Breastfeeding: A Guide to Action
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Foreword

The foundations for a healthy life are laid in infancy and childhood, and a commitment to the health of our children is a commitment to the health of New Zealanders now and in the future. There is no longer any argument with ‘breast is best’. There is plenty of evidence internationally that breastfeeding contributes positively to infant and also to maternal health, and this evidence confirms that breastfeeding will contribute positively to five of the 13 population health objectives in the New Zealand Health Strategy:

- 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.

The decision to breastfeed is strongly influenced by social norms and by the beliefs and values of women and their significant others. Once the decision to breastfeed is made, the continuity and quality of care received (especially at birth and in the immediate postpartum period) is of vital importance to the establishment and maintenance of breastfeeding. I believe that all of us working in the health and disability sector have a responsibility to further support and promote breastfeeding, especially with Māori and Pacific communities, by actively supporting whānau/families to achieve the six-month breastfeeding target.

This document sets out the Ministry of Health’s plan of action for improving the initiation and maintenance of breastfeeding throughout New Zealand during 2002-03. It is my hope that all relevant parties in the health sector, from policy developers to service providers, will be guided by it.

Hon Annette King
Minister of Health
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Introduction

International leadership

Internationally, the World Health Organization (WHO), the World Health Assembly (WHA), United Nation’s Children’s Fund (UNICEF) and the International Labour Organization (ILO) have shown considerable leadership in developing policies and programmes to protect, promote and support breastfeeding. These have informed the development of policies and programmes in New Zealand.

The key international policies and programmes are:

- Ottawa Charter for Health Promotion (1986)
- Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO 1990)

This year the WHO adopted the World Health Assembly resolution to ‘protect, promote and support exclusive breastfeeding for six months, and to provide safe and appropriate complementary foods, with continued breastfeeding for up to 2 years or beyond’ (WHO 2002). New Zealand has not yet undertaken a policy review to consider this resolution.

Why a health action plan for breastfeeding?

There has been little or no improvement in New Zealand’s breastfeeding rates for the past 10 years, and for Māori and Pacific babies the rate has remained consistently lower.

For New Zealand to support initiation and improve maintenance of breastfeeding throughout the country, and in particular within Māori and Pacific groups, there must be a concerted and co-ordinated approach nationally, regionally and locally to gaining that improvement.

This Action Plan specifies the continued monitoring and strengthening of existing initiatives as part of the Ministry of Health’s work programmes for maternity services and public health services. This needs to be coupled with the provision of consistent, up-to-date breastfeeding information, and a nationwide focus on achieving accredited Baby Friendly Hospitals. In order to achieve Baby Friendly Hospital status a maternity facility must be providing culturally competent services and be focused on improving rates of breastfeeding, especially for Māori and Pacific peoples.
The Baby Friendly Hospitals Initiative has been implemented in more than 15,000 hospitals in 136 countries and has contributed to improving the establishment of exclusive breastfeeding worldwide (BFHI News 2001). A recent audit of a selection of maternity facilities in New Zealand indicates New Zealand hospitals are progressing well toward implementation of the Baby Friendly Hospitals Initiative (Ministry of Health 2001a).

The outcome expected from this Action Plan is an improvement in the breastfeeding rates of Māori and Pacific peoples and the overall increase in the breastfeeding rate of other New Zealanders.
The Action Plan

The seven goals for the Action Plan are:

- to establish a national intersectoral breastfeeding committee
- to achieve Baby Friendly Hospitals throughout New Zealand
- to gain active participation of Māori and Pacific whānau/family to improve breastfeeding promotion, advocacy and support
- to establish nationally consistent breastfeeding reporting and statistics
- to increase breastfeeding promotion, advocacy and co-ordination at both national and local levels
- to ensure pregnant women can access antenatal education
- to ensure high quality and ongoing postpartum care.

The Ministry of Health will lead the action as part of its 2002–03 work programme.

Goals and action points

Goal one

To establish a national intersectoral breastfeeding committee.

Action points

- Begin work on developing a cross-sector national breastfeeding strategy. This will support the government and private sectors to address the wide range of social, employment and other barriers to breastfeeding (as recommended in the Innocenti Declaration).
- Review and modify breastfeeding targets.

Goal two

To achieve Baby Friendly Hospitals throughout New Zealand.

Action points

- Ensure all maternity facilities are working towards implementing the Baby Friendly
Hospital Initiative and have a plan and timeline for attaining accreditation.

- Engage with District Health Boards (DHBs), encouraging inclusion of breastfeeding initiatives in district strategic and annual plans and encourage auditing for the Baby Friendly Hospital Initiative (BFHI).
- Begin development of Baby Friendly Hospital Initiative guidelines that are culturally responsive for primary health care practitioners.
- Support the New Zealand Breastfeeding Authority (NZBA) to co-ordinate nationally training, quality and support for the Baby Friendly Hospitals Initiative.

**Goal three**

To gain the active participation of Māori and Pacific family/whānau to improve breastfeeding promotion, advocacy and support.

**Action points**

- Establish a national breastfeeding campaign specifically tailored for Māori and Pacific family/whānau and communities.
- Undertake an assessment of the Māori and Pacific peoples workforce to establish capacity and capability to provide family/whānau support within the communities.
- Support mainstream services to be culturally responsive in providing appropriate and accessible services to Māori and Pacific family/whānau and communities.

**Goal four**

To establish nationally consistent breastfeeding reporting and statistics.

**Action points**

- Standardise the Ministry of Health’s breastfeeding definitions and reporting requirements in all public health, maternity and well child service specifications.
- Ensure the annual report from the Maternal and New-born Information System includes a section on breastfeeding outcomes.
- Collect breastfeeding data automatically (eg, as part of Child Health Information Strategy) as soon as practicable.
- Encourage education of providers and women to enhance understanding, compliance and accuracy with breastfeeding definitions.
Goal five
To increase breastfeeding promotion, advocacy and co-ordination at both national and local levels.

