

National Strategic Plan of Action for Breastfeeding 2008–2012

**National Breastfeeding Advisory Committee
of New Zealand's advice to the
Director-General of Health**

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Disclaimer

This report reflects the advice and position of the National Breastfeeding Advisory Committee to the Director-General of Health. It does not necessarily reflect the views of the organisations with which the Committee members work, nor the views or policy of the Ministry of Health.

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The Committee would like to acknowledge all those who have contributed to the development of this Plan.

The National Breastfeeding Advisory Committee also acknowledges the work already done by individuals, government and non-government organisations and other agencies to protect, promote and support breastfeeding in New Zealand.

The National Breastfeeding Advisory Committee

The National Breastfeeding Advisory Committee (NBAC) was formed in 2006 with the purpose of providing expert advice and guidance to the Director-General of Health. The formation of a national advisory committee was identified as a goal in *Breastfeeding: A guide to action* (Ministry of Health 2002a).

The NBAC's membership, terms of reference and other information can be found on its webpage at: <http://www.moh.govt.nz/nbac>.

Executive summary

The National Strategic Plan of Action for Breastfeeding (the Plan) is the advice of the National Breastfeeding Advisory Committee to the Director-General of Health. The Ministry of Health asked the Committee to develop a strategic framework with the aim of improving breastfeeding rates in New Zealand.

Breastfeeding has a positive influence on the health status and social wellbeing of the baby, mother, family and community. New Zealand recognises this: the Ministry of Health recommends that infants are exclusively breastfed for their first six months of life.¹ Despite this, and the known risks of not breastfeeding, just 12 percent of New Zealand babies are exclusively breastfed during their first half year of life. Māori and Pacific peoples, low-income families and young mothers have lower breastfeeding rates than other groups. These discrepancies contribute to disparities in health status.

The influences on breastfeeding rates are complex. Measures to improve breastfeeding rates need to involve families, communities, and government and non-government groups and agencies. This Plan is set in the context of existing work and emerging programmes, and establishes the health sector as the leader in the protection, promotion and support of breastfeeding in this country. The Plan also extends to working across other sectors for a comprehensive approach to breastfeeding at local, regional and national levels.

The Plan centres on four key settings:

- government;
- family and community;
- health services; and
- workplace, childcare and early childhood education.

Under each of these settings, the Plan proposes outcomes and objectives that describe what needs to be done. The challenge for agencies, groups and communities is to work to achieve cultural change to support breastfeeding in New Zealand. The Committee view is that all parts of society need to be involved, directly or indirectly, in cultural change to ensure that breastfeeding rates increase within New Zealand.

1. Exclusive breastfeeding means that the infant has only ever received breast milk, with no water, formula or other liquid or solid food. Full breastfeeding means breast-milk only in the last 48 hours. Partial breastfeeding means some breast milk and some formula or other solid food in the last 48 hours. Artificial feeding means no breast milk but alternative liquid, such as formula (with or without solid food) in the last 48 hours. The World Health Organization recommends that in addition to six months' exclusive breastfeeding, babies should be breastfed, with appropriate complementary foods, into their second year and beyond (*Global Strategy for Infant and Young Child Feeding* WHO and UNICEF, 2003).

1. The vision for the National Strategic Plan of Action for Breastfeeding

Aotearoa New Zealand is a country in which breastfeeding is valued, protected, promoted and supported by the whole of society.

The statements on this page set out the achievements that will show that the vision has been realised in New Zealand.

Women and their whānau/family have the information they need to make confident and informed decisions about breastfeeding, and live and work in an environment that enables and supports their decisions. Women and families have access to support to help them gain, practise and pass on knowledge of breastfeeding to family, friends, and successive generations. Communities, along with health and social services, provide accessible, consistent and knowledgeable support to women and families who need it.

Within a society which values, protects, promotes and supports breastfeeding infants are exclusively breastfed for the first six months of life, and thereafter receive safe and adequate complementary foods while breastfeeding continues for up to two years of age or beyond. Breastfeeding rates show a significant improvement across all population groups, and there are no longer any significant differences between the breastfeeding rates of different ethnic, socioeconomic or geographic communities.

There are accessible and appropriate breastfeeding education and support services for all eligible women, fathers/partners, families and whānau from all cultural and ethnic groups, and for migrant communities, low-income families and young mothers.

Government planning, policy and service delivery decisions are thought through with a view to actively protecting, promoting and supporting breastfeeding. This occurs across all relevant government agencies in ways that fully involve and respond to communities. Where it is necessary, legislation actively and explicitly protects, promotes and supports breastfeeding.

1.1 Priority areas for action for the short term: 2008–2010

The Committee has identified a group of issues that need to be addressed in order to make demonstrable progress in improving breastfeeding rates in New Zealand. The priority areas are listed below:

Government

- Objective 1.1(a): The Ministry of Health provides the leadership for breastfeeding strategy and policy.
- Objective 1.2(a): The Ministry of Health continues to strengthen the accuracy and completeness of the existing dataset on breastfeeding.
- Objective 1.3(a): Identification of New Zealand-specific breastfeeding research needs.
- Objective 1.4(b) The Ministry of Health supports a programme of research into marketing of infant formula in New Zealand.

Family and community

- Objective 2.1(b): The Ministry of Health works with District Health Boards (DHBs) to assess and plan for improving access to ante-natal education.
- Objective 2.2(b): Communities work with DHBs and other providers to establish new or support existing peer support programmes for breastfeeding.
- Objective 2.3(a): the second phase of the national breastfeeding social marketing campaign promotes positive attitudes to breastfeeding in the community and public places.

Health services

- Objective 3.1(a): All DHBs achieve and maintain Baby Friendly Hospital accreditation.
- Objective 3.2(b): DHBs are aware of and act on the breastfeeding support needs of their Māori, Pacific and other ethnic communities.

Workplace childcare and early childhood education

- Objective 4.1(a): The Ministry of Health continues to link with other agencies (for example the Families Commission, Department of Labour) to support the development of a policy framework for options for extending current paid parental leave entitlements.

1.2 The need for the National Strategic Plan of Action on Breastfeeding

Breastfeeding is important for the physical, social, emotional and mental health and wellbeing of infants, mothers, fathers/partners and families. There are risks identified with not breastfeeding. The Ministry of Health has recognised in the Health Targets (Minister of Health 2007) the importance of breastfeeding on the health of individuals and communities (for example breastfeeding reduces the risk of sudden infant death syndrome, and potentially reduces the risk of overweight and obesity, and Type 2 diabetes), and now requires DHBs to actively work towards improving breastfeeding rates as one way of improving the health status of communities.

Concern over declining breastfeeding rates is not unique to New Zealand. *The Global Strategy for Infant and Young Child Feeding* (WHO and UNICEF 2003) recommends that infants be breastfed exclusively from birth to six months of age. After that time, appropriate complementary foods (solids) should be introduced and breastfeeding continued up to two years of age or beyond.

