

Implementing and Monitoring the *International Code of Marketing of Breast-milk Substitutes* in New Zealand:

# The Code in New Zealand

Te riunga ora mō ngā mokopuna  
The safe pathways to children's wellbeing

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MANATŪ HAUORA

# Foreword

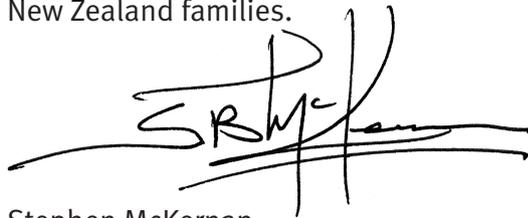
Breastfeeding is key to providing the best start for New Zealand infants, and important for both infant and maternal health. The overall Ministry of Health objectives are to increase the prevalence and duration of breastfeeding for all infants. All efforts made to promote and protect breastfeeding practices in New Zealand will contribute to reducing inequalities in health between Māori and non-Māori and between Pacific and non-Pacific peoples, in the short and long term.

This document is one action the Ministry of Health has taken to give effect to the articles of the *International Code of Marketing of Breast-Milk Substitutes* (WHO 1981) (the International Code), and subsequent relevant World Health Assembly resolutions.

The International Code aims to contribute to providing safe and adequate nutrition for infants by protecting and promoting breastfeeding. It also aims to ensure the proper use of breast milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. New Zealand is a signatory of the International Code, so is committed to working towards meeting its aims.

Following a review of New Zealand's interpretation of the International Code (Ministry of Health 2004a), the Ministry has prepared a single, standard reference document. This document includes the Code of Practice for Health Workers in New Zealand and the Code of Practice for the Marketing of Infant Formula (NZIFMA 2007). This will ensure the International Code is more accessible, more effectively used and more easily monitored in New Zealand.

This publication is intended to ensure the International Code's spirit and intent become the guiding principles for all parties concerned with infant nutrition and the health and wellbeing of New Zealand families.

A handwritten signature in black ink, appearing to read 'S. McKernan', with a horizontal line underneath.

Stephen McKernan  
Director-General of Health

# Acknowledgements

*Implementing and Monitoring the International Code of Marketing of Breast-Milk Substitutes in New Zealand: The Code in New Zealand (Te riunga ora mō ngā mokopuna)* has involved the valued input of a wide range of individuals and groups. The Ministry of Health would like to acknowledge and thank all those who have contributed to this publication, including sector stakeholders and Māori and Pacific health advisors.

In the context of Te riunga ora mō ngā mokopuna – The safe pathways to children’s wellbeing, the term ‘mokopuna’ includes all children (eg, grandchildren, great-grandchildren, great-great-grandchildren). The title conveys several concepts, including generational wellbeing, safe pathways, informed choice and a focus on mokopuna.

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# Introduction

## International Code of Marketing of Breast-Milk Substitutes

Breastfeeding has a range of well-recognised benefits to both mother and child (see Appendix 1). Recognising the benefits and observing that rates and duration of breastfeeding have historically been lower than ideal, the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) convened a landmark meeting on infant and young child feeding with representatives of governments, agencies of the United Nations system, non-governmental organisations, the infant-food industry, and experts in related disciplines. In 1981, a series of recommendations was adopted, including the *International Code of Marketing of Breast-milk Substitutes* (the International Code) (WHO 1981). (The International Code is reproduced on page 5. Answers to frequently asked questions about the International Code are in Appendix 2.)

The WHO urged all Member States to take action to give effect to the International Code's principles and aim, as appropriate to their social and legislative framework. Action included adopting national legislation, regulations or other suitable measures to put the International Code into effect, involving all stakeholder groups in the International Code's implementation, and monitoring compliance with the International Code.

The International Code aims to contribute to the provision of safe and adequate nutrition for infants by:

- protecting and promoting breastfeeding
- ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

The Ministry of Health (the Ministry) is committed to protecting, promoting and supporting breastfeeding. As well as the International Code, several other international documents encourage the Ministry's commitment, including:

- *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* (WHO and UNICEF 1990)
- *Global Strategy for Infant and Young Child Feeding* (WHO 2003)
- *Innocenti Declaration 2005: On infant and young child feeding* (WHO 2005).

The *Global Strategy for Infant and Young Child Feeding* reaffirms the International Code's ongoing importance, and asks governments to implement and monitor existing measures to give effect to the International Code and subsequent relevant World Health Assembly resolutions and, where appropriate, to strengthen them or adopt new measures. For details about the strategy's implementation in New Zealand, see Stewart (2006).

The Ministry has taken action to give effect to the International Code's principles and aim and subsequent relevant World Health Assembly resolutions, as appropriate to New Zealand's social and legislative framework (Appendix 3).

The International Code, Article 6.1, states that health authorities should give appropriate information and advice to health workers about their responsibilities under the International

Code. *Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand* is one such action.

## Implementing the International Code in New Zealand

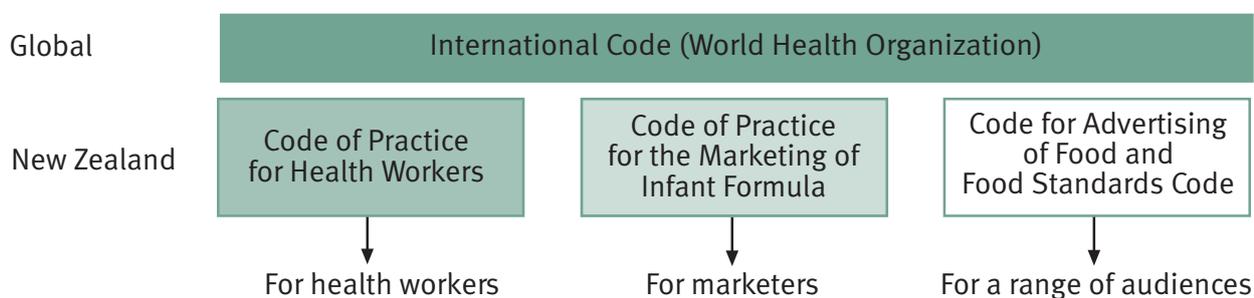
The International Code is implemented in New Zealand under four New Zealand codes. The codes, illustrated in Figure 1, are the:

- Code of Practice for Health Workers (Health Workers' Code)
- New Zealand Infant Formula Marketers' Association Code of Practice for the Marketing of Infant Formula (the NZIFMA Code of Practice) (NZIFMA 2007)
- Advertising Standards Authority Code for Advertising of Food (ASA 2006)
- Australia New Zealand Food Standards Code (Food Standards Code) (FSANZ 2002).

The Health Workers' Code and NZIFMA Code of Practice are based on the International Code and subsequent relevant World Health Assembly resolutions. The Food Standards Code draws on the International Code to cover labelling, composition and quality matters. The Code for Advertising of Food endorses the NZIFMA Code of Practice as the appropriate industry code of ethics.

The International Code is also relevant for health practitioner training providers, non-governmental organisations, community support groups, education authorities, the media, employers, supermarkets, pharmacies and other sales outlets.

**Figure 1: Codes implementing the International Code of Marketing of Breast-Milk Substitutes in New Zealand**



The Health Workers' Code, NZIFMA Code of Practice and Code for Advertising of Food are:

- **voluntary**, which means the people and organisations subject to the codes are not legally required to comply with them, but each code is a standard for practice
- **self-regulatory**, which means health workers, NZIFMA companies and the Advertising Standards Authority should manage their compliance processes to comply with their codes of practice, and may be asked to change their codes in response to any upheld complaints.

The Food Standards Code is:

- **not voluntary**, which means the people and organisations subject to this code are legally required to comply.

## Code of Practice for Health Workers

The Health Workers' Code (see page 13) comprises the bulk of this document, and represents part of the New Zealand response to international recommendations and the Ministry's strategic objectives in relation to breastfeeding and breast milk substitutes. In particular, it ensures the International Code is interpreted for New Zealand's specific situation and is communicated effectively to the New Zealand health sector. For example, the response especially includes consideration of Māori health and reducing inequalities.

A health worker's employer is responsible for implementing the Health Workers' Code in their organisation.

Recommendations from the International Code for formula companies and marketers have not been included in the Health Workers' Code because New Zealand has a voluntary and self-regulated industry code. However, the NZIFMA Code of Practice is referred to where appropriate, and its key principles are outlined, for completeness and because it is important health workers are aware of the NZIFMA Code of Practice.