Action points

- Establish biannual national meetings and quarterly teleconferences between the Ministry, DHBs and providers, including NZBA, in order to gain consistent direction and allow recognition of important breastfeeding and other health strategies.
- Establish breastfeeding advocacy services.
- Reprint culturally appropriate resources.
- Incorporate breastfeeding messages with other health media or marketing strategies as opportunities arise, and include information in other strategies and resources where breastfeeding provides benefits.
- Establish relationships with media and local councils, organisations and facility providers to promote messages in public places that depict breastfeeding as the norm and to prevent the portrayal of pacifiers and bottles.
- Establish relationships with employers, policy makers and others to enable and promote continued breastfeeding when mothers return to work.
- Undertake an international literature review of the effectiveness of social marketing and mass media campaigns. Promote breastfeeding through an annual World Breastfeeding Week.
- Complete the review of the New Zealand interpretation of the WHO Code and implement the recommendations to ensure that it is meeting the primary aim of protecting and promoting breastfeeding along with the provision of safe and adequate nutrition for infants.
- Include breastfeeding information in the Ministry of Health’s consumer information, which all practitioners working under the section 88 Maternity Notice are required to give to women.

Goal six
To ensure pregnant women can access antenatal education.

Action points

- Monitor current programmes for accessibility, especially for Māori and Pacific women and their whānau and families.
- Encourage DHBs to consider pregnancy and parenting education as a core service, and, as funding permits, make further courses available in areas of New Zealand where less than 30 percent of pregnant women have access to courses.
Goal seven

To ensure high quality and ongoing postpartum care.

Action points

- Secondary maternity services, via DHBs, are checked to ensure that they are providing a lactation consultancy service for women requiring specialist breastfeeding advice, and which is responsive to Māori and Pacific peoples.
- Ensure questions on breastfeeding are included in consumer surveys on maternity services.
- Identify those DHBs with poor breastfeeding outcomes and discuss strategies to improve outcomes with DHBs by December 2003.
- Monitor uptake of the new fee for additional midwifery postnatal home visits, allowing support for women who are having difficulty with breastfeeding.
- Monitor breastfeeding outcomes for all lead maternity carers to provide them with comparisons between individual and national outcomes.
- Audit accuracy of breastfeeding data being provided under the Section 88 Maternity Notice of the New Zealand Public Health and Disability Act 2000.
- Encourage lead maternity carers to provide clear leadership in terms of consistency of advice and support for women around breastfeeding during both their hospital stay and immediately following discharge.
- Encourage the transfer to well child services occurs in a planned way and in consultation with the woman, her lead maternity carer, and her choice of well child carer.
- Encourage continuity of care between lead maternity carers and well child care where the woman/infant has additional needs, especially for establishment and continuance of breastfeeding.
- Support DHBs to implement the new framework for delivering well child services over the next two to three years.
How Are We Doing?

New Zealand’s breastfeeding rates

New Zealand’s reported breastfeeding rates compare favourably with the rates of other OECD countries. However, there has been little or no improvement in New Zealand’s rates for the past 10 years, and for Māori and Pacific peoples the rate has remained consistently lower. There are limitations in the New Zealand data due to inconsistencies in definition, age of collection, and the percentage of the population from whom the data is captured.

In the past four years 19–21 percent of European and other babies are reported to be fully breastfeeding at six months. This compares with 17–18 percent for Pacific babies, and for Māori babies this rate decreases to 13–14 percent.

In the past six to eight years there have been a number of initiatives to promote and support breastfeeding in New Zealand, and some of these specifically target Māori. The development of clear and consistent breastfeeding definitions in February 1999 and the incorporation of these definitions into provider reporting requirements from 2003 will improve the quality of breastfeeding data in the future.

Figure 1: Babies with ‘any’ breastfeeding when first seen by Plunket 1922–2001
Figure 1 records ‘any’ breastfeeding when first seen (any time from birth to six weeks). It should be noted that the drop-off from 1997 in Figure 1 above is due to the first visit by the Plunket nurse being later due to midwives visiting longer.

As Table 1 below indicates, there has been no significant change in ‘any’ breastfeeding rates between 1997 and 2001.

Table 1: Breastfeeding rates 6 weeks, 3 months and 4–6 months

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Māori</th>
<th>Pacific</th>
<th>European &amp; Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully breastfed at 5–6 weeks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>65.1%</td>
<td>1997 54%</td>
<td>1997 54%</td>
<td>1997 67%</td>
</tr>
<tr>
<td>2001</td>
<td>65.6%²</td>
<td>1998 56%</td>
<td>1998 60%</td>
<td>1998 69%</td>
</tr>
<tr>
<td>2000</td>
<td>57%</td>
<td>1999 57%</td>
<td>1999 56%</td>
<td>1999 69%</td>
</tr>
<tr>
<td>2001</td>
<td>55%</td>
<td>2000 57%</td>
<td>2000 57%</td>
<td>2000 68%</td>
</tr>
<tr>
<td><strong>Fully breastfed at 3 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>51%¹</td>
<td>1997 36%</td>
<td>1997 41%</td>
<td>1997 53%</td>
</tr>
<tr>
<td>1999</td>
<td>40%</td>
<td>1998 40%</td>
<td>1998 46%</td>
<td>1998 53%</td>
</tr>
<tr>
<td>2000</td>
<td>40%</td>
<td>1999 43%</td>
<td>1999 43%</td>
<td>1999 56%</td>
</tr>
<tr>
<td>2001</td>
<td>41%</td>
<td>2000 45%</td>
<td>2001 43%</td>
<td>2000 56%</td>
</tr>
<tr>
<td><strong>Fully or partially breastfed at 4–6 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>60%¹</td>
<td>1998 53%</td>
<td>1997 56%</td>
<td>1997 60%</td>
</tr>
<tr>
<td>1997</td>
<td>50%</td>
<td>1999 52%</td>
<td>1998 61%</td>
<td>1998 61%</td>
</tr>
<tr>
<td>2000</td>
<td>53%</td>
<td>1999 59%</td>
<td>1999 59%</td>
<td>1999 61%</td>
</tr>
<tr>
<td>2001</td>
<td>52%</td>
<td>2000 59%</td>
<td>2001 60%</td>
<td>2000 61%</td>
</tr>
</tbody>
</table>