Despite Global Strategy targets, only approximately 12 percent of New Zealand babies are exclusively breastfed for six months. In 2005, 80.5 percent of infants born in Baby Friendly Hospitals were exclusively breastfed on discharge.² By six weeks, only about 50 percent of babies were exclusively breastfed, with the rate dropping to less than 40 percent by three months of age. Breastfeeding rates for Māori, Pacific and Asian peoples are significantly lower than those of other New Zealanders. These figures indicate a clear need for action.

Breastfeeding is a human rights issue. A woman has a right to breastfeed and is protected from discrimination for breastfeeding under the Human Rights Act 1993 and international law. Similarly,

2. New Zealand Breastfeeding Authority personal communication.

it is a child's right to be breastfed if that is what his or her mother wishes. Protecting, promoting and supporting this human right will ensure that infants, mothers, fathers/partners, families and communities can experience the benefits of breastfeeding. The Plan's vision and desired outcomes aim to ensure that this human right is able to be given effect in every day life.

Context for the National Strategic Plan of Action for Breastfeeding

The Plan does not occur within a vacuum and the Committee acknowledges the work of those already involved in protecting, promoting and supporting breastfeeding in this country. Currently, most DHB maternity units have now also become Baby Friendly Hospital Initiative (BFHI) accredited, and some also provide specialist support in the form of lactation consultants and clinics. The Baby Friendly Communities Initiative (BFCI) is currently being piloted in New Zealand.

The Healthy Eating–Health Action (HEHA) Strategy (Ministry of Health 2003a) includes a number of programmes designed to promote and support breastfeeding, which specifically work with DHBs to meet local and regional needs, and the Health Targets set by the Ministry of Health. While all this work is valuable, the impact on breastfeeding targets has been limited by the lack of a single breastfeeding strategy and strong, focused leadership.

Leaders, champions and advocates for breastfeeding

Establishing and maintaining a breastfeeding culture in New Zealand will require leadership and advocacy at national, regional and local levels. Leaders and advocates have a key role in ensuring that breastfeeding gets and stays on the agenda for funding, policy and service development in the health sector, and other relevant areas. Advocates have a role in challenging the status quo, identifying and reporting on barriers to breastfeeding, and empowering women, families and communities to get the support they need.

Leaders and advocates raise the profile of issues and encourage individuals and agencies to be better informed, in this case on the importance of protecting, promoting and supporting breastfeeding.

Intersectoral linkages

While the health sector can make a strong impact on improving breastfeeding rates, a coordinated approach is essential if a true breastfeeding culture is to develop. Other sectors, including the Ministries of Education, Social Development and Justice, and the Departments of Labour and Corrections all have an important part to play in promoting and supporting a breastfeeding culture.

The Plan encourages other government and non-government agencies to recognise the influence they can have on breastfeeding. While not all objectives will be relevant to all stakeholders, the Plan assumes that a comprehensive approach will minimise gaps and overlaps, and will be the most effective way to support breastfeeding mothers and babies.

A population approach

The Plan first acknowledges the need for a strategy to improve breastfeeding rates across the whole population, and within that general framework, to develop and implement strategies that improve breastfeeding rates within specific groups with lower breastfeeding rates to ensure equity for all groups. Services need to be tailored to the communities to which they are targeted.

It is important to ensure that monitoring of changes in breastfeeding rates includes tracking inequalities between groups. Improvements in breastfeeding rates should be equally enjoyed by all sectors of the community.

1.3 Implementing the Plan

The Committee's intention is for the Plan to be adopted at a strategic level and provide a reference point for the protection, promotion and support of breastfeeding in New Zealand. At the level of service delivery to mothers, babies and whānau, the Plan will guide the development, implementation and maintenance of programmes consistent with its objectives and outcomes.

1.4 The future of the National Breastfeeding Advisory Committee

The Committee anticipates that as the implementation of the Plan progresses, its role will shift from strategic planning to the provision of expert advice to the Ministry of Health, including advice on progress against the Plan's objectives and outcomes. The Plan will be systematically reviewed and revised by the Committee to ensure its relevance, and to track and report on resulting progress.

1.5 Foundation documents

International guiding documents

The Plan is informed by a well-established international framework provided by:

- the *International Code of Marketing of Breast-milk Substitutes* (WHO 1981) and subsequent relevant World Health Assembly resolutions;
- the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (1990 updated 2005);
- the Baby-Friendly Hospital Initiative and, as implementation progresses, the Baby-Friendly Community Initiative (initiated in 1997);
- International Labour Organization Maternity Protection Convention 183 (2000);
- the WHO/UNICEF *Global Strategy on Infant and Young Child Feeding* (2003);
- United Nations Convention on the Rights of the Child (1990); and
- World Breastfeeding Trends Initiative established by the International Baby Food Action Network (IBFAN)*.

The Plan addresses the five action areas of the Ottawa Charter for Health Promotion:

- promoting healthy public policy;
- developing personal skills;
- reorienting health services;
- strengthening community action; and
- creating supportive environments.

* www.worldbreastfeedingtrends.org

New Zealand guiding documents

- Te Tiriti o Waitangi

Te Uru (participation); Te Tiaki (protection) and Te Mahi Ngatahi (partnership), the three principles of the Treaty of Waitangi, are acknowledged and reflected in the Plan. The Plan recognises that as tāngata whenua and partners to the Treaty, Māori have the right to enjoy a health status that is at least the same as that enjoyed by non-Māori.

Improved breastfeeding rates will make a significant contribution to the reduction of inequalities between the health status of Māori and non-Māori. Breastfeeding benefits tinana (physical health), wairua (spiritual), hinengaro (mental and emotional health), and whānau (health of the family). All these aspects of health are intertwined, and need to be effectively addressed to achieve the vision of this Plan.

Relevant government strategies and work programmes

The Plan recognises and may influence the implementation of the following New Zealand strategies and policies:

- Healthy Eating–Healthy Action (HEHA) Oranga Kai Oranga Pumau (Ministry of Health 2003), in particular DHB breastfeeding action plans facilitated by DHB HEHA Project Managers; delivery of a national breastfeeding social marketing campaign; and maternity and Well Child workforce development initiatives.
- *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper* (2008).
- *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper* (Ministry of Health 2006).
- *Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand* (Ministry of Health 2007).
- *Health Targets 2007* (Minister of Health 2007).
- *Breastfeeding: A Guide to Action* (Ministry of Health 2002a).
- *Child Health Strategy* (Ministry of Health 1998) and the *Well Child Framework* (2002c).
- *Primary Health Care Strategy* (Minister of Health 2001).
- *Achieving Public Health for All People: Whakatutuki te Oranga Hauora Mo Nga Tangata Katoa* (Ministry of Health 2003).
- *He Oranga Korowai: Māori Health Strategy* (Ministry of Health and Associate Minister of Health 2002) and the *Māori Public Health Action Plan* (Ministry of Health 2003).
- *Pacific Health and Disability Action Plan* (Minister of Health 2002).
- *Good Oral Health for All: A strategic vision for oral health in New Zealand* (Ministry of Health 2006).
- *A Guide for Employers: Breastfeeding in the Workplace* (Department of Labour 2007a).
- *New Zealand's Agenda for Children: Making Life Better for Children* (Ministry of Social Development 2000).
- *Baby Friendly Hospital Initiative and Baby Friendly Communities Initiative* (New Zealand Breastfeeding Authority).