## Code of Practice for the Marketing of Infant Formula

The NZIFMA Code of Practice (NZIFMA 2007) applies to the marketing of infant formula products suitable for infants up to the age of six months. The NZIFMA developed the code in consultation with the Ministry. It applies to the manufacturers, marketers and distributors of infant formula.

The NZIFMA is responsible for liaising with and educating the industry sector to ensure the NZIFMA Code of Practice is adhered to.

The NZIFMA Code of Practice is not a Ministry of Health or health sector document, so it is not reproduced in this document. However, a copy of the code is provided separately with this document. All health workers and other interested parties are encouraged to be aware of the content of the NZIFMA Code of Practice.

## Code for Advertising of Food

The Advertising Standards Authority is an independent body the advertising industry set up to administer the rules laid down in advertising codes, including the Code for Advertising of Food (ASA 2006) which is available from the Authority's website <http://www.asa.co.nz>

The authority uses the principles of the Code for Advertising of Food and guidelines supplied by the NZIFMA for the marketing of follow-on formula for infants aged over six months to help it to decide on complaints about the advertising of these products.

The principles of the Code for Advertising of Food are as follows.

- The advertising of food will be conducted in a socially responsible manner.
- Advertisements should not by implication, omission, ambiguity or exaggerated claim mislead or deceive, or be likely to mislead or deceive consumers, abuse the trust or exploit the lack of knowledge of consumers, exploit the superstitious, or without justifiable reason play on people's fear.

- Advertisements should not undermine the Government’s Healthy Eating – Healthy Action policy (Ministry of Health 2004b), the Ministry’s Food and Nutrition Guidelines (Ministry of Health 2000), or the health and wellbeing of individuals.
- Advertisements should comply with New Zealand law and the appropriate industry code of ethics (in this case the NZIFMA Code of Practice).

## Food Standards Code

The Government has legislated for the labelling, composition and quality of infant formula and follow-on formula through the Food Standards Code (FSANZ 2002). All infant formula and follow-on formula sold in New Zealand must conform with Standard 2.9.1 of the Food Standards Code for labelling, composition and quality.

You can view the Food Standards Code <http://www.foodstandards.gov.au/thecode/foodstandardscode.cfm>

## Monitoring the Code in New Zealand

The Ministry is responsible for monitoring the implementation of the Health Workers’ Code and the NZIFMA Code of Practice. The Ministry does this by receiving complaints about potential breaches of either Code of Practice. If an issue is not resolved to the complainant’s satisfaction through a natural justice process, it will be submitted to a Compliance Panel for a decision. There is an appeal process, presided over by an adjudicator, for complaints unresolved by the Compliance Panel (See page 21 for how to make a complaint).

The Advertising Standards Complaints Board (ASCB) is responsible for monitoring compliance with the Code for Advertising of Food (see page 22 for how to make a complaint).

The New Zealand Food Safety Authority is responsible for administering and monitoring compliance with the Food Standards Code (see page 22 for how to make a complaint).

# International Code of Marketing of Breast-milk Substitutes

The International Code is included in this document before the New Zealand Health Workers' Code and NZIFMA Code of Practice to signify its position as the foundation for the New Zealand codes.

## Context

In 1981 the World Health Assembly adopted the International Code, which recommended as a basis for action various requirements and restrictions in relation to the marketing and distributing of breast-milk substitutes. The New Zealand Government adopted the International Code in 1983 through a process of consensus and discussion rather than through regulation.

## Key points from the International Code

The 10 key points from the International Code, which apply to products within the scope of the International Code, are as follows.

1. Products should not be advertised or otherwise promoted to the public.
2. Mothers and pregnant women and their families should not be given samples of products.
3. Health care providers should not be given free or subsidised supplies of products and must not promote products.
4. People responsible for marketing products should not try to contact mothers or pregnant women or their families.
5. The labels on products should not use words or pictures, including pictures of infants, to idealise the use of the products.
6. Health workers should not be given gifts.
7. Health workers should not be given samples of products, except for professional evaluation or research at the institution level.
8. Material for health workers should contain only scientific and factual information and must not imply or create a belief that bottle-feeding is equivalent or superior to breastfeeding.
9. All information and educational materials for pregnant women and mothers, including labels, should explain the benefits and superiority of breastfeeding, the social and financial implications of its use, and the health hazards of the unnecessary or improper use of formula.
10. All products should be of a high quality and take account of the climate and storage conditions of the country where they are used.

## Articles of the International Code

### Article 1: Aim of the Code

The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

### Article 2: Scope of the Code

The Code applies to the marketing, and practices related thereto, of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breastmilk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.

### Article 3: Definitions

For the purposes of this Code:

‘Breast-milk substitute’ means any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

‘Complementary food’ means any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called ‘weaning food’ or ‘breast-milk’ supplement.

‘Container’ means any form of packaging of products for sale as a normal retail unit, including wrappers. ‘Distributor’ means a person, corporation or any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this Code. A ‘primary distributor’ is a manufacturer’s sales agent, representative, national distributor or broker.

‘Health care system’ means governmental, non-governmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or childcare institutions. It also includes health workers in private practice. For the purposes of this Code, the health care system does not include pharmacies or other established sales outlets.

‘Health worker’ means a person working in a component of such a health care system, whether professional or non-professional, including voluntary, unpaid workers.

‘Infant formula’ means a breast-milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as ‘home prepared’.

‘Label’ means any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see above) of any products within the scope of this Code.

‘Manufacturer’ means a corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this Code.

‘Marketing’ means product promotion, distribution, selling, advertising, product public relations, and information services.

‘Marketing personnel’ means any persons whose functions involve the marketing of a product or products coming within the scope of this Code.

‘Samples’ means single or small quantities of a product provided without cost.

‘Supplies’ means quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

## Article 4: Information and education

- 4.1 Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.
- 4.2 Informational and educational materials, whether written, audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on the following points:
  - the benefits and superiority of breastfeeding
  - maternal nutrition, and the preparation for and maintenance of breastfeeding
  - the negative effect on breastfeeding of introducing partial bottle feeding
  - the difficulty of reversing the decision not to breastfeed
  - where needed, the proper use of infant formula, whether manufactured industrially or home prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of their use; the health hazards of inappropriate foods or feeding methods; and in particular, the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes. Such materials should not use any pictures or text which may idealise the use of breast-milk substitutes.
- 4.3 Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by governments for this purpose. Such equipment or materials may bear the donating company’s name or logo, but should not refer to a proprietary product that is within the scope of this Code, and should be distributed only through the health care systems.

## Article 5: The general public and mothers

- 5.1 There should be no advertising or other form of promotion to the general public of products within the scope of this Code.
- 5.2 Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.
- 5.3 In conformity with paragraphs one and two of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at lower prices on a long-term basis.
- 5.4 Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.
- 5.5 Marketing personnel, in their business capacity, should not seek direct or indirect contact of any kind with pregnant women or with mothers of infants and young children.

## Article 6: Health care systems

- 6.1 The health authorities in Member States should take appropriate measures to encourage and protect breastfeeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their responsibilities, including the information specified in Article 4.2.
- 6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code does not, however, preclude the dissemination of information to health professionals as provided in Article 7.2.
- 6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products, or for the distribution of material provided by a manufacturer or distributor other than that specified in Article 4.3.
- 6.4 The use by the health care system of ‘professional service representatives’, ‘mothercraft nurses’, or ‘similar personnel’, provided or paid for by manufacturers or distributors should not be permitted.
- 6.5 Feeding with infant formula, whether manufactured or home prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.
- 6.6 Donations or low-price sales to institutions or organisations of supplies of infant formula or other products within the scope of this Code, whether for use in institutions or for distributions outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breast-milk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organisations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.

- 6.7 Where donated supplies of infant formula or other products within the scope of this Code are distributed outside an institution, the institution or organisation should take steps to ensure that supplies can be continued as long as the infant concerned need them. Donors, as well as institutions or organisations concerned, should bear in mind this responsibility.
- 6.8 Equipment and materials, in addition to those referred to in Article 4.3, donated to a health care system may bear a company's name or logo, but should not refer to any proprietary product within the scope of the Code. (WHA resolution 39.28 passed in May 1986, urges member states 'to ensure that the small amounts of breast-milk substitutes needed for the minority of infants who require them in maternity wards and hospitals are made through the normal procurement channels and not through free or subsidised supplies'.)