Notes:
1. Progress on Health Outcome Targets (1999)
3. Plunket Management Information System (MIS)

Between 1998 and 2001 the data in Table 1 above is reflective of live births as follows:

- 5–6 weeks data for Māori reflects 37–43 percent of Māori births; 11–15 weeks, 53–57 percent of Māori births; and 4–6 months, 53–57 percent of Māori births
- 5–6 weeks data for Pacific reflects 71–75 percent of Pacific births; 11–15 weeks, 82–90 percent of Pacific births; and 4–6 months, 82–90 percent of Pacific births
- 5–6 weeks data for European and Other reflects 45–55 percent of European and Other births; 11–15 weeks, 88–91 percent of European and Other births; and 4–6 months, 88–91 percent of European and Other births.
Since 1999 a number of new Māori and Pacific providers have been established and the data in Tables 1 and 2 does not reflect statistics from these service providers at this point in time.

According to the Ministry of Health 2001/02 Indicator Dictionary there are considerable variations in breastfeeding rates within New Zealand both geographically, and for the different ethnic groups at both six weeks and at 11–15 weeks (three months). The drop-off rate is high during the first three months, with 65.1 percent fully (includes exclusive) breastfeeding at six weeks and 50.7 percent by three months. As Table 2 below illustrates, the drop-off rate from six weeks to three months is particularly high for Māori.

Table 2: Full breastfeeding rate by DHB, July to December 2001 (Ministry of Health 2001/02)

<table>
<thead>
<tr>
<th>Region</th>
<th>Total 6 wks</th>
<th>11–15 wks</th>
<th>Māori 6 wks</th>
<th>11–15 wks</th>
<th>Pacific 6 wks</th>
<th>11–15 wks</th>
<th>European &amp; Other 6 wks</th>
<th>11–15 wks</th>
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</thead>
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<tr>
<td>Northland</td>
<td>70.22</td>
<td>56.42</td>
<td>63.82</td>
<td>50.48</td>
<td>62.50</td>
<td>_</td>
<td>76.38</td>
<td>61.06</td>
</tr>
<tr>
<td>Waitemata</td>
<td>64.99</td>
<td>49.40</td>
<td>58.31</td>
<td>42.01</td>
<td>56.80</td>
<td>41.14</td>
<td>67.90</td>
<td>52.01</td>
</tr>
<tr>
<td>Auckland</td>
<td>65.44</td>
<td>51.35</td>
<td>57.60</td>
<td>35.90</td>
<td>54.76</td>
<td>40.78</td>
<td>69.79</td>
<td>56.09</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>58.78</td>
<td>43.77</td>
<td>53.14</td>
<td>34.91</td>
<td>61.32</td>
<td>44.16</td>
<td>59.93</td>
<td>47.53</td>
</tr>
<tr>
<td>Waikato</td>
<td>68.50</td>
<td>52.45</td>
<td>54.25</td>
<td>42.14</td>
<td>45.00</td>
<td>48.15</td>
<td>75.78</td>
<td>57.11</td>
</tr>
<tr>
<td>Lakes</td>
<td>72.99</td>
<td>58.69</td>
<td>70.24</td>
<td>48.22</td>
<td>100.00</td>
<td>57.14</td>
<td>73.33</td>
<td>66.19</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>68.06</td>
<td>57.41</td>
<td>63.82</td>
<td>54.09</td>
<td>65.00</td>
<td>56.45</td>
<td>70.16</td>
<td>58.98</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>55.84</td>
<td>44.00</td>
<td>43.75</td>
<td>42.86</td>
<td>_</td>
<td>_</td>
<td>81.48</td>
<td>49.09</td>
</tr>
<tr>
<td>Taranaki</td>
<td>74.07</td>
<td>59.27</td>
<td>68.83</td>
<td>47.83</td>
<td>_</td>
<td>_</td>
<td>75.43</td>
<td>63.72</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>60.49</td>
<td>47.45</td>
<td>52.02</td>
<td>32.73</td>
<td>64.52</td>
<td>63.41</td>
<td>64.19</td>
<td>53.66</td>
</tr>
<tr>
<td>Whanganui</td>
<td>66.12</td>
<td>46.18</td>
<td>69.23</td>
<td>42.06</td>
<td>_</td>
<td>63.64</td>
<td>64.63</td>
<td>47.30</td>
</tr>
<tr>
<td>MidCentral</td>
<td>63.59</td>
<td>51.97</td>
<td>58.87</td>
<td>42.26</td>
<td>47.83</td>
<td>46.15</td>
<td>65.75</td>
<td>54.74</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>76.57</td>
<td>56.85</td>
<td>70.06</td>
<td>40.00</td>
<td>67.74</td>
<td>43.10</td>
<td>79.03</td>
<td>61.92</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>62.44</td>
<td>46.67</td>
<td>59.79</td>
<td>37.44</td>
<td>53.76</td>
<td>41.30</td>
<td>64.62</td>
<td>50.48</td>
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<td>Wairarapa</td>
<td>58.87</td>
<td>36.45</td>
<td>55.77</td>
<td>31.25</td>
<td>75.00</td>
<td>_</td>
<td>59.06</td>
<td>39.73</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>69.88</td>
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<td>66.67</td>
<td>52.70</td>
<td>100.00</td>
<td>85.71</td>
<td>69.92</td>
<td>62.27</td>
</tr>
<tr>
<td>West Coast</td>
<td>53.85</td>
<td>47.83</td>
<td>46.43</td>
<td>56.00</td>
<td>_</td>
<td>_</td>
<td>56.76</td>
<td>45.54</td>
</tr>
<tr>
<td>Canterbury</td>
<td>67.54</td>
<td>53.76</td>
<td>66.14</td>
<td>45.00</td>
<td>69.51</td>
<td>58.18</td>
<td>67.64</td>
<td>54.53</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>68.67</td>
<td>57.09</td>
<td>70.00</td>
<td>45.00</td>
<td>_</td>
<td>_</td>
<td>68.58</td>
<td>58.16</td>
</tr>
<tr>
<td>Otago</td>
<td>60.40</td>
<td>52.88</td>
<td>56.25</td>
<td>43.33</td>
<td>69.23</td>
<td>61.29</td>
<td>60.45</td>
<td>53.32</td>
</tr>
<tr>
<td>Southland</td>
<td>62.11</td>
<td>43.10</td>
<td>58.91</td>
<td>31.82</td>
<td>41.18</td>
<td>_</td>
<td>63.33</td>
<td>46.01</td>
</tr>
<tr>
<td>New Zealand</td>
<td>65.63</td>
<td>50.98</td>
<td>59.50</td>
<td>41.57</td>
<td>59.52</td>
<td>44.29</td>
<td>68.26</td>
<td>54.72</td>
</tr>
</tbody>
</table>