National Breastfeeding Advisory Committee literature review

The Plan draws on a literature review, a stock take of the breastfeeding sector in New Zealand, and the expertise of the National Breastfeeding Advisory Committee.

The literature review, entitled *Protecting, Promoting and Supporting Breastfeeding in New Zealand: A review of the context of breastfeeding in this country and of the evidence for successful interventions supporting breastfeeding* is available at www.moh.govt.nz/nbac.

2. The purpose of the National Strategic Plan of Action on Breastfeeding

The Plan is the expert advice of the National Breastfeeding Advisory Committee to the Director-General of Health, focusing on strategies to improve breastfeeding rates in New Zealand.

2.1 Guiding principles

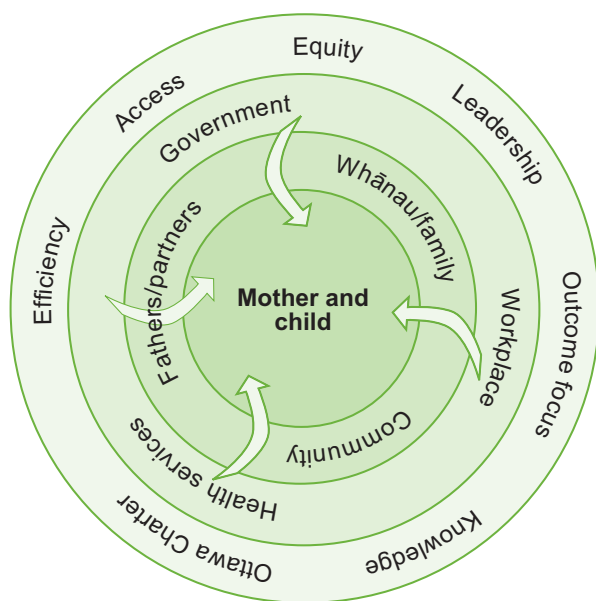
The Committee fully and unequivocally supports the recommendation of the WHO Global Strategy for Infant and Young Child Feeding as a goal for New Zealand:

Infants are exclusively breastfed for the first six months of life, and thereafter receive safe and adequate complementary foods while breastfeeding continues for up to two years of age or beyond.

The Plan is underpinned by nine guiding principles which apply to all outcomes and objectives:

1. The mother–child relationship is central to the Plan.
2. Fathers, partners, family/whānau and the community play an important role in supporting a woman's decision to breastfeed.
3. A focus on outcomes: there will be measurable improvements in the rate and duration of breastfeeding.
4. Equity: improved breastfeeding rates will help reduce inequalities in health status.
5. Access: all members of a community will have access to appropriate information and services that protect, promote and support breastfeeding.
6. Knowledge: data, research, monitoring and evaluation will support New Zealand-specific best practice for breastfeeding.
7. Ottawa Charter: goals and objectives will be consistent with the five action areas of the Ottawa Charter (see 1.5 above).
8. Cooperation and efficiency: there will be communication, collaboration and effective joint planning between and within all agencies with roles and responsibilities that affect breastfeeding.
9. Leadership: there will be clear leadership on breastfeeding protection, promotion and support at local, regional and national levels.

Figure 1: The relationship between the settings and principles, with the mother–child dyad at the centre of all approaches and activities



2.2 Structure of the National Strategic Plan of Action for Breastfeeding

The experience of Committee members, a review of current evidence and the situation in New Zealand, and a review of international documents identified areas and approaches central to effectively supporting mothers, babies, fathers and families/whānau to breastfeed exclusively for six months and continue breastfeeding, with appropriate complementary foods, for two years or beyond.

The Plan focuses on the four identified settings. Under each setting is a list of desired outcomes that directly contribute to the achievement of the vision for the Plan in the short, medium and longer term. The settings are:

1. government;
2. family and community;
3. health services; and
4. workplace, childcare and early childhood education.

Alongside the settings, there are five common approaches that are important for all areas of work on breastfeeding. They are:

- services for Māori and Pacific women and whānau;
- cultural responsiveness;
- education and information;
- training and support; and
- collaboration and communication.

The timeframes for the Plan are:

Short term: 2008–2010
Medium term: 2010–2012
Long term: 2012 onwards

A note on outcomes and objectives

The outcomes: statements of what the Plan is aiming to achieve under each setting. The objectives: statements that identify expected progress within each time period.

Setting one: Government

... the time is right for governments, with the support of international organisations and other concerned parties ... to reconsider how best to ensure the appropriate feeding of infants and young children and to renew their collective commitment to meeting this challenge (WHO 2003).

Government has a role in creating policy, regulation and legislation that protects, promotes and supports breastfeeding through the integration of breastfeeding into all health and development policies (Innocenti Declaration 2005). Effective protection and support of breastfeeding extends beyond the health sector. Evidence (EU 2004b) shows that healthy public policy across all relevant government agencies – not only the health sector – is a characteristic of government in societies with high breastfeeding rates and positive, supportive attitudes toward breastfeeding.

Government is the most influential provider of funding and resources to support breastfeeding in New Zealand, and can give effect to international agreements and conventions on breastfeeding. European Union research indicates that to be effective, all relevant agencies in government must recognise and act on their roles and responsibilities regarding breastfeeding (EU 2004b).

One of the key international documents is the International Code of Marketing of Breast-milk Substitutes (the Code) which sets minimum standards for the protection and promotion of breastfeeding by ensuring the proper use of breast-milk substitutes through appropriate marketing and distribution.

New Zealand is a signatory to the Code, and has taken steps to implement it. There is a New Zealand interpretation of the Code. It was reviewed in 2004 and published by the Ministry of Health in 2007 as The Code in New Zealand (Ministry of Health 2007). The revised document includes a code of practice for healthcare workers, and a code of practice for the marketing of infant formula. There is a new complaints and compliance process that supports the New Zealand Code interpretation.

The Committee's advice is that the New Zealand measures do not meet the minimum standards envisaged by the International Code, particularly regarding marketing of follow-on formula, toddler milk, teats and bottles, and internet marketing. The impacts of the revised New Zealand Code interpretation need to be monitored to determine whether its outcomes will achieve full compliance with the International Code, and are consistent with the recommendations of the Global Strategy.