## Article 7: Health workers

- 7.1 Health workers should encourage and protect breastfeeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under this Code, including the information specified in Article 4.2.
- 7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breastfeeding. It should also include the information specified in Article 4.2.
- 7.3 No financial or material inducements to promote products within the scope of this Code should be offered by manufacturers or distributors to health workers or members of their families, nor should these be accepted by health workers or members of their families.
- 7.4 Samples of infant formula or other products within the scope of this Code, or of equipment or utensils for their preparation or use, should not be provided to health workers except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.
- 7.5 Manufacturers and distributors of products within the scope of this Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to him or on his behalf for fellowships, study tours, research grants, attendance at professional conferences, or the like. Similar disclosures should be made by the recipient.

## Article 8: Persons employed by manufacturers and distributors

- 8.1 In systems of sales incentives for marketing personnel, the volume of sales of products within the scope of this Code, should not be included in the calculation of bonuses, nor should quotas be set specifically for sales of these products. This should not be understood to prevent the payment of bonuses based on the overall sales by a company of other products marketed by it.
- 8.2 Personnel employed in marketing products within the scope of this Code should not, as part of their job responsibilities, perform educational functions in relation to pregnant women or mothers of infants and young children. This should not be understood as

preventing such personnel from being used for other functions by the health care systems at the request and with the written approval of the appropriate authority of the government concerned.

## Article 9: Labelling

- 9.1 Labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breastfeeding.
- 9.2 Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the following points:
  - the words ‘Important Notice’ or their equivalent
  - a statement of the superiority of breastfeeding
  - a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use
  - instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation. Neither the container nor the label should have pictures of infants nor should they have other pictures or text which may idealise the use of infant formula. They may however have graphics for easy identification of the product as a breast-milk substitute and for illustrating methods of preparation. The terms ‘humanised’, ‘maternalised’, or similar terms should not be used. Inserts subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above should apply.
- 9.3 Food products within the scope of this Code, marketed for infant feeding, which do not meet the requirements of an infant formula, but which can be modified to do so, should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.
- 9.4 The label of food products within the scope of this Code should also state all the following points:
  - the ingredients used
  - the composition/analysis of the product
  - the storage conditions required
  - the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

## Article 10: Quality

- 10.1 The quality of the products is an essential element for the protection of the health of infants and therefore should be of a high recognised standard.
- 10.2 Food products within the scope of this Code should, when sold or otherwise distributed, meet the applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and Children.

## Article 11: Implementation and monitoring

- 11.1 Governments should take action to give effect to the principles and aim of the Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, co-operation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.
- 11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organization as provided in paragraphs six and seven of this Article. The manufacturers and distributors of products within the scope of this Code, and appropriate non-governmental organisations, professional groups, and consumer organisations should collaborate with governments to this end.
- 11.3 Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.
- 11.4 Non-governmental organisations, professional groups, institutions and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.
- 11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.
- 11.6 In accordance with Article 62 of the Constitution of the World Health Organization, Member States should communicate annually to the Director-General information on action taken to give effect to the principles and aim of this Code.
- 11.7 The Director-General shall report in even years to the World Health Assembly on the status of the implementation of the Code; and shall on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.



# Code of Practice for Health Workers

## Context

The Code of Practice for Health Workers (Health Workers' Code) is based on the International Code and has been developed by the Ministry of Health after consultation with the health sector. It recommends best practice for health workers only, so does not apply to other groups such as formula companies.

The Health Workers' Code replaces *Infant Feeding Guidelines for New Zealand Health Workers* (Ministry of Health 1997).

Relevant professional bodies and employer organisations are expected to support health workers to uphold the principles and aims of the Health Workers' Code and their responsibilities under it by developing policies and practices and providing ongoing training.

Breastfeeding forms a unique biological and emotional basis for the health of both mother and child and is the best and safest way to feed infants (see Appendix 1). Breast milk is the ideal food for infants, and meets all an infant's nutritional and fluid requirements for up to the first six months of life, and most of the nutritional and fluid requirements from around six months to one year of age.

When breast milk is not available, infants must be given an appropriate infant formula until they are one year old. Infant formula can be used for up to 12 months of age. Unmodified cow's milk is not recommended as the primary drink before the age of one year, because it can lead to anaemia from poor iron absorption and gastrointestinal bleeding. This can be made worse if iron-containing complementary foods are not given from six months of age (Ministry of Health 2000).

For more information about infant nutrition, see *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper* ([www.moh.govt.nz/nutrition](http://www.moh.govt.nz/nutrition)).

## Purpose

The Health Workers' Code has the same aim as the International Code. That is to contribute to the provision of safe and adequate nutrition for infants by:

- protecting and promoting breastfeeding
- ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Specifically, the Health Workers' Code wants health workers to:

- protect, promote and support breastfeeding, giving clear, consistent and accurate information about the importance of breastfeeding and the health consequences of not breastfeeding
- encourage mothers and families before the birth of their infant to make an informed decision on the feeding method they will use

- help mothers and families to prevent and resolve the most common problems that cause mothers to stop breastfeeding
- meet their obligation to give detailed information and advice to parents, caregivers and families of breastfed and formula-fed infants on infant feeding
- ensure the appropriate and safe preparation, usage and storage of formula when necessary
- be aware of the complaints processes (see page 21) for use when they are confronted with potential breaches of the codes.

## Scope

The Health Workers' Code is based on Ministry policy from *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*, and the International Code, and includes all types of formula for infants 0-12 months.<sup>1</sup> Therefore, it differs from the NZIFMA Code of Practice which applies to infant formula only.<sup>2</sup>

Health care providers should develop policies in their organisation on the use of formula, formula samples, gifts from formula companies, product information, and feeding bottles and teats. Policies should include how to promote, protect and support breastfeeding in difficult circumstances, for example, hospitalisation of infant and/or mother or a natural disaster. The policies should be based on *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*, the spirit and intent of the International Code, the Health Workers' Code, the Baby Friendly Hospital Initiative, and the Baby Friendly Community Initiative. Health care providers, including pharmacists, need to be aware of these documents and initiatives and accept responsibility for ensuring staff implement them in the workplace.

Note that the term health worker applies to a person working for a health care provider, including a voluntary, unpaid worker and anyone providing information to pregnant women and mothers. A health practitioner is a subset of this wider group, and is defined as a practitioner of a particular health profession who is registered with, and overseen by an authority, for example, a dietitian, doctor, nurse, pharmacist (see the Glossary for Code of Practice for Health Workers, page 25).

## Articles of the Code of Practice for Health Workers

### 1. Health workers must protect, promote and support breastfeeding.

- 1.1 The Ministry expects health workers to protect, promote and support breastfeeding and be familiar with their responsibilities under the Health Workers' Code, and other Ministry policies and strategies, for example, the Baby Friendly Hospital Initiative, the Baby Friendly Community Initiative and the Well Child Framework.
- 1.2 Health workers play an essential role in guiding feeding practices. They do this by encouraging and facilitating breastfeeding and providing objective and consistent advice to mothers and families about the superior value of breastfeeding.

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1 Includes infant formula and follow-on formula.

2 Follow-on formula is not marketed as a breast milk substitute in New Zealand.

## **2. Health workers should enable mothers to make an informed decision about infant feeding.**

- 2.1 Health workers should give accurate, objective and consistent information and educational material on breastfeeding and formula feeding, and should discuss the benefits and problems associated with the different methods of feeding so parents can make an informed decision.
- 2.2 Health workers should be aware of individual circumstances, and apply best clinical practice for those circumstances to ensure appropriate health care and safe and adequate nutrition for all infants. For example, although virtually all women can breastfeed, some mothers decide not to breastfeed their infants, are unable to breastfeed, or try to breastfeed without success. In some medical situations, establishing breastfeeding is more difficult than others. In such cases specialist lactation services may be required. If the mother is unable to establish breastfeeding, an appropriate infant formula should be provided for the baby or donor milk if available and acceptable to the mother. If used, donor milk must meet the required standards for safe collection and storage.
- 2.3 Antenatally, information on appropriate infant nutrition should always be presented in the context of breastfeeding as the biological norm and as an unparalleled way of feeding an infant. Pregnant women should also be told that if they want to formula feed then information is available. Any instructions in the use of infant formula should be undertaken one to one with the woman concerned and not in a class setting.
- 2.4 Mothers who do not breastfeed their infants should receive the same attention from health workers and the health care system since not breastfeeding is associated with increased risks to the health of infants and mothers.