Notes:
1. Data is for the 2001/02 financial year.
2. Rates in bold indicate the DHB rate is significantly less than the overall rate (99% confidence interval).
3. Underscore (_) indicates the number of babies breastfed at less than five
4. Data is aggregated by provider location.
Definitions and targets

In 1999 the Ministry of Health adopted the following standard breastfeeding definitions for New Zealand (Coubrough 1999).

Definitions

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. (This matches the WHO exclusive rate indicator.)

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.

Recommended data collection times:

Initiation:  48 hours following birth #
            2 weeks

Established breastfeeding:  6 weeks
                           3 months #
                           6 months #

Continued breastfeeding:  12 months #
                          2 years

# The priority collection points.

Targets

In 2002 the Ministry of Health recommended the New Zealand breastfeeding targets as outlined below:

• to increase the breastfeeding (exclusive and fully) rate at 6 weeks to 74 percent by 2005, and 90 percent by 2010

• to increase the breastfeeding rate (exclusive and fully) at 3 months to 57 percent by 2005, and 70 percent by 2010

• to increase breastfeeding rate (exclusive and fully) at 6 months to 21 percent by 2005, and 27 percent by 2010.

1 Prescribed as per the Medicines Act 1981
What Are the Barriers to Success?

For the purpose of this report the known barriers to breastfeeding have been grouped into:

- societal and environmental factors
- continuity and quality of care.

Societal and environmental factors

Societal norms, and the values and beliefs of women

There are many norms and beliefs that influence women in their choice of feeding methods, just as there are many factors that determine the duration of breastfeeding. Of interest is the fact that research shows that women have made their feeding choice early in their pregnancy or some time before conception (Lennan 1997). This research suggests that breastfeeding promotion needs to occur before women become pregnant and certainly early in the antenatal period.

Paternal or partner attitudes

One of the key influences of a woman’s choice of infant feeding method is the attitude of the father or partner to breastfeeding. A recent Australian study by Scott et al (1997) showed that women whose partners expressed a definite preference for breastfeeding were 10 times more likely to initiate breastfeeding than those whose partners either preferred bottle-feeding or were unsure about breastfeeding.

The bottle-feeding culture

This is when bottle-feeding is seen as the norm, or when breastfeeding is viewed as acceptable for a short period postnatally, and beyond this bottle-feeding is normal and continuing to breastfeed can be viewed as unusual or indulgent. In the past, maternity hospitals have reinforced this culture by making bottles available in wards, and by the eagerness with which some staff both recommend a bottle and bottle-feed babies in hospitals ‘so as not to wake the mother’.

The prevalence of marketing infant formula and the limited breastfeeding promotion in New Zealand also contribute to a normalisation of a bottle-feeding culture.
Socioeconomic status and educational attainment

Breastfeeding, like many health-related behaviours and health outcomes, is socially patterned: women with lower educational attainment and socioeconomic status breastfeed for shorter periods of time than women with higher educational attainment and socioeconomic status. In addition, Māori and Pacific women have lower breastfeeding rates than other women.

The lower Māori and Pacific breastfeeding rates are likely to be due, to some extent, to the inequitable distribution of economic resources in New Zealand, with Māori and Pacific peoples being concentrated into the lower end of the socioeconomic distribution. Māori at all levels of socioeconomic status have poorer health status than non-Māori. The same is true for Pacific peoples. Howden-Chapman and Tobias (2000) suggest that there are other characteristics of New Zealand society that cause poor health for Māori and Pacific peoples. These characteristics are thought to include racism and, for Māori, the ongoing effects of colonisation.

Returning to work and lack of workplace support

One of the main reasons women give for not starting breastfeeding or breastfeeding for only a short time is the need to return to work (Lennan 1997).