Table one: Government

Outcomes	Short term objectives	Medium term objectives	Long term objectives
1.1 The Ministry of Health works collaboratively to actively protect, promote and support breastfeeding.	1.1 (a) The Ministry of Health provides the leadership for breastfeeding strategy and policy for the health sector, with a particular emphasis on leading the way for policy support for Māori and Pacific peoples, and other groups with low breastfeeding rates.	1.1 (c) Through the Health Impact Assessment and other available policy processes, the Ministry of Health works with other government agencies to consider the impact on breastfeeding rates as part of policy and programme development.	1.1 (f) Opportunities for intersectoral initiatives to protect, promote and support breastfeeding are identified and put in place using collaborative approaches.
	1.1 (b) The Ministry of Health identifies relevant government agencies that have a role in influencing breastfeeding rates, and engages and informs those agencies using a cross-government forum on breastfeeding.	1.1 (d) Government agencies develop a common base of knowledge about breastfeeding that is widely disseminated and easily accessible. 1.1 (e) The Ministry of Health is established as a leader organisation by becoming a breastfeeding-friendly workplace (see Department of Labour guidelines ³).	1.1 (g) Government agencies work collaboratively to protect, promote, and support breastfeeding as part of policy and strategic development (where relevant). 1.1 (h) Government agencies are baby-friendly employers.

3. Guidelines for employers are provided in the New Zealand Department of Labour’s publication: *Breastfeeding in the Workplace: A guide for employers* (2007), accessed at: <http://www.ers.dol.govt.nz/publications/pdfs/breastfeeding.pdf>.

Outcomes	Short term objectives	Medium term objectives	Long term objectives
1.2 There is an accurate, accessible, comprehensive breastfeeding dataset.	1.2 (a) The Ministry of Health continues to strengthen the accuracy and completeness of the existing dataset on breastfeeding rates.	1.2 (b) The breastfeeding dataset extends to include children up to one year of age.	These long term objectives are for both 1.2 and 1.3: 1.2 (c) Data and research are used to design, monitor and evaluate breastfeeding strategies and programmes at national, regional and local level.
1.3 New Zealand-specific breastfeeding research provides a robust evidence base and body of knowledge about breastfeeding in this country.	1.3 (a) Identification of New Zealand-specific breastfeeding research needs with a focus on breastfeeding in Māori and Pacific communities, and other high need groups (including outcomes, barriers, enabling factors, and experiences).	1.3 (b) A breastfeeding research plan provides a programme to support targeted breastfeeding research.	1.2 (d) New Zealand-specific breastfeeding research is widely disseminated and easily accessible. 1.2 (e) Government and research funders recognise breastfeeding as a priority area for research funding and capacity-building, in particular, research with Māori and Pacific communities and other high needs groups.

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>1.4 The regulatory framework supports breastfeeding.</p>	<p>1.4 (a) Led by the Ministry of Health, work continues to implement the 11 actions resulting from the 2004 review, including a new compliance panel with independent adjudication and transparency around decisions.</p> <p>1.4 (b) The Ministry of Health supports a programme of research into marketing of formula in New Zealand, for example the impact of the marketing of follow-on formula and toddler milks.</p> <p>1.4 (c) The Ministry of Health considers options to support breastfeeding when developing and implementing relevant legislation or regulations (for example non-communicable disease measures in the Public Health Bill). Link to 1.1(c).</p>	<p>1.4 (d) The Ministry monitors and publishes reports on compliance with the New Zealand Code interpretation and the International Code. Reports identify and make recommendations (where required) to strengthen compliance with New Zealand's interpretation of the Code and the International Code. This may include direction on making the International Code mandatory in New Zealand.</p> <p>1.4 (e) Breastfeeding is explicitly considered in development of relevant legislation, regulation or attendant guidelines across government.</p>	<p>1.4 (f) Monitoring shows that the infant formula and infant feeding equipment industries demonstrate consistent compliance with the Code in New Zealand and the International Code (as per the outcomes of 1.4(d)). Link to 1.1(f).</p>

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>1.5 Relevant publicly funded programmes improve breastfeeding rates and duration.</p> <p>Link with objectives under 1.1 to improve government engagement and knowledge on breastfeeding.</p>	<p>1.5 (a) The Ministry of Health links with other agencies (including those outside the health sector) to identify community programmes with an influence on breastfeeding, particularly among Māori and Pacific peoples, and other high need groups.</p> <p>1.5 (b) The Ministry of Health considers the options for and effectiveness of developing multi-objective community health programmes (for example targeting breastfeeding and smoking, or breastfeeding and nutrition) in high needs groups.</p> <p>1.5 (c) The Health Targets provide a focal point for establishing effectiveness of DHB breastfeeding support programmes.</p> <p>1.5 (d) The Ministry of Health establishes a monitoring framework for its breastfeeding promotion work to record impact on rates.</p>	<p>1.5 (e) Using linkages established with other government agencies, the Ministry of Health works with those agencies to establish the effect of such programmes on breastfeeding rates.</p> <p>1.5 (f) The Ministry of Health links with DHBs to monitor and evaluate the effect of their breastfeeding support programmes.</p> <p>1.5 (g) Supported by DHBs, community-based providers work to evaluate the effectiveness of their programmes.</p>	<p>1.5 (h) Agencies and communities share knowledge and information on programmes that have had a significant effect on breastfeeding.</p> <p>1.5 (i) There is a demonstrable link between publicly funded breastfeeding protection, promotion and support programmes and improved breastfeeding rates.</p> <p>1.5 (j) There is an established model for good practice in funding, monitoring and evaluating programmes that protect, promote and support breastfeeding.</p>

Setting two: Family and community

There is good evidence for four general areas that can positively influence breastfeeding:

- making a decision to breastfeed before giving birth;
- fathers/partners supporting breastfeeding;
- mothers being knowledgeable about breastfeeding and confident in their ability to breastfeed; and
- mothers who are informed about common breastfeeding problems and how to avoid and overcome them (Gerrard 2000; McLeod et al 1998; Basire et al 1997).

There are likely to be a number of other specific factors that are important in specific groups within society. Family and community is a broad setting. Many women connect with more than one family group, and most with more than one community. This can include ethnic communities, social groups, women in the workplace and women at home.

Fathers/partners, the family and whānau and the community play an important role in supporting a woman's decision to breastfeed. Within the family and community, barriers to breastfeeding can be categorised as attitudinal, practical, societal, economic, or political. Where barriers to breastfeeding exist, communities and families have a role to play in advocating for and establishing a culture that values breastfeeding as the biological and social norm.

Evidence indicates that effective and appropriate peer support and family links are critical for breastfeeding women, and have a positive influence on breastfeeding rates and duration (DeSouza 2006; NICE 2005; Ellison-Loschmann 1997). Like all services, interventions at whānau and community level need to involve and be tailored for the needs of the target groups. A specific example is women who stay at home with their children, as they face different (and perhaps less visible) barriers to breastfeeding than women who return to work. Other target groups include Māori and Pacific peoples, immigrants, young mothers, low income mothers, rural communities and mothers without support from their whānau/family or community.