## **3. Health workers must assist mothers and families to breastfeed.**

- 3.1 Health workers should be knowledgeable about breastfeeding and breastfeeding management, skilled in helping mothers and able to access further information and support as required. Even though it is a natural act, breastfeeding is also a learned behaviour. Virtually all mothers can breastfeed provided they have accurate information and support within their families and communities and from the health care system.
- 3.2 Health workers need to work with women in a way that increases women's confidence in their ability to breastfeed. Health workers must not undermine breastfeeding by creating negative perceptions and behaviour towards breastfeeding.
- 3.3 Health workers should help to prevent or resolve the most common problems that cause mothers to stop breastfeeding.
- 3.4 Health workers should acknowledge the important role of skilled and knowledgeable peer supporters and peer support groups, refer mothers to them and work in collaboration with these groups in the community.
- 3.5 Health workers should, where appropriate, provide mothers with information about sterilising bottles and storing expressed breast milk. Information should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding. Mothers should be informed that there is a cup method of feeding expressed breast milk.

#### **4. Health workers must ensure appropriate use of formula when necessary.**

- 4.1 Only health workers should demonstrate to mothers or family members how to prepare and use formula. Family members who need to use formula require instruction and information on the preparation and safe storage of formula, feeding techniques and types of formula available.
- 4.2 Health workers who cannot provide a family with information about formula feeding must refer the family to another health service provider who can provide the information.
- 4.3 Health workers should strengthen the health and nutrition education of these mothers and their family members in order to foster preparation for the initiation and maintenance of breastfeeding of any future infants born, whatever the previous feeding experience. These mothers should be referred to community-based breastfeeding support groups antenatally for future births.
- 4.4 Health workers should not promote a specific brand of formula, or be involved in the promotion of products used for infant feeding.

#### **5. All information prepared by health workers on formula feeding should explain the benefits of breastfeeding, and the costs and health hazards of the unnecessary or improper use of formula.**

- 5.1 Information and educational materials (whether written, audio or visual) dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on the following points.
  - The benefits and superiority of breastfeeding.
  - Maternal nutrition, and the preparation for and maintenance of breastfeeding.
  - The negative effect on breastfeeding of introducing partial formula feeding.
  - The difficulty of reversing the decision not to breastfeed.
  - Where needed, the proper use of formula. When such material contains information about the use of formula, the information should include the social and financial implications of formula use; the health hazards of inappropriate foods or feeding methods; and, in particular, the health hazards of the unnecessary or improper use of formula.
- 5.2 Information and educational materials should not use pictures or text that may idealise the use of formula.
- 5.3 All materials used to provide information should be objective and consistent with current knowledge.
- 5.4 For a list of information and support providers and resources available nationally, see *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*.

## **6. Health workers must be aware of the key principles in the New Zealand Infant Formula Marketers' Association (NZIFMA) Code of Practice for the Marketing of Infant Formula.**

- 6.1 The key principles are provided on page 19.
- 6.2 A health worker may contact a formula company for scientific and factual product information.
- 6.3 Health workers may meet individually or collectively with formula company representatives to be informed about company products.
- 6.4 For general information on infant feeding, health workers should consult *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*.

## **7. Health workers should not accept samples from formula companies.**

- 7.1 Health workers should not accept samples of formula, equipment or utensils for their preparations or use except when necessary for the purpose of professional evaluation and research at an institutional level. They may be used for educating parents who have decided to use formula, in the correct preparation of formula, while not promoting a specific brand of formula (see 4.4).
- 7.2 Health workers should not give samples of formula to pregnant women, mothers of infants, or members of their families.

## **8. Health workers should not accept gifts from formula companies.**

- 8.1 Health workers or members of their family should not accept financial or material inducements to promote products.
- 8.2 Health workers should disclose to the institution to which they are affiliated, any contribution made to him or her on his or her behalf for fellowships, study tours, research grants, attendance at professional conferences or the like. Health workers should ensure that financial support does not create conflict of interest.

## **9. Health care facilities should not promote formula products in their facilities.**

- 9.1 A health care provider environment should not display items provided by companies such as formula, bottles, teats, posters, growth charts, calendars or formula preparation charts.
- 9.2 Health workers may ask for materials such as pamphlets, posters and booklets and equipment from manufacturers and distributors, providing the material is restricted to scientific and factual matters. Such material should not imply or create a belief that bottle feeding is equivalent or superior to breastfeeding.
- 9.3 All infant formula information and educational material prepared by manufacturers and distributors, whether written, audio or visual, must be consistent with the NZIFMA Code of Practice. Such materials may bear the donating company's name or logo, but should not refer to the product brand name, with the exception of product information brochures for health practitioners and advertisements in medical publications, and should be distributed only through (ie, within) the health care system.
- 9.4 Only mothers and families who have decided to use formula may be given information relating to formula products on discharge.

## **10. Formula products should not be donated to health care facilities.**

- 10.1 Health care facilities may purchase formula at wholesale prices in accordance with the principles of the Baby Friendly Hospital Initiative and the Baby Friendly Community Initiative, through the normal procurement channels, and not through free or subsidised supplies.
- 10.2 Organisations and institutions should not accept donated supplies of formula from manufacturers or distributors. In the case of a natural disaster or similar situation donated supplies may be given but only if infants are medically required to be fed or are already fed on formula. The supply must be continued as long as the special circumstances continue and must not be used as a sales inducement.

# Code of Practice for the Marketing of Infant Formula

## Context

The Code of Practice for the Marketing of Infant Formula (NZIFMA Code of Practice) was developed by the New Zealand Infant Formula Marketers' Association and applies to manufacturers, marketers and distributors of infant formula covered by the NZIFMA, so they can:

- take steps to ensure their conduct at every level conforms to the NZIFMA Code of Practice
- promote the spirit and intent of the International Code and its proper implementation.

The NZIFMA is responsible for liaising with and educating the industry sector to ensure the NZIFMA Code of Practice is adhered to.

The NZIFMA Code of Practice (2007) replaces the NZIFMA Code of Practice (1997).

## Key principles of the NZIFMA Code of Practice

The NZIFMA voluntary Code of Marketing Practice applies to the marketing of infant formula products suitable for infants up to the age of six months. Follow-on formula, for infants over six months of age, is excluded from the provisions of the NZIFMA Code of Practice.

The companies represented on the New Zealand Infant Formula Marketers' Association (NZIFMA) have agreed that the following key principles will apply for the marketing of infant formula.

- a) NZIFMA and its member companies encourage and support breastfeeding as the best choice for babies.
- b) NZIFMA companies should not advertise infant formula products directly to consumers.
- c) NZIFMA companies should not initiate direct or indirect contact with pregnant mothers or family members to promote infant formula.
- d) NZIFMA companies should not distribute samples of infant formula to pregnant women, mothers of infants, their families and infant caregivers but may provide samples to the health sector for the purpose of professional evaluation or research.
- e) All infant formula education and information material prepared by NZIFMA companies and circulated through the health sector should be in accordance with the letter and spirit of the NZIFMA Code of Practice.
- f) NZIFMA companies should not give financial or material incentives to health practitioners for the purpose of promoting infant formula.
- g) Infant formula product and usage information published by or under the local control of NZIFMA companies through the electronic media, and accessible to consumers as well as health professionals, should also be in accordance with the letter and spirit of the NZIFMA Code of Practice.
- h) NZIFMA companies will inform retailers of the provisions of the NZIFMA Code of Practice. Retailer advertisements and the in-store promotion of infant formula products should be limited to product names, price and price savings.

## The NZIFMA Code of Practice

For the complete NZIFMA Code of Practice, see the separate attachment to this document or go to the NZIFMA website <http://www.nzifma.org.nz/index.html>. The NZIFMA Code of Practice ISBN is 978-0-473-12468-7.

## NZIFMA follow-on formula marketing guidelines

NZIFMA companies have adopted guidelines for the marketing of follow-on formula. These guidelines have been provided to the Advertising Standards Complaints Board in order to assist it with its decision-making on complaints about follow-on formula advertising.

The guidelines state:

- To avoid any confusion with infant formula, which is a breast milk substitute suitable for infants under six months of age, follow-on formula advertising and informational material prepared by NZIFMA companies should position this product as being suitable for (1) infants already on infant formula when they reach the age of at least six months, and (2) infants of six months of age or over, who are receiving complementary foods, in preference to cows' milk.
- Follow-on formula is marketed in New Zealand as an alternative to cows' milk, not as an alternative to breast milk. This product is not suitable for infants under six months of age.