Auerbach (1990) suggests that breastfeeding and employment are often viewed as mutually exclusive activities. However, with the right help and support women can effectively breastfeed and work. Those women who most successfully combine breastfeeding with outside employment responsibilities are those who take leave for as long as possible and initially return to work on a part-time basis.

Galtry (1995), using information from the Ministry of Women’s Affairs, states that mothers most likely to resume paid employment in the early postpartum period appear to form two distinct groups: those who return to work for their careers, and those who return for economic reasons. The second group often has less control and flexibility in the workplace and less negotiating power in terms of gaining appropriate employment conditions to facilitate continued breastfeeding. Māori and Pacific women are most likely to be concentrated in the second group.

Unavailable or inappropriate community facilities

Unsuitable public facilities in city or town centres or shopping malls are another barrier for women wanting to breastfeed. Many women feel uncomfortable breastfeeding in public.

A significant issue in New Zealand is that facilities, where they do exist, are often co-located with toilets. This situation makes it difficult for all women to feel comfortable about breastfeeding, particularly Māori women, as this breaches concepts of tapu and noa.
Continuity and quality of care

Barriers during the antenatal and birth period

- **Limited or no antenatal education**
  Mothers who do not attend antenatal classes are less likely to breastfeed (Clements et al 1997).

- **Maternal age**
  Young maternal age (under 20 years) and not being married were factors found to be associated with a lower rate of breastfeeding at four weeks after birth (Ford 1994).

- **Low birth weight and multiple births**
  Twins, babies born under 2500g, and babies admitted to a neonatal unit are less likely to be breastfed at four weeks (Ford 1994).

Barriers during the postnatal period

- **Poor initiation of breastfeeding**
  Successful initiation of breastfeeding is associated with a longer duration of breastfeeding. To initiate breastfeeding successfully infants should be allowed to breastfeed within an hour of birth when both their reflexes and their mother’s sensitivity to tactile stimuli of the areola and nipple are strongest (Akre 1990).

- **Perceived inadequate breast milk supply**
  Whilst many mothers start breastfeeding, the breastfeeding rate declines significantly with time after birth. In the study by Essex et al (1995) the range of reasons why women stop breastfeeding is similar to those found in other studies both in New Zealand and overseas, and that perceived inadequate supply of breast milk is the most common reason women gave for stopping breastfeeding at all ages in the first six months.

- **Poor suckling/attachment**
  The study by Essex et al (1995) also found that the reasons change in relation to the time postpartum. In the first week postpartum breast problems such as sore nipples, sucking difficulties and difficulties in attachment were the main reasons for stopping breastfeeding. The study concluded that with maternal support and breastfeeding education these were potentially preventable.

- **Pacifiers**
  In a study of 1500 New Zealand infants, Ford et al (1994) found that not exclusively breastfeeding at time of discharge from hospital was associated with subsequent pacifier use.
Daily use of a pacifier in the first month has been shown to shorten significantly the period of breastfeeding. The use of pacifiers can prevent the continuation of breastfeeding by reducing breast milk supply through reduced demand for breast milk (Vogel 1999).

- **Infant formula**

  Infants who received infant formula at any time in the first month, irrespective of quantity, are more than three times more likely to cease breastfeeding early.

  The use of a bottle in the first month, whether it contained water, formula or breast milk, is associated with more than doubling the probability of early cessation of breastfeeding (Vogel 1999).

- **Early weaning and introduction of solids**

  Lack of support will often lead to early weaning. This is particularly so when maternal employment is added to the equation.

  A nutritionally adequate weaning diet is essential for achieving optimal growth and brain development in the first year. Up to half the infants in New Zealand are probably being started on solids earlier than recommended (Ford et al 1995). A study by Plunket found Māori and Pacific peoples are more likely than Europeans to introduce solids before 26 weeks (Tuohy et al 1997).

- **Maternal smoking**

  Maternal smoking has been linked to early weaning, lowered milk production and inhibition of the milk ejection (let-down) reflex.

  The results of the 1996/97 New Zealand Health Survey showed that around one-quarter of all New Zealanders were current smokers: 26.4 percent of men, and 23.5 percent of women. Smoking prevalence was strongly related to socioeconomic status, whether measured in terms of family income, educational status or NZDep96 score. In all cases people from lower socioeconomic groups were more likely to be smokers (Ministry of Health 1999).

**Quality of hospital environment**

In all recent surveys, aspects of hospital facilities and care were the most common areas of concern for women.

Despite an overall 70 percent satisfaction level with hospital care, the National Health Committee (NHC) postal survey (1999) revealed 19.5 percent were not satisfied with their hospital care. The most common suggestion for improvement was about human resources at the facility in terms of staffing levels and nursing care. Both the maternity facility and the lead maternity carer are responsible for services provided while in hospital.
Thirty-four percent of women in the Health Funding Authority (HFA) survey of maternity services (1999) felt there were times a health professional was too busy to attend to their needs. Twenty-four percent of women did not feel adequately informed about what kind of breastfeeding help and advice would be available (NHC Review 1999).

**Early discharge from hospital**

Shorter postnatal hospital stays have constituted a major change in maternity care in recent years. Most research from overseas studies reveals that the advantages of planned early discharge far outweigh the disadvantages (Brice 1993).

While none of the studies outlined by Lennan (1997) showed a conclusive link between early discharge and problems with breastfeeding, comments made suggest the planned early discharge is very different from early discharge forced by hospital policy. All studies suggested that timely effective support after discharge is important if breastfeeding is to be effective.

In the HFA survey (1999) two-thirds of the respondents had hospital stays of between two to five days, with 22 percent having a stay of one day or less. Most women (82%) said they were given a choice of how long they would stay (NHC Review 1999).