There is also evidence that New Zealand have experienced negative reactions to breastfeeding in public.⁴ Fear of or experience of a negative reaction to breastfeeding can dissuade women from breastfeeding (Dignam 1998). As a human rights principle, it is important that women are able to breastfeed where they and their child or children would otherwise be legally permitted to be: in shopping malls, cafes, libraries, theatres, museums, swimming pools, shops, schools, parks, and restaurants.

4. In 2004 Liz Weatherley launched a petition calling for legal protection of women breastfeeding in public after she was asked to stop feeding her child at a preschool. Other instances reported in the media include women being asked to leave cafes, libraries, and swimming pools.

Research in New Zealand indicates that for Māori, having a breastfeeding culture in the whānau, appropriate and accessible professional support and accurate knowledge about breastfeeding are keys to establishing and continuing breastfeeding (Glover et al 2007a). The concept of whānau includes whāngai whānau: the nourishing, care, and/or adoption of a child or children by other members of the whānau. This is one example of a cultural tradition where appropriate and supportive approaches are needed ensure that all families and communities can be involved in improving breastfeeding rates.

The outcomes for this setting will link to the Baby Friendly Communities Initiative (BFCI) led by the New Zealand Breastfeeding Authority. The vision of the BFCI is that breastfeeding is the cultural norm in society and it is based on a plan for the protection, promotion and support of breastfeeding in the community (refer to Appendix One).

Table two: Family and community

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>2.1 Mothers and babies are supported by fathers/ partners, their families/ whānau, and by breastfeeding knowledge that is embedded in their communities.</p>	<p>2.1 (a) The national breastfeeding social marketing campaign supports existing community-developed information where appropriate.</p> <p>2.1 (b) The Ministry of Health works with DHBs to assess and plan for improving access to ante-natal education, with a particular focus on programmes specifically for Māori and Pacific women and whānau, and targeting areas that have limited or no current services.</p> <p>2.1 (c) Based on the results of a stocktake by DHB HEHA coordinators, each DHB develops and distributes a directory of ante- and post-natal breastfeeding services (health service and community-based) in each community.</p>	<p>2.1 (d) The breastfeeding promotion campaign results in improved environmental support for breastfeeding, such as an increase in positive images and stories about breastfeeding in mainstream media.</p> <p>2.1 (e) Knowledge about breastfeeding is improved in relevant agencies and services. Link to 1.1(b), 1.1(d) and 3.1(d).</p> <p>2.1 (f) There is a significant increase in sustainable, community specific pregnancy and parenting education and post-natal support programmes available in targeted geographic areas, for Māori and Pacific families, other ethnic groups, young parents and other high needs groups.</p> <p>2.1 (g) The Ministry of Health links with Ministry of Education to support the inclusion of breastfeeding information into the Health and Physical Activity curriculum. Link with 1.1 (b),(d) and (g).</p>	<p>2.1 (h) All eligible mothers, fathers and families, and high need groups have free, accessible, appropriate and targeted ante-natal education about breastfeeding available to them. Link to 1.5(e) and 1.5(f).</p> <p>2.1 (i) Women report being enabled to make informed choices about infant feeding, including complementary feeding.</p> <p>2.1 (j) There is sustainable funding for ante- and post-natal breastfeeding support services.</p>

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>2.2 Communities have the resources to provide and/or advocate for coordinated, appropriate and accessible breastfeeding support services.</p> <p>Link with objectives under 3.2(d) relating to developing advocacy skills in the health workforce.</p>	<p>2.2 (a) DHBs are encouraged to establish a focal point for breastfeeding support within their communities.</p> <p>2.2 (b) Communities work with DHBs and other providers to establish new or support existing peer support programmes for breastfeeding mothers and babies that are free, targeted, complementary to (and may be linked with) professional services, and include fathers/partners and their family/whānau.</p>	<p>2.2 (c) DHBs use opportunities to link with other local and regional agencies and programmes with a role in protecting, promoting and supporting breastfeeding including the BFCI. Link with 1.1(b) and 1.1(d).</p> <p>2.2 (d) Communities can provide feedback to DHBs on services provided, and on local barriers to breastfeeding (unsuitable facilities, policies banning breastfeeding etc).</p>	<p>2.2 (e) Communities are active participants in advocating for and/or providing breastfeeding support services and programmes, including universal access to formal or informal peer support.</p> <p>2.2 (f) Communities, service providers and other relevant agencies (e.g. local government) have a collaborative approach to protecting, promoting and supporting breastfeeding.</p>
<p>2.3 Communities positively support breastfeeding in public places as the established norm.</p>	<p>2.3 (a) The second phase of the national breastfeeding social marketing campaign effectively promotes positive attitudes to breastfeeding in the community and in public places.</p>	<p>2.3 (b) The Ministry of Health, DHBs and other agencies work with local government New Zealand and private organisations to establish a programme to encourage breastfeeding friendly public places.</p>	<p>2.3 (e) Women report feeling comfortable breastfeeding in public.</p> <p>2.3 (f) Public institutions and private businesses provide a supportive and friendly environment for breastfeeding and include breastfeeding needs in place design.</p>

Setting three: Health services

In order to ensure that women have the opportunity to make fully informed decisions about infant feeding, service providers and other relevant agencies need to protect, promote and support breastfeeding by ensuring that all women, fathers/partners and whānau have access to information (both the benefits of breastfeeding and the risks of artificial feeding) and appropriate breastfeeding support.

The role of the health workforce⁵ is recognised by international and national strategies as central to the protection, promotion and support of breastfeeding (WHO 1981, 2003). The health workforce includes hospital-based services as well as those in the community, including lead maternity carers, general practitioner services, Plunket and other Well Child providers, and other community health workers. All have a role to play in the protection, promotion and support of breastfeeding through their often long-term contact with mothers, fathers/partners and families.

Health and social services need to be coordinated to effectively protect, promote and support breastfeeding among families and the wider community (WHO 1991, 2003). Coordination of services is important if they are to be delivered efficiently and effectively, and gaps and overlaps are to be minimised.

In addition to the provision of community-based services for the majority of women able to breastfeed without complications, specialist services are needed to provide advice and support in more complex cases, for example, hospitalised mothers and/or infants, multiple births, and infants with disabilities.

Internationally donor milk banking is in place. Currently, the need or demand for donor milk in New Zealand is not well documented. WHO recognises donor milk as preferable to artificial infant formula; however further examination of this issue would be useful in the New Zealand-specific context, taking into account the cultural practices of Māori, Pacific and other ethnic groups.

The National Breastfeeding Advisory Committee acknowledges the current significant shortage of skilled practitioners and funded positions in midwifery, lactation support and provision of Well Child Tamariki Ora services. This issue is currently under review by the Ministry of Health.