# Complaints

If you are considering making a complaint about an activity, you need to consider all four codes discussed in this document:

- the Health Workers' Code
- the NZIFMA Code of Practice
- the Code for Advertising of Food
- the Food Standards Code.

To determine which code you consider may have been breached, read the text below.

Complaints about the activities of individuals or groups who are not covered by these codes can also be brought to the Ministry's attention, which can deal with them in conjunction with the relevant organisations.

## How to make a complaint about the practices of a health worker

If you have concerns about the practices of a health worker or an organisation, for example, they are providing inadequate information to mothers about infant feeding or inappropriately distributing samples, then consult the Health Workers' Code to determine which section of the code you consider the activity is in breach of.

Send your complaint to: Complaints under NZ WHO Code  
Population Health Directorate  
Ministry of Health  
PO Box 5013  
Wellington.

The complaints process is summarised in Figure 2.

## How to make a complaint about the marketing of infant formula for infants from birth to six months of age

If you have concerns about NZIFMA companies' marketing, for example, an advertising campaign, the content of infant formula information and educational material appearing in brochures or advertisements, or the distribution of samples, then consult the NZIFMA Code of Practice to determine whether the activity falls within the scope of this code, and which article and clause you consider the activity to be in breach of.

Send your complaint to: Complaints under NZ WHO Code  
Population Health Directorate  
Ministry of Health  
PO Box 5013  
Wellington.

The complaints process is summarised in Figure 2.

## How to make a complaint about the advertising of formula for infants aged over six months

If you have concerns about the advertising of follow-on formula or food for infants aged over six months, you can make a complaint to the Advertising Standards Complaints Board under the Code for Advertising of Food. The board will use the guidelines provided by the NZIFMA (see page 20) when considering complaints about follow-on formula.

For more information on how to make a complaint to the Advertising Standards Complaints Board, contact the:

Advertising Standards Authority

Phone: 0800 234 357

Email: [asa@asa.co.nz](mailto:asa@asa.co.nz)

Website: <http://www.asa.co.nz>

## How to make a complaint about the labelling, composition or quality of formula

If you have concerns about the labelling, composition or quality of formula or other food products, you can make a complaint to the New Zealand Food Safety Authority under the Food Standards Code.

For more information on how to make a complaint to the New Zealand Food Safety Authority, contact the:

New Zealand Food Safety Authority

Phone: 0800 693 721

Email: [nzfsa.govt.nz](mailto:nzfsa.govt.nz)

Website: <http://www.nzfsa.govt.nz>

## Preparing your complaint

When preparing your complaint, state clearly what you consider the activity is in breach of. Provide as much information, evidence and documentation as possible, for example, dates, names, location and photographs.

If you are unsure how to prepare a complaint or have difficulty preparing your complaint, seek assistance from your organisation, an organisation involved in the provision of Well Child services or a community group.

Figure 2: The complaints process

Two examples of the complaints process for non-compliance with the Codes of Practice for Health Workers or NZIFMA in New Zealand

**Complaint about a health worker’s action**

Eg, parents’ request for information on infant formula from a health worker is denied

Ministry acknowledges letter and actions process  
 ↓  
 Ministry writes to health worker seeking comment on the complaint  
 ↓  
 Health worker replies and Ministry notifies complainant of explanation (20 days for process)

**Complaint about marketer’s action**

Eg, unsolicited infant formula product information is distributed to a pregnant woman

Ministry acknowledges letter and actions process  
 ↓  
 Ministry forwards complaint to NZIFMA  
 ↓  
 NZIFMA seeks comment on complaint from marketer  
 ↓  
 Marketer replies and NZIFMA notifies Ministry of explanation (20 days for process). Ministry notifies complainant.

Complaint is lodged with Ministry of Health

Either

Complainant satisfied

Or

Complainant is dissatisfied. Complaint is referred to Compliance Panel to consider

Compliance Panel considers complaint

Complainant notified of outcome

Either

Complainant accepts outcome

Or

Complainant submits new information to chair of Compliance Panel

Chair considers whether decision should be reviewed by adjudicator

Either

Complainant told original decision is final

Or

Adjudicator notified

Adjudicator decides

Complainant and health worker or marketer informed of outcome

Panel may convene three times a year if necessary

## Abbreviations

ASA	Advertising Standards Authority
ASCB	Advertising Standards Complaints Board
FSANZ	Food Standards Australia New Zealand
FSC	Food Standards Code
NZFSA	New Zealand Food Safety Authority
NZIFMA	New Zealand Infant Formula Marketers' Association
UNICEF	United Nations Children's Fund
WHO	World Health Organization

# Glossary for the Code of Practice for Health Workers

Term	Definition
<b>Breast milk substitute</b>	Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose, for example infant formula.
<b>Community worker</b>	A person working with individuals, families, groups and organisations to help and support community development according to their needs.
<b>Complementary food</b>	Any food, whether manufactured or prepared at home, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called weaning food or solids.
<b>Container</b>	Any form of packaging of products for sale as a normal retail unit, including wrappers.
<b>Distributor</b>	A person, corporation or any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this code. A 'primary distributor' is a manufacturer's sales agent, representative, national distributor or broker.
<b>Follow-on formula</b>	A formula product represented either as a breast milk substitute or replacement for infant formula that constitutes the principal liquid source of nourishment in a progressively diversified diet for infants aged six to 12 months (FSANZ 2002).
<b>Formula feeding</b>	Providing infants with a formula product, either exclusively or as a supplement to breastfeeding.
<b>Health care provider</b>	Public, private and non-governmental institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice. It does not include pharmacies or other established sales outlets.
<b>Health practitioner</b>	A practitioner of a particular health profession who is registered with, and overseen by an authority. For example, dietitian, doctor, nurse, pharmacist.
<b>Health worker</b>	A person working in a component of a health care system (provider), including voluntary, unpaid workers and those providing information to pregnant women and mothers.
<b>Infant</b>	A person under the age of 12 months (FSANZ 2002).
<b>Infant formula</b>	An infant formula product represented as a breast milk substitute for infants which satisfies the nutritional requirements of infants aged up to four to six months, and adapted to their physiological characteristics (FSANZ 2002).

Term	Definition
<b>Label</b>	Any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see the definition above) of any products within the scope of this code.
<b>Lead maternity carer (LMC)</b>	<p>A person who provides maternity care, who may be a midwife, general practitioner or specialist obstetrician.</p> <p>The lead maternity carer is responsible for ensuring continuity of care for their client from the time of registration through to four to six weeks following birth when they are required to hand over to a Well Child provider of the woman's choice.</p>
<b>Manufacturer</b>	A corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this code.
<b>Marketing</b>	Product promotion, distribution, selling, advertising, product public relations, and information services.
<b>Marketing personnel</b>	Any persons whose functions involve the marketing of a product or products coming within the scope of this code.
<b>Samples</b>	Single or small quantities of a product provided without cost.
<b>Supplies</b>	Quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

# Appendix 1: Background Information about Breastfeeding

## Benefits of breastfeeding

Breast milk is the ideal food for infants, and meets all the infant's nutritional and fluid requirements for up to the first six months of life, and most of the nutritional and fluid requirements from around six months to one year. Breastfeeding supplies nutrients in a hygienic, cost-effective, balanced and easily absorbed way. It forms a unique biological and emotional basis for the health of both mother and child. The anti-infective properties of breast milk help to protect infants against disease.

Benefits for children include:

- reduced incidence of diarrhoea, respiratory tract and inner-ear infection
- improved cognitive development and visual acuity
- reduced risk of type 2 diabetes, childhood obesity and coeliac disease
- reduced mortality during the first year of life
- long-term benefits of cardiovascular health (Ministry of Health 2004a).

Mothers and families benefit too. Benefits for the mothers include a reduced risk of:

- postpartum haemorrhaging
- breast and ovarian cancer (Ministry of Health 2004a).

For more detailed information on the benefits of breastfeeding see *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*

Breastfeeding contributes positively to five of the 13 population health objectives in the New Zealand Health Strategy (Minister of Health 2000) by:

- improving nutrition
- reducing obesity
- reducing the incidence and impact of cancer
- reducing the incidence and impact of cardiovascular disease
- reducing the incidence and impact of diabetes.