**Knowledge of, and advice from, health professionals**

While successful breastfeeding is reliant on a number of factors, the provision of information, support and instruction from professionals is important.

In the NHC Survey (1999) 80 percent of women reported they had received helpful advice on breastfeeding, but 30 percent said they had received conflicting advice from different health professionals (NHC 1999).

While a lead maternity carer is responsible for continuity of care, they are not the only health professional caring for women in the initial postpartum period. While in the maternity facility a number of other health professionals provide support and advice to women, which means that conflicting messages can frequently be given, especially in relation to breastfeeding.

The cultural effectiveness of advice also needs consideration, with qualitative research suggesting that many women do not receive culturally effective maternity services (Lusk et al 2000).

Basire et al (1997) found that although women are generally well informed about the benefits of breastfeeding, they often feel pressured to breastfeed, feel guilty about bottle-feeding and, after the birth, find that the information about infant feeding was generally inconsistent, unrealistic and incomplete.
Silos between providers/organisations with an interest in breastfeeding

In recent years there has been a marked increase in the number of providers delivering parallel services during the breastfeeding period and this has resulted in fragmentation of service delivery for the consumer; for example, general practitioners, lead maternity carers, advocates, and well child providers. There is a need for funders, providers and organisations with an interest in breastfeeding to work together on a regular basis in order to gain a consistent approach to protect, support and promote breastfeeding.
What Initiatives Are in Place Now?

Current initiatives funded through the Ministry of Health and District Health Boards to improve breastfeeding have been grouped as:

- societal and environmental factors
- continuity and quality of care.

Societal and environmental factors

For successful initiation of breastfeeding, societal and environmental influences need to be addressed. Strategies within the health sector at present include the establishment of the New Zealand Breastfeeding Authority (NZBA) and the move to implement the Baby Friendly Hospital Initiative, the provision of consistent and up-to-date breastfeeding information to providers and the implementation of breastfeeding advocates in the northern region. The Baby Friendly Hospital Initiative is clearly a large step in the right direction as international evidence is already confirming. Nationally consistent and up-to-date breastfeeding information for providers, women and families is essential and breastfeeding promotion and resources are an ongoing public health priority.

New Zealand Breastfeeding Authority

The NZBA is a coalition of 30 breastfeeding stakeholder organisations, established in 1998 to promote breastfeeding in New Zealand. It includes representatives from hospital maternity managers, midwives, Māori, Pacific, medical groups, lactation consultants, dietitians, Plunket, Parents Centre and La Leche League.

This group has three key roles:

- **Baby Friendly Hospital Initiative**
  NZBA has developed Baby Friendly Hospital Initiative guidelines – *Baby Friendly Hospital Initiative: hospital level implementation for Aotearoa New Zealand* – trained Baby Friendly Hospital Initiative assessors and conducted audits of maternity facilities throughout New Zealand.

- **Co-ordination**
  NZBA is perfectly placed to provide independent advice and to provide the forum for co-ordination of breastfeeding strategies throughout New Zealand.
• Advocacy

NZBA is currently providing national advocacy, and has a small contract to support breastfeeding advocates in the northern region of the North Island.

Baby Friendly Hospital Initiative

The Baby Friendly Hospital Initiative is a joint UNICEF and WHO project launched in 1992 and is aimed at increasing breastfeeding rates and encouraging global breastfeeding standards for maternity services. The project sets out to encourage hospitals and health care facilities – particularly maternity wards – to adopt practices that fully protect, promote and support exclusive breastfeeding from birth.

There is already evidence to suggest that implementation of the ‘10 steps to successful breastfeeding’ of the Baby Friendly Hospital Initiative leads to an increase in breastfeeding rates. According to a survey by UNICEF, UK Baby Friendly Hospital Initiative hospitals increase their breastfeeding rate by more than 10 percent in four years when they receive a Baby Friendly Award.

The Ministry of Health toolkit for DHBs, Improve Nutrition, requires DHBs to ensure that all maternity facilities are promoting breastfeeding, are working towards meeting the criteria for the Baby Friendly Hospital Initiative and to have a plan and timeline for becoming accredited.

New Zealand interpretation of WHO Code of Marketing of Breast-milk Substitutes

In June 1997 the New Zealand interpretation of the WHO Code was released. This is outlined in the Ministry of Health’s publication Infant Feeding: Guidelines for New Zealand Health Workers (1997) and the New Zealand Infant Formula Marketers’ Association (NZIFMA) publication Code of Practice for the Marketing of Infant Formula (1997).

Compliance with the WHO Code is voluntary and monitored through self-regulation. A compliance panel considers complaints that have not been resolved through self-regulation. There is also an independent adjudicator who oversees the appeals process. The Ministry of Health is reviewing the New Zealand interpretation of the WHO Code in 2002/03.

Regional breastfeeding advocates

The Ministry of Health has breastfeeding advocacy contracts in place in Northland and Auckland to promote policies and strategies that support breastfeeding. The focus is on the wider social environment, and activities aim to shift the understanding and norms
around breastfeeding in our society and its institutions. This includes addressing partner and family support for breastfeeding. Advocates work with a wide range of agencies and sectors including the media, councils, employers and health providers.

Well child health promotion

The Ministry of Health has a number of public health contracts throughout New Zealand to promote breastfeeding. These are mainly with Māori and Pacific well child and SIDS providers, and focus on taking consistent health promotion messages to the community and to other well child providers. The contracts are funded through sustainable funding augmented from time to time with one-off funding for special projects.

For Māori, education of the wider whānau is required in order to best support the mother. For the survival and maintenance of whānau wellbeing, promotion strategies must focus on the whānau, and particularly on the benefits that breastfeeding has on the health and wellbeing of the whānau, hapū, and iwi.