The Committee recommends the implementation of innovative short-term approaches as the health workforce builds toward full strength, noting that such approaches will build on existing knowledge and expertise, and, if well-supported, will make an ongoing contribution to breastfeeding in the longer term. The Committee recognises that strong, effective community-based breastfeeding support places information and knowledge within families and communities (see Setting two: Family and Community).

5. The Committee defines the health workforce as including midwives, obstetricians, paediatricians, neonatologists, general practitioners, hospital and community-based nurses, lactation consultants and community health workers.

Table three: Health sector

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>3.1 There is a strong, capable workforce with the capacity to actively protect, promote and support breastfeeding.</p>	<p>3.1 (a) DHBs, with the Ministry of Health and other service providers, identify innovative ways to support breastfeeding and breastfeeding education while health workforce shortages exist. Link to 1.5(d), 1.5(e), 2.1(c), and 2.2(b).</p> <p>3.1 (b) DHBs and the Ministry of Health work to support and maintain the current maternity and Well Child workforce.</p>	<p>3.1 (c) There is an agreed baseline workforce capacity (e.g. number of full time equivalents (FTEs)) established for each DHB, linked to the Health Targets for breastfeeding.</p> <p>3.1 (d) There is a collaborative approach between training organisations, government and employers to include education on breastfeeding promotion and support in relevant curricula.</p>	<p>3.1 (e) Health workers in the community, DHBs, Well Child, Primary Health Organisations (PHOs), GPs and other relevant agencies have the education, training, capacity, support and resources to provide consistent, accurate advice and support to breastfeeding women, fathers/partners and families.</p>
<p>3.2 Services that support or influence breastfeeding are high quality and well coordinated.</p>	<p>3.2 (a) All DHBs achieve and maintain Baby Friendly Hospital accreditation.</p> <p>3.2 (b) The Ministry of Health, together with DHBNZ and the sector engage in a process to identify a mechanism to monitor women’s access to responsive, consistent breastfeeding support services within their community.</p> <p>3.2 (c) DHBs, PHOs, GPs and Well Child providers take an active role in the national breastfeeding social marketing campaign.</p>	<p>3.2 (d) Breastfeeding advocacy is readily identifiable and active within DHBs, PHOs, maternity and Well Child services.</p> <p>3.2 (e) Mothers and families with complex breastfeeding needs have access to free specialist lactation consultant services.</p> <p>3.2 (f) DHB policies support breastfeeding mothers who are hospitalised, and mothers with babies in hospital.</p> <p>3.2 (g) DHBs work toward being breastfeeding-friendly employers and facility providers. Link to 1.1(e).</p>	<p>3.2 (h) Regular monitoring indicates that women and families have access to responsive, consistent breastfeeding support services within their community.</p> <p>3.2 (i) Communities are encouraged and resourced to develop innovative approaches to protect, promote and support breastfeeding. These programmes are piloted and evaluated.</p> <p>3.2 (j) DHBs lead their local community in becoming breastfeeding-friendly employers and organisations.</p>

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>3.3 The health workforce is responsive to the breastfeeding support needs of Māori, Pacific and other ethnic communities.</p>	<p>3.3 (a) DHBs are aware of the capacity and capability of the Māori and Pacific people’s health workforce to provide whānau support within their communities.</p> <p>3.3 (b) DHBs are aware of and act on the breastfeeding support and information needs of their Māori, Pacific and other ethnic communities. Link to 2.1(c).</p>	<p>3.3 (c) Health Targets include breastfeeding targets for Māori and Pacific communities. Link to 1.2(a) and 1.2(b): accurate data are required for this objective.</p> <p>3.3 (d) The health workforce supports Māori and Pacific communities to establish and deliver family-centred breastfeeding support services that meet their particular needs.</p> <p>3.3 (e) Māori and Pacific providers and groups that influence breastfeeding (may be outside the health sector), are supported to link with or provide breastfeeding support services.</p> <p>3.3 (f) The Ministry of Health links with Education and DHBs to work toward career and education pathways for Māori and Pacific health workers, peer supporters, and community advocates.</p>	<p>3.3 (g) All women, and specifically Māori and Pacific women, whānau and communities have access to local breastfeeding support services (formal or informal) designed to meet their whānau and community needs, that are coordinated and delivered with a community development focus.</p> <p>3.3 (h) Māori and Pacific breastfeeding rates meet or exceed targets and are at least as high as the national average.</p> <p>3.3 (i) There is a significant increase in the number of Māori and Pacific practitioners working in maternity, Well Child and other parts of the health workforce relevant to breastfeeding.</p>

Setting four: The workplace, childcare and early childhood education

Breastfeeding among employed mothers is influenced by the development and implementation of appropriate labour market legislation; policy and regulations governing workplaces; and by the policies and practices of individual companies, workplaces and childcare facilities.

There is strong evidence that labour policies influence breastfeeding duration. Countries with the longest duration of paid parental leave, coupled with supportive social environments, tend to be those with the highest rates of breastfeeding at six months and beyond (Galtry 2003).

Returning to work, particularly within six months of a baby's birth, has a negative effect on breastfeeding duration, often associated with practical considerations (for example access to the infant, facilities for breastfeeding or expressing (Ferreira-Rea et al 2004)). Breastfeeding women who return to work for economic reasons are less likely to be eligible for either paid parental leave or to be employed in a workplace that values and enables breastfeeding (Galtry 2002; McInernery 2002). Policies and practices are needed to ensure supportive workplace environments for breastfeeding mothers across all employers.

For women who choose to or need to return to work and who wish to continue breastfeeding, childcare and early childhood education policies and practices are also critical. Currently, New Zealand has no national policy or regulation requiring childcare centres or early childhood education providers to support breastfeeding (Farquhar and Galtry 2003).

Mothers of infants who choose to stay at home and/or in the voluntary workforce can be supported by specific income support and labour market policies, so long as these are designed in an appropriate way. Community services can also help support breastfeeding women who are not in the paid workforce (for example those who are active in the voluntary sector). Consideration needs to be given to the types of services which best meet the needs of these women and their families.

Women and families may also use childcare centres or early childhood education for reasons other than returning to work. It is important that all whānau who use childcare or early childhood education facilities have access to providers whose policies and procedures protect and support breastfeeding.