## Breastfeeding rates

We need to increase breastfeeding rates. New Zealand's breastfeeding rates changed very little between 1997 and 2001, with some improvement between 2001 and 2005 (Table 1). However, the rates among Māori and Pacific peoples are still lower than rates among the European/Other group, and the rate for Māori is lower than for Pacific peoples.

**Table 1: New Zealand breastfeeding rates by ethnicity at six weeks, three months and six months, 1997–2006**

	Year	Rate (%)				
		Māori	Pacific	Asian*	Other	All*
<b>Exclusive and full breastfeeding at six weeks</b>	1997	54	54		67	
	1998	56	60		69	
	1999	57	56		69	
	2000	57	57		68	65
	2001	55	57		68	65
	2002	59	61		68	66
	2003	62	62	49	71	67
	2004	60	59	55	71	67
	2005	58	58	58	71	66
	2006	59	57	55	70	66
<b>Exclusive and full breastfeeding at three months</b>	1997	36	41		53	
	1998	40	46		53	51
	1999	40	43		56	
	2000	40	45		56	50
	2001	41	43		56	51
	2002	47	50		58	55
	2003	46	49	49	59	55
	2004	47	49	51	60	56
	2005	45	48	52	60	56
	2006	45	48	53	60	55
<b>Exclusive and full breastfeeding at six months</b>	1997	12	13		19	
	1998	14	17		19	
	1999	13	18		19	
	2000	13	17		20	18
	2001	13	17		21	19
	2002	16	20		25	23
	2003	16	19	20	26	23
	2004	18	20	22	27	24
	2005	18	19	23	28	25
	2006	17	19	25	29	25

\* Complete data not available

Source: Plunket data covering approximately 90 percent of all births

## Definitions

The following are the standard breastfeeding definitions for New Zealand as recommended to the Ministry of Health (Coubrough 1999). These definitions have been used by the Ministry to develop the breastfeeding targets (Ministry of Health 2002).

- Exclusive** The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breast milk, from the breast or expressed, and prescribed medicines have been given from birth.
- Fully** The infant has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.
- Partial** The infant has taken some breast milk and some infant formula or other solid food in the past 48 hours.
- Artificial** The infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

In 2002 the Ministry of Health recommended the following New Zealand breastfeeding targets (Ministry of Health 2002).

- Increase the breastfeeding (exclusive and fully) rate at six weeks to 74 percent by 2005, and 90 percent by 2010.
- Increase the breastfeeding rate (exclusive and fully) at three months to 57 percent by 2005, and 70 percent by 2010.
- Increase the breastfeeding rate (exclusive and fully) at six months to 21 percent by 2005, and 27 percent by 2010.

In 2007, the Ministry restated breastfeeding targets.

- Increase the proportion of infants exclusively and fully breastfed at six weeks to 74 percent or greater, three months to 57 percent or greater, and six months to 27 percent or greater.

## Breastfeeding for Māori

For Māori, breastfeeding is a traditional and valued practice and embodies the importance of nourishment, protection, sustenance and continuity for Māori health. Breastfeeding is viewed as imperative in maintaining and sustaining child development and wellbeing.

The foundation for considering Māori health is laid out in He Korowai Oranga: Māori health Strategy (Minister of Health and Associate Minister of Health 2002). The overall aim of He Korowai Oranga is whānau ora: Māori families supported to achieve their maximum health and wellbeing. Whānau ora recognises the interdependence of people, that health and wellbeing are influenced and affected by the collective as well as the individual, and the importance of working with people in their social contexts, not just their physical symptoms. Whānau ora is a strategic tool to assist in working together with iwi, Māori providers and Māori communities and whānau to increase the life span of Māori, improve their health and quality of life and reduce disparities with other New Zealanders.

*Breastfeeding: A guide to action* (Ministry of Health 2002) calls for the active participation of Māori to improve breastfeeding promotion and support.

Breastfeeding is identified in *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau Implementation Plan: 2004–2010* (HEHA) (Ministry of Health 2004b) as one of the key messages. An outcome specified is that breastfeeding is promoted to New Zealand women and their families, particularly Māori and Pacific women.

Māori have lower rates of breastfeeding than do non-Māori (see Table 1). The lower rates may be due, to some extent, to the inequitable distribution of economic resources in New Zealand, with Māori being concentrated into the lower end of the socioeconomic distribution. However, both socioeconomic position and ethnicity affect health (Ministry of Health 2006).

Consultation during the review of the New Zealand interpretation of the International Code, revealed a lower awareness of the International Code and the New Zealand interpretation among Māori and Pacific health practitioners than among other health practitioners.

## Breastfeeding for Pacific peoples

For Pacific peoples, breastfeeding is a normal, traditional and valued practice. In Pacific societies and among families, Pacific women are used to seeing women breastfeeding as a natural way of life, and breastfeed their infants whenever they need to be fed. Pacific women are motivated to breastfeed because it is seen as best for baby (and recommended by health practitioners), as natural, as building a stronger mother to child bond, and as a link to cultural heritage. Breastfeeding is also felt to be more convenient and less expensive than the alternatives (Butler et al 2004).

Although breastfeeding is not specifically mentioned, child and youth health, and promoting healthy lifestyles and wellbeing are priorities in the Pacific Health and Disability Action Plan (Minister of Health 2002). *Breastfeeding: A guide to action* calls for the active participation of Pacific peoples to improve breastfeeding promotion and support (Ministry of Health 2002).

Breastfeeding is identified in HEHA as one of the key messages. An outcome specified is that breastfeeding is promoted to New Zealand women and their families, particularly Māori and Pacific women.

Despite the strong cultural basis for breastfeeding, Pacific peoples have lower rates of breastfeeding than European/Other (see Table 1). As for Māori, the lower rates may be due, to some extent, to the inequitable distribution of economic resources in New Zealand, with Pacific peoples being concentrated at the lower end of the socioeconomic distribution.

Barriers to continued breastfeeding include a lack of breastfeeding education and support, returning to paid work, and the cost of equipment for expressing. Traditional practices of expressing and discarding colostrum, and taking the baby away to let the mother rest, will affect initiation and duration of breastfeeding (Lusk, et al 2000). Pacific mothers tend to introduce complementary foods earlier than do other population groups (Tuohy 1997). This may be because of the perception that Pacific babies need extra nourishment earlier because they are bigger.

Consultation during the review of the New Zealand interpretation of the International Code revealed a lower awareness of the code among Māori and Pacific health practitioners than among other health professionals.

## Reducing inequalities

In New Zealand, as elsewhere, inequalities in health exist between ethnic groups and socioeconomic groups. These inequalities are not random: in all countries socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and lesser access to high quality health services than their counterparts. In addition indigenous and minority populations tend to have poorer health. The Government has acknowledged that the persistence of these inequalities is unacceptable and has made reducing inequalities a key priority.

Improving breastfeeding rates for Māori and Pacific populations, which are currently lower than non-Māori and non-Pacific populations, represents an area of opportunity to reduce health inequalities. Indeed, given the short-term and long-term health benefits of breast feeding to the infant, mother, and the whānau/family, initiatives aimed at increasing breastfeeding rates among Māori and Pacific populations should continue to be prioritised.

# Appendix 2: Frequently Asked Questions about the International Code of Marketing of Breast-Milk Substitutes

The World Health Organization has prepared answers to frequently asked questions (WHO 2006) about the International Code of Marketing of Breast-Milk Substitutes. These questions and answers are reproduced in this appendix.

## 1. What is the International Code of Marketing of Breast-milk Substitutes?

The Code is a set of recommendations to regulate the marketing of breast-milk substitutes, feeding bottles and teats. The Code was formulated in response to the realisation that poor infant feeding practices were negatively affecting the growth, health and development of children, and were a major cause of mortality in infants and young children. Poor infant feeding practices therefore were a serious obstacle to social and economic development. The 34th session of the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981 as a minimum requirement to protect and promote appropriate infant and young child feeding.

The Code aims to contribute 'to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution' (Article 1).

The Code advocates that babies be breastfed. If babies are not breastfed, for whatever reason, the Code also advocates that they be fed safely on the best available nutritional alternative. Breast-milk substitutes should be available when needed, but not be promoted.

The Code was adopted through a WHA resolution and represents an expression of the collective will of governments to ensure the protection and promotion of optimal feeding for infants and young children.

## 2. What are the current WHO recommendations for feeding infants and young children?

To achieve optimal growth, development and health, WHO recommends that infants should be exclusively breastfed for the first six months of life. Thereafter, to meet their nutritional requirements, infants should receive adequate and safe complementary foods while breastfeeding continues up to two years of age and beyond.