Continuity and quality of care

It requires a team effort on the part of both the mother and the infant for breastfeeding to be successful. Initiation and duration of breastfeeding is markedly affected by suckling or attachment problems, use of pacifiers, or use of infant formula. These issues can be further compounded when care is fragmented or when there is conflicting or poor advice from the practitioners delivering the care.

Services have recently been introduced (or are about to be introduced) that target first-time parents and those families who are more likely to be experiencing multiple and persistent problems that increase the risk of poor health outcomes for children. These services are well linked to the lead maternity carer and include antenatal group education, education and information resources, pre- and post-discharge support and well child services. Complementing these services is the ongoing support service provided by La Leche League. It is expected these will make a difference to breastfeeding rates, especially as they are linked with the Baby Friendly Hospital Initiative.

Maternity information for consumers

Getting women registered with a lead maternity carer is the key to a well-managed pregnancy and birth, and to successful breastfeeding. The 0800 telephone helpline, 0800 Mum 2 Be (0800 686 223) provides up-to-date information about lead maternity carer providers throughout New Zealand.
A Maternity Services Information Kit is given to all women when they first access a health professional in relation to their pregnancy. She is given a copy of her maternity care plan, and a copy of her care notes after each module of care so as to encourage the woman’s involvement in her own maternity care.

**Antenatal education**

There are currently at least 52 government-funded providers delivering pregnancy and parenting programmes in nearly 100 locations throughout New Zealand. The goal is for 30 percent of pregnant women (all first-time parents) to be able to access these programmes.

The pregnancy and parenting programmes provide antenatal group education, including breastfeeding, for pregnant women and their family or whānau. The objective of the service is to give pregnant women and their family or whānau the opportunity to acknowledge and enhance their own experience and knowledge, which empowers them to trust themselves and to know how to seek additional maternity information and support when they need it. Each course has a maximum of 12 pregnant women and involves a minimum of 12 education hours. The educators are expected to have recognised qualifications in childbirth education, although they may be midwives, physiotherapists or ‘he kuia whare tapu’.

**Lead maternity carer**

Under Section 88 of the New Zealand Public Health and Disability Act 2000 the Government purchases maternity care from a lead maternity carer, who may be a midwife, general practitioner or specialist obstetrician.

The lead maternity carer is responsible for ensuring continuity of care for their client from 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.

The lead maternity carer takes responsibility for assessing the woman’s needs at time of registration and for planning the care provided throughout her pregnancy and postpartum period, including the management of labour and birth. This includes ensuring good co-ordination of care and referral to support groups, community agencies and other health services as required.

During the pregnancy the lead maternity carer is required to provide individual antenatal education and to inform the woman of the availability of antenatal courses.

Parents can also expect an emphasis on health education (this includes breastfeeding), understanding options for planned parenthood and promoting good health care in pregnancy and following birth. The latter is particularly relevant if there is a risk of adverse
outcomes for the women and/or the babies, for example, postnatal depression, poor parenting, low birthweight babies.

All lead maternity carers are required to support the maternity facility in implementing the Baby Friendly Hospital Initiative.

**National education and information resources**

The Ministry of Health provides ongoing funding for the development, publication and distribution of a wide range of population-based health education resources for the New Zealand public. These resources include the food and nutrition guidelines and pamphlets on nutrition and breastfeeding. The Ministry of Health has also recently published a range of breastfeeding resources in English, Māori, Samoan, Tongan and Chinese.

A catalogue of this material is available electronically on www.healthed.govt.nz and distribution of material is done through a network of authorised providers who are often based in the local Public Health Units of DHBs. All materials are provided free of charge to users.

**Quit smoking/smoking management**

Smoking reduction programmes are available for all pregnant women throughout New Zealand, and the New Zealand College of Midwives is contracted to provide smoking reduction training for midwives nationally.

The Aukati Kai Paipa Programme is a Quit Smoking programme for Māori, and is being offered in approximately 20 locations nationally.

**Length of stay/post-discharge support**

Under the Section 88 Maternity Notice of the New Zealand Public Health and Disability Act 2000 there are contractual requirements for lead maternity carers to discharge women only when they are clinically ready for discharge and able to be managed appropriately in their own home and within the visits allocated for the postpartum period. Establishment of breastfeeding is not a clinical reason in itself to remain in hospital, but the need for more than daily breastfeeding support should be considered a clinical reason to remain in hospital.

There are contractual requirements for lead maternity carers to provide between five and 10 midwifery postnatal home visits in the first six weeks following birth, and more visits if clinically needed. Fewer than five postnatal visits should occur only if a woman declines further visits. Care during this time includes, amongst other things, breastfeeding advice.
and support. A midwife is considered to be competent to assist with standard breastfeeding problems. Some midwives will have further expertise and may also be trained as lactation consultants.

**Whānau Ora Maternity Support**

The Whānau Ora Maternity Support service aims to facilitate access to maternity and other health services for a targeted group of women. It is targeted to women who have high needs during the maternity period and who require a range of health and disability services but who, for various reasons, need assistance in order to access these services.

Whānau Ora Maternity Support services are currently being provided by 23 Māori organisations. These services are delivered by community health workers with cultural competence, networking experience, proven parenting skills, and who role-model a healthy lifestyle. The aim of this service is to link a community health worker with a family during pregnancy and for that worker to support the family through to six weeks postpartum.

**Specialist neonatal and neonatal home-care services**

Specialist neonatal services provide inpatient care for neonates who are born with additional needs or who develop additional needs prior to discharge.

While the baby is in hospital the mother will be receiving lead maternity carer services even if she is staying at the hospital. Both the lead maternity carer and the specialist neonatal service are responsible for supporting breastfeeding.

