loose the shackles of failure and to reach out for new opportunities". It was Johanna who supported Shirley's application to re-join the

Dietitians Association of Australia (DAA), thus beginning a long period of service by Shirley to DAA.

During the 20 years that Shirley worked in Tasmania, her achievements were significant. She started the Nutrition and Diabetes Education Department at St Helen's Private Hospital, later becoming Food Services Manager, then General Manager. She was elected to the Board of DAA and chaired the 1991 DAA National Conference held in Tasmania. Her passion and commitment to diabetes education continued and she served on many voluntary committees and board roles for Diabetes Australia, Diabetes Tasmania and the International Diabetes Federation. Shirley was instrumental in ensuring private health funds recognised the services of dietitians, and she completed a postgraduate diploma of Business in Professional Management at the University of Tasmania.

When Shirley and Kevin relocated back to Melbourne in 1999, Shirley moved into the field of project management within the research sector. She developed planning, strategy and logistic skills in running large population field studies, including the Australian Obesity and Diabetes (AusDiab) study and the Victorian Rural Population Health Study. She had the opportunity to travel again when she coordinated a research project examining the availability and affordability of insulin in Eastern Europe, setting up a population-based diabetes study in the United Arab Emirates. This experience led to opportunities to expand diabetes education within this country. Shirley finally retired in 2014 and she and Kevin are now living back in Tasmania enjoying looking after their grandchildren.

When I first met Shirley in 1987, Judy Seal and I were two new graduates left to run the nutrition department at the Royal Hobart Hospital. Shirley's empowering style, combined with her mentorship, made all the difference to us being

able to survive our baptism of fire in Tasmania. The characteristics of networking, support, collegiality and a generosity of spirit have continued amongst Tasmanian dietitians and I can't help but think that Shirley and Johanna's legacy has had a lot to do with this.

Empowerment and breastfeeding

In honouring Shirley Murray, I have highlighted her role as an educator, and her commitment to empowering people through education. In my role as a community dietitian I am continually seeking ways to empower communities to improve access to healthy, affordable food, and for mothers to breastfeed.

Empowerment occurs when people gain control over decisions and resources that influence their lives (1). In order to achieve this, we need to understand and challenge power imbalances. When it comes to breastfeeding, the aim of empowerment is significantly influenced by the cultural and societal norms of our society. Like other parts of Australia, breastfeeding rates in Tasmania drop off dramatically after women leave hospital and are back home in their communities (2). There is a large disparity in breastfeeding rates between communities with exclusive breastfeeding at four months, ranging between less than 25% in the more disadvantaged communities to greater than 50% in the more advantaged ones (3).

It is more likely someone won't breastfeed if they live in a more disadvantaged community in Tasmania, exposing both babies and mothers to greater health risks. Over the past 30 years the evidence behind breastfeeding recommendations has evolved markedly. Traditionally, the importance of breastfeeding was thought about in terms of protection from infectious disease or malnutrition caused by contaminated water or an over dilution of formula. We now know breastfeeding protects against a range of adverse health outcomes, and

the health benefits are substantial and can continue well beyond the period that breastfeeding is stopped. For example, breastfeeding reduces the risk of asthma, SIDS, respiratory illness, obesity and diabetes (4, 5).

It is difficult for someone to feel empowered enough to breastfeed in communities where bottle feeding is the norm. Because of the multiple societal factors that can affect breastfeeding, it is clear that women, in making their decisions about infant feeding, are not always doing so on an even playing field. Clearly a range of strategies is required to address this significant health inequity. Greater investment in local community-based breastfeeding programs is needed, including peer support. Stronger community support is also needed for breastfeeding, including accessible antenatal and postnatal services and supportive environments and settings such as workplaces, childcare centres, community facilities and businesses.

But importantly we also need good policy, direction and leadership. Because of the huge inequity that exists in breastfeeding rates, the case for the protection of breastfeeding is stronger than ever in Australia (6). A key part of our efforts need to minimise the marketing influences that have the potential to undermine breastfeeding. Gabrielle Palmer describes the importance of providing parents with impartial infant feeding information, not from commercial sources, to enable informed decision making (7).