Exclusive breastfeeding from birth is possible for most women who choose to do so. It is recommended for all children except for a few medical conditions, such as maternal medication with radioactive substances (WHO/UNICEF 1993). Exclusive breastfeeding as often and as long as the baby wants results in ample milk production.

### 3. Why is breastfeeding important?

Breastfeeding is unparalleled in providing the ideal food for infants. Breast milk is safe, clean and contains antibodies which help protect the infant against many common childhood illnesses.

The protection, promotion and support of breastfeeding rank among the most effective interventions to improve child survival. It is estimated that high coverage of optimal breastfeeding practices could avert 13 percent of the 10.6 million deaths of children under five years occurring globally every year. Exclusive breastfeeding in the first six months of life is particularly beneficial, and infants who are not breastfed in the first month of life may be as much as 25 times more likely to die than infants who are exclusively breastfed.

Positive effects of breastfeeding on the health of mothers and infants are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, haemophilus influenza, meningitis and urinary tract infection. It also protects against chronic conditions in the child such as allergies, type I diabetes, ulcerative colitis, and Crohn's disease. Breastfeeding promotes child development and is associated with higher IQ scores in low-birth-weight babies. It is also associated with lower risk factors for cardiovascular diseases including high blood pressure (Martin et al, 2005) and obesity (Owen et al, 2005).

Breastfeeding delays early return of fertility in the mother and reduces her risk of postpartum hemorrhage and breast and ovarian cancer.

Interventions to improve breastfeeding practices are cost-effective and rank among those with the highest cost-benefit ratio. The cost per child is low compared to that for curative interventions.

### 4. Does WHO provide guidelines for mothers who are unable to or choose not to breastfeed?

WHO has developed guidelines for feeding very low-birth-weight babies whose nutritional requirements cannot be met by breast milk alone, as well as for counselling working women on how to sustain breastfeeding with the addition of other feeding options, if needed.

Guidance is also available for HIV-positive women who choose not to breastfeed on adequate and safe alternatives. The guidelines, training materials and job aids on HIV and infant feeding provide detailed instructions on how to prepare, administer and safely store breast-milk substitutes, including commercially prepared infant formula as well as home modified animal milks (WHO/UNICEF 2003).

### 5. What products are covered by the Code?

The Code applies to the marketing and related practices of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods; feeding bottles, and teats. It also applies to their quality and availability, and to information concerning their use.

Since the Code covers products that are suitable for use as a partial or total replacement of breast milk, it should be read in conjunction with current global recommendations for

breastfeeding and complementary feeding, such as the Global Strategy for Infant and Young Child Feeding. For example, as the global recommendation is exclusive breastfeeding for six months, any food or drink promoted to be suitable for feeding a baby during this period is a breast-milk substitute, and thus covered by the Code. This would include baby teas, juices and waters. Formulas for infants with special medical or nutritional needs also fall within the scope of the Code.

## 6. Why is the Code important?

The Code is an important part of creating an overall environment that enables mothers to make the best possible feeding choice, based on impartial information and free of commercial influences, and to be fully supported in doing so.

Poor breastfeeding practices are still common, both in developing and developed countries. Only about 39 percent of children globally are exclusively breastfed for four months and a considerably smaller proportion for the full recommended six months. In addition to the risks posed by not having breast milk's protective qualities, breast-milk substitutes and feeding bottles in particular carry a high risk of contamination that can lead to life-threatening infections in young infants. Infant formula is not a sterile product and it may carry germs that can cause fatal illnesses. Artificial feeding is expensive, requires clean water, the ability of the mother or caregiver to read and comply with mixing instructions and a minimum standard of overall household hygiene – factors not readily met in many households in the world.

Improper marketing and promotion of food products that compete with breastfeeding are important factors that often negatively affect the choice and ability of a mother to breastfeed her infant optimally. Given the special vulnerability of infants and the risks involved in inappropriate feeding practices, usual marketing practices are therefore unsuitable for these products.

## 7. What aspects does the Code cover?

The Code sets out detailed provisions with regard to, inter alia:

1. Information and education on infant feeding.
2. Promotion of breast-milk substitutes and related products to the general public and mothers.
3. Promotion of breast-milk substitutes and related products to health workers and in health care settings.
4. Labelling and quality of breast-milk substitutes and related products.
5. Implementation and monitoring of the Code.

## 8. What does the Code say about information and education on infant feeding?

The Code and subsequent relevant WHA resolutions call upon governments to ensure that objective and consistent information is provided on infant and young child feeding, both to families and others involved in infant and young child nutrition.

Informational and educational materials should clearly state the benefits and superiority of breastfeeding, the social as well as financial costs of using infant formula, the health hazards associated with artificial feeding and instructions for the proper use of infant formula.

## 9. What are the limits set by the code on the promotion of breast-milk substitutes to the general public and mothers?

The Code explicitly states that ‘there should be no advertising or other form of promotion to the general public’ and that ‘manufacturers and distributors should not provide ... to pregnant women, mothers or members of their families, samples of products ...’.

Promotion through any type of sales device, including special displays, discount coupons and special sales, is prohibited.

Furthermore, no company personnel should seek direct or indirect contact with, or provide advice to, pregnant women or mothers.

## 10. Does the Code restrict promotional activities to health workers and in health care settings?

The Code and subsequent relevant WHA resolutions call for a total prohibition of any type of promotion of products that fall within their scope in the health services.

Furthermore, donations of free or subsidised supplies of breast-milk substitutes or other products, as well as gifts or personal samples to health workers, are not allowed in any part of the health care system.

Also, information provided by manufacturers and distributors to health professionals regarding products should be restricted to scientific and factual matters.

## 11. What does the code say about labelling and quality of breast-milk substitutes?

No pictures of infants or other pictures idealising the use of breast-milk substitutes are permitted on the labels of the products.

Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with the unnecessary or improper use of infant formula and other breast-milk substitutes.

Unsuitable products for feeding infants, such as sweetened condensed milk, should not be promoted.

## 12. What are the requirements for the implementation of the code?

Governments should act on the Code, taking into consideration subsequent relevant WHA resolutions. They can adopt legislation, regulations or other measures such as national policies or codes.

The Code is a minimum requirement, and therefore governments can adopt additional, possibly more stringent, measures than those set out in the Code and make them legally binding.

### 13. Has the Code been updated since 1981?

No, there is only one version of the Code. However, there have been a number of WHA resolutions adopted since 1981 that refer to the marketing and distribution of breast-milk substitutes.<sup>3</sup> The Code and subsequent WHA resolutions must be considered together in the interpretation and translation into national measures.

### 14. Who should be involved to make implementation of the Code a reality?

While governments have the primary responsibility to take action on the International Code, they can only achieve this with the full co-operation of all concerned stakeholders, including food manufacturers and distributors, health care professionals, non-governmental organisations and consumer organisations. The Global Strategy for Infant and Young Child Feeding (see below) specifies roles and obligations of many actors in the implementation of the Code and in protecting, promoting and supporting breastfeeding more generally.

### 15. Is the implementation of the Code sufficient for the improvement of infant and young child feeding?

No, additional measures are required as stipulated in the Global Strategy for Infant and Young Child Feeding endorsed by WHO Member States in 2002. The Global Strategy includes nine operational targets consistent with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions, the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and the Baby Friendly Hospital Initiative.

In addition to the implementation of the Code, the Global Strategy also calls for actions to:

- ensure that every facility providing maternity services fully practices the ‘Ten steps to successful breastfeeding’
- enact imaginative legislation protecting breastfeeding rights of working women and enforce them
- develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding
- ensure that the health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding for up to two years or beyond; and that they also promote timely, adequate, safe and appropriate complementary feeding from six months onwards
- provide guidance on feeding infants in exceptionally difficult circumstances.

To ensure full implementation of all its components, the Global Strategy calls upon governments to appoint a national co-ordinator with appropriate authority and to constitute an effective broad-based body to lead co-ordinated multi-sectoral implementation of the strategy by all concerned parties.

<sup>3</sup> World Health Assembly Resolutions 33.32, 34.22, 35.26, 37.30, 39.28, 41.11, 43.3, 45.34, 46.7, 47.5, 49.15, 54.2 and 55.25 have further clarified or extended certain provisions of the Code.

## 16. Is the Code consistent with international human rights and other legal instruments and what does this mean in terms of legal obligations?