Table four: The workplace, childcare and early childhood education

Outcomes	Short term objectives	Medium term objectives	Long term objectives
<p>4.1 Extended paid parental leave (and/or alternative strategies) contribute to the improve breastfeeding rates and duration for New Zealand mothers and babies.</p>	<p>4.1 (a) The Ministry of Health continues to link with other agencies (e.g. the Families Commission, Department of Labour) to support the development of a policy framework for options for extending current paid parental leave entitlements.</p>	<p>4.1 (b) Policy options for extended paid parental leave (and/ or alternative or additional strategies) are developed and consulted on. Options include consideration of the extension of entitlement to those currently ineligible for paid parental leave.</p>	<p>4.1 (c) The Ministry of Health supports policies which provide for paid parental leave for at least 12 months (or equivalent).</p> <p>4.1 (d) Research shows that paid parental leave supports longer breastfeeding duration in New Zealand.</p>
<p>4.2 Breastfeeding women and their babies are supported by labour market policies, workplace policies, and by tangible support within in the workplace.</p>	<p>4.2 (a) The Ministry of Health links with the Department of Labour and the Families Commission to support awareness of breastfeeding-friendly workplaces within the health sector. Link to 1.1(e) and (h).</p> <p>4.2 (b) The national breastfeeding social marketing campaign messages provide an environmental support framework that includes workplaces.</p>	<p>4.2 (c) The Ministry of Health links with the Ministry of Education to support early childhood education providers to develop policies, workplaces and facilities that are breastfeeding-friendly. Link to 1.1(e).</p> <p>4.2 (d) The Ministry and DHBs develop a working relationship with the Department of Labour to develop and disseminate information to other government agencies on being a breastfeeding-friendly workplace and provide opportunities for shared learning amongst government agencies. Link to 3.2(g).</p>	<p>4.2 (g) The proportion of working mothers who continue to breastfeed is significantly increased, particularly among Māori and Pacific whānau.</p> <p>4.2 (h) Research in New Zealand indicates that the implementation of breastfeeding-friendly policies and facilities are widely used, and support longer breastfeeding duration among women who return to work. Link to 1.3.</p>

Outcomes	Short term objectives	Medium term objectives	Long term objectives
		<p>4.2 (e) The Ministry of Health works with Department of Labour to support employers to be breastfeeding friendly, particularly in workplaces with a high proportion of female and/or Māori and Pacific and temporary employees.</p> <p>4.2 (f) The Ministry of Health provides information to women returning to work on best practice for breastfeeding in the workplace (including expressing and storing milk).</p>	

3. Breastfeeding: a brief background

This section provides a brief overview of the importance of breastfeeding, breastfeeding in New Zealand, and a summary of evidence on what works to protect, promote and support breastfeeding.

For comprehensive information on breastfeeding, please see the National Breastfeeding Advisory Committee's Background report: *Protecting, promoting and supporting breastfeeding in New Zealand*. The report can be found at: www.moh.govt/nbac.

3.1 The importance of breastfeeding

In infancy, no gift is more precious than breastfeeding (WHO 2003)

The protection, promotion and support of breastfeeding are fundamental to achieving optimum health for the nation (Ministry of Health 1997). Breastfeeding is important for the physical health of mothers and infants, and there is strong evidence to show that breastfeeding and appropriate infant feeding contributes to the social and emotional wellbeing of infants, mothers and families (WHO 2003).

The World Health Organization (WHO) recommends that infants be breastfed exclusively⁶ for the first six months of life and continue to be breastfed, along with the introduction of appropriate complementary foods, up to two years of age or beyond.

The WHO hierarchy for infant feeding is as follows:

1. Breastfeeding from the infant's mother;
2. Expressed breast milk from the infant's mother;
3. Breast milk from another woman (donor milk); and
4. Artificial feeding with powdered infant formula (least favoured) (WHO 2003).

There is strong evidence to support this hierarchy. Breastfeeding provides for optimal infant nutrition, social and emotional development. According to the American Academy of Paediatrics (2005), compared with artificially fed infants, breastfed infants have:

- improved resistance against illnesses such as diarrhoea, asthma, respiratory tract infections, and urinary tract infections;
- lower mortality in the first year of life;
- improved mental development and visual acuity;
- decreased risk of developing type 1 and type 2 diabetes, childhood obesity, necrotising enterocolitis in premature infants, and coeliac disease; and
- lower levels of cardiovascular disease in later life.

6. Exclusive breastfeeding means that the infant has only ever received breast milk, with no water, formula or other liquid or solid food. Full breastfeeding means breast milk only in the last 48 hours. Partial breastfeeding means some breast milk and some formula or other solid food in the last 48 hours. Artificial feeding means no breast milk but alternative liquid, such as formula (with or without solid food) in the last 48 hours.

Mothers and babies form an inseparable biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other (WHO 2003). Women who breastfeed experience lower rates of post-partum haemorrhage and, in the longer term, lower rates of breast and ovarian cancer. Breastfeeding is linked with increased maternal sensitivity, responsiveness and bonding with their infants (Britton et al 2006), and with women's and families' social and cultural connectedness (Ellison-Loschmann 1997). The 'naturalness' of breastfeeding and emotional bonding with their infant are some of main reasons women intend to breastfeed (Arora et al 2000).

Breastfeeding is economically beneficial. Artificial feeding is expensive for families, and can contribute to additional costs to the health system, as artificially-fed infants are significantly more likely to be seen in primary care and/or admitted to hospital and to experience health problems in later life (Cattaneo et al 2005; Leon-Cava et al 2002). Breastfeeding is sustainable: it does not involve the use of resources associated with dairy farming or the production, packaging and transport of artificial infant formula; or the production and disposal of bottles, teats and other artificial feeding equipment.

Increasing the visibility of breastfeeding will help the preservation of breastfeeding knowledge and cultural traditions, and will help support the establishment of a breastfeeding culture. Women who openly breastfeed demonstrate and reinforce to families, friends, employers and society that breastfeeding is the normal, natural way to feed an infant.

The risks of artificial milk

There are significant risks associated with feeding infants artificial milk. Powdered infant formulas are artificial substitutes for breastfeeding and breast milk. Artificially-fed infants and their mothers do not receive the protective qualities of breast milk, and are at greater risk of health and developmental problems during infancy and beyond.

Artificially fed infants are at risk of infections related to contamination of inappropriately prepared or stored infant formula. Inappropriate infant feeding practices such as early introduction of solid foods, and feeding of solids and drinks of low nutritional value also present risks to infant health. Both artificial milk feeding and inappropriate infant feeding are common in New Zealand (Ministry of Health 2007; Butler et al 2004; see also table 1, below).

Evidence of the risks of not breastfeeding is such that the WHO recommends that:

Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system as they constitute an at-risk group (WHO 2003).

3.2 Breastfeeding in New Zealand

Since the early 1970s, positive changes have occurred around breastfeeding in New Zealand. In the early 1970s, fewer than 50 percent of infants received any breast milk when first seen by a Plunket nurse or clinic⁷ at around six weeks of age. In contrast, the current rate of any breastfeeding at around six weeks is approximately 80 percent. The challenge is to extend this improvement to significantly increase the rates of breastfeeding at six weeks, three months, and six months and beyond.