Neonatal home care provides specialised nursing care for neonates who have additional needs following discharge into the community from a specialist neonatal service.

**Secondary maternity services**

A woman who has complications during her pregnancy and birth experience may be referred to secondary maternity services, either for a consultation or a full transfer of clinical responsibility. Complications include breastfeeding issues that fall outside the usual breastfeeding problems, and which can be dealt with most appropriately in the community setting by the lead maternity carer or well child provider. Where there are complex breastfeeding problems, the secondary maternity service will provide specialist breastfeeding advice to the woman’s lead maternity carer and/or directly to the woman on referral. This specialist advice may be provided by a lactation consultant or midwife with additional expertise in breastfeeding.
La Leche League

The La Leche League is a voluntary organisation that provides breastfeeding support for women throughout New Zealand. Accredited leaders provide breastfeeding support mainly through monthly discussion meetings or by phone.

Plunketline

The Royal New Zealand Plunket Society provides a 24-hour 0800 telephone helpline that provides advice and support for families with infants from birth to five years of age.

Handover to well child and general practice team

A well-managed handover by the lead maternity carer to the woman’s chosen well child provider and the general practice team will positively affect continuity of care and, in particular, breastfeeding management.

A written referral made before discharge from the lead maternity carer, but no later than four weeks postpartum, is designed to ensure this continuity is achieved. Where the baby has unusually high needs the lead maternity carer may request that the well child provider becomes involved as early as two weeks from birth to provide concurrent and co-ordinated care with the lead maternity carer (Section 88, New Zealand Public Health and Disability Act 2000).

Well child services

Well child providers provide a screening, surveillance, education and support service to all New Zealand infants and their families/whānau and which links to, and follows on from, the care provided by the lead maternity carer. Breastfeeding and infant and maternal nutrition is one of their key focuses. There is a minimum of eight core contacts, delivered by a registered nurse or doctor, which every child is entitled to receive in the period from two to four weeks through to five years.

A registered general and obstetric nurse, or a registered comprehensive nurse who has met the competencies for child health/well child approved by the New Zealand Nursing Council is considered competent to assist with standard breastfeeding problems. Some registered nurses will have further expertise and may also be trained as lactation consultants.
Appendix

Ottawa Charter for Health Promotion (1986)

The first formal commitment to health promotion at an international level was made at the First International Conference on Health Promotion held in Ottawa, Canada in 1986. This conference resulted in the Ottawa Charter.

It enshrines the idea of health creation as the cornerstone of the health promotion approach: ‘Health is created where people live, love, work and play’.

The Ottawa Charter defined health promotion as ‘the process of enabling people to increase control over and to improve their health’ and it identified five priority action areas:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient health services.

In the wake of the Charter’s adoption, a new approach to improving and promoting public health was developed: Settings for Health.

Settings for Health emphasises practical networks and projects to create healthy environments such as healthy schools, health-promoting hospitals, healthy workplaces and healthy cities. Settings for Health builds on the premise that there is a health development potential in practically every organisation and/or community.

The health of an organisation or community, the Settings for Health approach argues, is thus much more than the aggregate health of its citizens. The presence of environmental stress can predict the likelihood of people becoming sick, but not which disease they might contract. The appropriate public health response is thus to promote and build the potential for good health before it becomes a question of combating a specific disease or other health problem.

Settings for Health projects have come to have the following elements in common, and which can be fostered through a series of defined strategies:

- policy/strategic objectives
- action at both political and technical levels
- focus on organisational development and institutional change
- building alliances and collaboration between sectors, disciplines and political/executive decision-makers
- community involvement and community empowerment (WHO Fact Sheet 171 1998).
Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO 1990)

The Innocenti Declaration identified four operational targets. By the year 1995, all governments should have:

1. Appointed a national breastfeeding co-ordinator of appropriate authority and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organisations and health professional associations.

2. Ensured that every facility providing maternity services fully practises the Ten Steps to Successful Breastfeeding set out in the joint WHO/UNICEF statement Protecting, promoting and supporting breastfeeding: the special role of maternity services.

3. Taken action to give effect to the principles and aims of all articles of the International Code on the Marketing of Breast Milk Substitutes and subsequent World Health Assembly resolutions in their entirety.

4. Enacted imaginative legislation protecting breastfeeding rights of working women and established means for its enforcement.


Every facility providing maternity services and care for newborn infants should:

1. have a written breastfeeding policy that is routinely communicated to all health care staff

2. train all health care staff in skills necessary to implement this policy

3. inform all pregnant women about the benefits and management of breastfeeding

4. help mothers initiate breastfeeding within a half-hour of birth

5. show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants

6. give newborn infants no food or drink other than breast milk unless medically indicated

7. practice rooming in: allow mothers and infants to remain together 24 hours a day

8. encourage breastfeeding on demand

9. give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants

10. foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.

In 1981 the World Health Assembly adopted the WHO International Code of Marketing of Breast-milk Substitutes. To achieve this it recommended, as a basis for action, various requirements and restrictions in relation to marketing and distributing breast milk substitutes. The New Zealand Minister of Health adopted the Code in its entirety in 1983 through consensus and discussion rather than through legislation.

In June 1997 the New Zealand interpretation of the WHO Code was released. This is outlined in the Ministry of Health’s publication Infant Feeding: Guidelines for New Zealand Health Workers (1997) and the New Zealand Infant Formula Marketers’ Association (NZIFMA) publication Code of Practice for the Marketing of Infant Formula (1997).
References


Health Funding Authority. 1999. *Consumer Perspectives of Maternity Care: Results of the 1999 National Survey*. Wellington: Health Funding Authority.