Today, a wide and increasing range of international human rights standards and norms can be called upon to enhance and protect infant and young child feeding practices, including exclusive breastfeeding, from any disruptive influences.

The *United Nations Convention on the Rights of the Child* (CRC) is the most comprehensive international human rights framework in this regard. Numerous articles of the CRC are supportive of the aim of the Code, particularly the right of children to the highest attainable standard of health, by, inter alia, reducing infant mortality, and promoting breastfeeding. The CRC not only reflects the legal obligations of Governments towards all children and mothers under its jurisdiction, but also provides legal and normative guidance on protecting, promoting and supporting infant and young child feeding.

Countries having ratified the CRC are legally bound by its provisions. In other words, governments can be legally held accountable for action or inaction which hinders the enjoyment of the rights and freedoms set forth in it. Therefore, both national and international mechanisms for monitoring CRC implementation should address the implementation of the Code in their activities.

## 17. What are the requirements for monitoring of national measures?

Resolutions WHA 49.15 and 54.2 call upon governments to ensure proper and effective monitoring and reporting mechanisms and processes for effective implementation of the Code and subsequent relevant WHA resolutions. These should be **transparent, independent, and free from commercial influence** and address labelling, all forms of advertising and commercial promotion across all media. Responsible bodies should be empowered to investigate Code violations, and impose appropriate sanctions according to existing legal systems.

## 18. Who is responsible for monitoring the implementation of the International Code?

Primary responsibility for the implementation and monitoring of the Code lies with governments, acting individually and collectively through the World Health Organization. Other concerned parties, nationally and internationally, should collaborate fully with governments in this endeavour.

In this respect, manufacturers and distributors of products that fall within the scope of the Code are responsible for monitoring their marketing practices, and taking steps to ensure that their conduct fully conforms with the Code.

Similarly, health professionals and health managers have a responsibility to monitor marketing practices and ensure that their institutions or practices fully comply with the provisions set forth in the Code.

Non-governmental organisations, institutions and individuals can draw the attention of manufacturers and distributors to activities which are incompatible with the Code, and inform the government so that action can be taken.

To foster collective action, Member States should report annually to the Director-General of WHO on their action on the recommendations, enabling the Director-General to report in alternate years to the WHA on the status of the implementation of the Code.

## 19. Who is responsible for taking action when violations of the Code are reported by concerned individuals or organisations?

According to the decision of the WHA, governments of Member States decide on the legislation, regulations and/or other suitable measures to give effect to the Code and the subsequent relevant WHA resolutions in their own countries. This means that it is up to individual Member States to decide what, if any, actions they would take in response to a violation of the Code.

## 20. How does the Code apply in the context of HIV?

Global recommendations on infant feeding for HIV-infected mothers are:

- when replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected mothers is recommended
- otherwise, exclusive breastfeeding is recommended for the first few months
- to minimise the risk of HIV transmission, breastfeeding should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including malnutrition and infections other than HIV)
- when HIV-positive mothers choose not to breastfeed from birth or stop breastfeeding later, they should be provided with specific guidance and support for at least the first two years of the child's life to ensure adequate replacement feeding. Programmes should strive to improve conditions that will make replacement feeding safer for HIV-positive mothers and families.

The fact that HIV can be transmitted through breast milk should not undermine efforts to support breastfeeding for most infants, as their health and survival are greatly improved by breastfeeding. At the same time, the Code seeks to ensure the proper and informed use of breast-milk substitutes when these are necessary. The Code and the WHA resolutions therefore:

- recommend that governments regulate the distribution of free or subsidised supplies of breast-milk substitutes to prevent spillover to babies who would benefit from breastfeeding and whose mothers are HIV-negative or unaware of their status
- protect children fed with breast-milk substitutes by ensuring that product labels carry necessary warnings and instructions for safe preparation and use
- ensure that the product is chosen on the basis of independent medical advice.

With the rising prevalence of HIV, governments may consider accepting free or low-cost supplies for distribution to HIV-positive mothers. WHA resolution 47.5, 2.(2), however, urges Member States to ensure that there are no donations of free or subsidised supplies of breast-milk substitutes and other products covered by the Code in any part of the health care system. Instead of accepting donations, national authorities should consider negotiating prices with manufacturers and offer breast-milk substitutes at a subsidized price or free of charge to be used for infants of mothers living with HIV. It is recommended that this be done in a manner that:

- is sustainable
- does not create dependency on donated or low-cost supplies
- does not undermine breastfeeding for the majority of infants

- does not in effect promote breast-milk substitutes to the general public or the health care system
- assures sufficient quantities for as long as individual infants need them.

## 21. How does the Code apply in complex emergencies?

For the majority of infants and young children in emergency situations, the emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding. There will always be a small number of infants who will need to be fed breast-milk substitutes for the long or short term. This may be necessary if their mother is dead or absent; or too ill, malnourished or traumatized to breastfeed until she has recovered, and if no wet-nurse is available. Breast-milk substitutes should be procured and distributed as part of the regular inventory of feeds and medicines, in quantities only as needed. There should be clear criteria for their use and education for caregivers about hygienic and appropriate feeding. When breast-milk substitutes are distributed without control in emergency situations, the result is often a dangerous and unnecessary increase in early cessation of breastfeeding.

## 22. How does the Code apply to medical institutions dealing with infants who have a medical indication not to breastfeed

To be accredited as 'baby-friendly', a hospital is required to avoid all promotion of breast-milk substitutes and related products, bottles and teats, not accept free or low-cost supplies or give out samples of those products. Hence, infant formula needed for infants with medical reasons for its use should be obtained through normal procurement channels.

## Appendix 3: Background Information about Implementation of the International Code in New Zealand

New Zealand adopted the International Code in 1983. A voluntary, self-regulatory implementation and monitoring process was set up in 1997.

The process was set up as voluntary and self-regulatory because the Government directed that the International Code was to be implemented and monitored through consensus and discussion, not through legislation. Article 5 of the International Code specifies that products within the scope of the International Code are not advertised. In New Zealand, it was not possible to legally restrict the advertising of products without contravening the Commerce Act 1986 and the Fair Trading Act 1986. However, the members of the New Zealand Infant Formula Marketers' Association (NZIFMA) accepted the need for a voluntary code of practice of marketing because of the widely accepted benefits of infants receiving breast milk in the first six months of life. The NZIFMA Code of Practice means there should be no marketing of infant formula and no marketing of follow-on formula as a breast milk substitute in New Zealand.

As a government agency the Ministry is required to preserve the principles of fairness, transparency, natural justice and self-regulation. To preserve these principles, the Ministry is required to:

- consult with all parties, including industry, when developing a system that affects their practice or business
- make all processes and documentation available on request to all parties under the Official Information Act 1982
- make the subject of a complaint aware of the complaint against their practice, and allow a right of reply
- allow the behaviour of the subject of a complaint to be regulated by their employer or responsible body.

A review of the voluntary, self-regulatory implementation and monitoring process for the New Zealand interpretation of the International Code began in 2001.

The consultation phase consisted of a public submission process and meetings with Pacific health practitioners, Māori health practitioners and consumer groups. Fifty-nine questionnaires and 14 written submissions were received during the submission process. This represented a considerable amount of work on the part of the submitters who provided comprehensive and researched responses. The Ministry considered the diverse and strong views expressed during the consultation phase of the review. The Ministry became aware that the International Code was not well known in New Zealand and that some misinterpretations existed. For example, the International Code was being misinterpreted to mean health practitioners were not allowed to provide information about formula feeding and this was creating difficulties for families and caregivers who were not breastfeeding.

To find a way forward, the Ministry set up a consensus process where two meetings were held in 2003 and 2004 with representatives from stakeholder groups to assist in the completion of the review. The Ministry considered all the issues raised in the consultation and consensus process, along with its responsibility to protect, promote and support breastfeeding; the legislative context; and its responsibility to preserve the principles of fairness, transparency, natural justice and self-regulation. The Ministry decided to continue with a voluntary, self-regulatory approach to implementing and monitoring the International Code in New Zealand. However, the Ministry acknowledged that attention needs to be paid to raising awareness of the International Code in New Zealand, and to the marketing of follow-on formula.

The review was completed and the review report published in 2004 (Ministry of Health 2004a). The review resulted in 11 actions to refine and strengthen the implementation and monitoring in New Zealand.

The Ministry held a third meeting in 2006 with the stakeholder group to begin the process for implementing the actions in the review.

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