The World Health Organisation's International Code of Marketing Breastmilk Substitutes (WHO Code) is designed to do just that. Published in 1981, its aim is to protect and promote breastfeeding and ensure appropriate marketing and distribution of breastmilk substitutes, which include infant formula, follow-on formula, toddler milks, baby foods and drinks marketed for use before the baby is six months old, and feeding bottles and teats (8). Resolutions by the

World Health Assembly have occurred every two years and form part of the WHO Code.

The WHO Code states, among other things, that there should be no advertising or marketing of breastmilk substitutes directly to the public, and product labels should not use pictures, images or words that idealise the use of breastmilk substitutes. As a signatory to the WHO Code, Australia's main response has been to establish the Marketing in Australia of Infant Formula (MAIF) Agreement. Developed in 1992, MAIF is a voluntary self-regulatory agreement between formula manufacturers and importers who are signatories.

Unfortunately, MAIF may be considered too narrow in scope and out of date to be able to achieve its intended purpose of protecting breastfeeding. Of the complaints submitted between 2006 and 2011 approximately 80% were considered out of its scope (15). Since the development of MAIF, toddler milks have been introduced into the Australian market (9), which have not limited by advertising restrictions. Toddler milks are deemed by most dietitians to be unnecessary food products, branded and presented in packaging that is nearly identical to that of infant formula. This technique, known as brand stretching or brand extension, makes it difficult for parents to distinguish between toddler milk and infant formula (10, 11). Recently the World Health Assembly (Resolution WHA69.9) clarified that toddler and junior milks marketed for feeding young children up to the age of three years are included under the scope of the WHO code and there should be no cross-promotion via brand stretching or extension (12). Yet the practice continues unabated.

Another commonly occurring marketing practice is the use of nutrition and health claims to promote breastmilk substitutes. The WHO Code urges member states to ensure that nutrition and health claims are not permitted for foods for infants and young children, except where

specifically provided for, in relevant standards or national legislation. The Ministerial Policy Guideline on the Regulation of Infant Formula Products in Australia (13), and our food standard codes, do not allow health and nutrient claims on infant formula. But unfortunately, this regulatory mechanism is failing because of a long drawn out review and an absence of investment in monitoring and enforcement strategies.

There is ample evidence of nutrition and health claims being used by companies in television advertisements, promotional brochures, website content and labelling on tins (11). For example, some advertisements are promoting functional ingredients and claiming they may benefit eye and brain development and immune systems. Others are suggesting that special formulas for ‘hungry baby’ or ‘colicky baby’ could fix common infant complaints. These claims all imply the products offer a health advantage, giving the impression they are equivalent to, or even better than, breastmilk.

Many reviews and reports have acknowledged the limited scope of the MAIF Agreement and the need to update it to ensure it remains relevant in the context of changing marketing strategies. Some have recommended additional strategies be implemented to complement MAIF to ensure full implementation of the WHO Code (12, 14, 15). Despite these landmark reports we are no further along in being able to shape a more comprehensive approach to fully implementing the WHO Code in Australia.

The Australian Government is currently consulting on the development of a high-level enduring breastfeeding strategy. It aims to address barriers to women establishing and maintaining breastfeeding (16). Dietitians have an opportunity to advocate for the strategy to include full implementation of the WHO Code to protect breastfeeding. The MAIF Agreement also should be updated in line with changes in

marketing practices and include toddler milk in its scope. It is also within our power to submit complaints about inappropriate marketing practices to the MAIF Complaints Tribunal, which is managed by the Ethics Centre in consultation with the Department of Health. Even if our complaints are deemed out of scope of the agreement it is our only formal mechanism to record community concern.

We need our national breastfeeding strategy to shift the focus of breastfeeding promotion so that personal choice and individual responsibility around infant feeding decisions occurs within a society that truly values, supports and protects breastfeeding. This can occur if we have supportive regulatory and social environments and build cultural norms where breastfeed is considered usual, no matter which community you live in.

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Conflict of Interest

The author has no conflict of interest to declare.

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