7. The Royal New Zealand Plunket Society (Inc).

Data collected by the New Zealand Breastfeeding Authority (NZBA) indicates that New Zealand has a relatively high rate of exclusive breastfeeding initiation. In Baby Friendly Hospitals in 2005, 80.5 percent of babies were exclusively breastfed at discharge.⁸

There is, however, a significant decline in the prevalence of exclusive breastfeeding through the first six months of infants' lives across the population, as shown in Tables 1 and 2. Exclusive and full breastfeeding rates have not changed significantly over the last eight years although there is a trend toward exclusive and/or full breastfeeding and away from partial breastfeeding (see Table 2), particularly among Māori, Pacific and Asian communities.

Notes on the data

Data prior to 2002 are not included as definitions for breastfeeding intensity were not employed before that year. These data are drawn from information from the Plunket database, the only source of national data on breastfeeding post discharge from maternity facilities and the Lead Maternity Carer. While Plunket sees over 90 percent of babies, it does not see every baby in New Zealand. As a result, these data should not be generalised, and should not be used as a replacement for collecting and using specific local or regional data, including data for particular ethnic groups.

Many babies will have begun complementary feeding by six months and may therefore be recorded as being partially breastfed. Improving the completeness of breastfeeding data is a key strategic issue for the Plan (see Setting one: Government).

Table 1: Breastfeeding intensity by ethnicity 2002–2007

	Year	Māori (%)	Pacific (%)	Asian (%)	European New Zealander/ other (%)	All (%)
Exclusive and full breastfeeding at six weeks Target for 2007–08: 74 percent	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
	2007	58	53	56	70	65
	Exclusive and full breastfeeding at three months Target for 2007–08: 57 percent	2002	47	50	–	58
2003		46	49	49	59	55
2004		47	49	51	60	56
2005		45	48	52	60	56
2006		45	48	53	60	55
2007		44	43	52	59	54
Exclusive and full breastfeeding at six months Target for 2007–08: 27 percent		2002	16	20	–	25
	2003	16	19	20	26	23
	2004	18	20	22	27	24
	2005	18	19	23	28	25
	2006	17	19	25	29	25
	2007	17	18	26	29	26

8. NZBA personal communication, February 2007. Note that this figure does not include Middlemore Hospital or National Women's Hospital, New Zealand's two largest maternity units.

Table 2: Breastfeeding type, by age of infant, 2002–2007

Six weeks	Exclusive (%)	Full (%)	Partial (%)	Artificial (%)
2002	46	19	15	19
2003	49	18	15	19
2004	50	18	14	19
2005	51	16	15	19
2006	51	15	16	18
2007	51.5	12.5	17	19

Three months	Exclusive (%)	Full (%)	Partial (%)	Artificial (%)
2002	33	19	18	30
2003	36	19	15	30
2004	37	18	15	30
2005	38	17	15	29
2006	39	16	16	29
2007	39	15	17	29

Six months	Exclusive (%)	Full (%)	Partial (%)	Artificial (%)
2002	9	12	38	41
2003	10	14	35	41
2004	10	14	35	41
2005	11	14	35	40
2006	13	12	35	40
2007	14	11	34	41

3.3 Breastfeeding support services

All governments (will) ensure that all mothers are aware of their rights and have access to support, information and counselling in breastfeeding and complementary feeding from health workers and peer groups (Innocenti Declaration 2005).

Breastfeeding support services are provided by health workers and by community-based groups, including peer support. The two complement each other, and each has a key role to play in improving breastfeeding rates in New Zealand.

Effective ante-natal education has been identified as an important influence on infant feeding decisions (NICE 2005).⁹ In New Zealand, ante-natal education is provided by a range of community groups, by private providers, and some DHBs. There is usually a cost associated with these programmes, which are not available in all geographic areas and may not be culturally appropriate and relevant for Māori, Pacific and other ethnic communities. In addition to ante-natal education there is also a wide diversity of breastfeeding support services available in New Zealand, within a community and government-funded framework that has the potential to be highly effective.

9. National Institute for Health and Clinical Evidence (NICE) based in London.

Breastfeeding support is provided at community level by a range of groups, including (but not limited to):

- midwives and other lead maternity carers;
- mother-to-mother support including formal and informal groups and one-to-one;
- DHBs;
- Well Child Tamariki Ora providers; and
- local breastfeeding support initiatives.

The New Zealand maternity care system established under the Section 88 Maternity Notice for Lead Maternity Carers is consistent with recognised good practice because it includes home visits, continuity of care, and pregnancy and parenting education from trained health professionals (NICE 2005).

Lead maternity carers are required to provide between five and ten home visits in the six weeks following birth, and more visits if clinically indicated. In practice, limited workforce capacity means that in some geographic areas, not all women receive all six visits. Women report the quality of breastfeeding advice and support can also vary (Ministry of Health 2002b; DeSouza 2006).

In addition to maternity care, DHBs provide lactation consultant support within hospitals and birthing units and through outpatient clinics for women with complex or specific needs. Access to free lactation consultant clinics varies across the country depending on workforce availability, and variations in service delivery and planning between DHBs.

Private lactation consultants offer fee-for-service advice and support. These services are generally limited to the main centres. Cost is likely to be a barrier to many women, particularly those who face the most barriers to breastfeeding.

Whilst these services are important, there is little in the way of a coordinated, sustainable and effective network of high quality breastfeeding support services that meet the needs of all families within each community. The focus of many services is on initiation of breastfeeding and the correction of breastfeeding problems once they occur. Little has been done to support longer duration of breastfeeding to six months and beyond and informing families why this is important. Most women in New Zealand initiate breastfeeding, but do not continue to enjoy the full benefits that are available for baby, mother and family (WHO 2003).

A nationally coordinated approach will help to ensure that all women and families have access to breastfeeding support services regardless of their location, ethnicity, socioeconomic status, or the type of needs they have. There is a need for national coordination to support the coordination of and sustainable funding support for services within communities, and identify and meet gaps with appropriate and effective services.

3.4 Breastfeeding support for Māori

Historical accounts suggest that prior to European colonisation, Māori lived communally and shared the responsibility of raising children in all aspects of their lives. Breastfeeding was not viewed as being separate from conception, birthing or parenting. Many Māori women commonly practiced wet nursing.¹⁰ Urban migration, particular in the mid 20th century, the erosion of Māori communal settings, and modern societal attitudes and medicalisation of birth have had a negative influence on breastfeeding among Māori (Abel et al 2001 cited in Glover et al 2007a). Glover et al (2007b) note that the intent to breastfeed is strong amongst wahine Māori, and that breastfeeding is acknowledged as the tika (right) way to feed baby. Locating knowledge and support within whānau and hapū is the key to improving breastfeeding rates among Māori, building on the positive intentions and offering protection from influences that lead wahine Māori from ceasing breastfeeding. Glover et al note that these influences include loss of acknowledgement of breastfeeding as the norm within the whānau; early difficulties with breastfeeding; insufficient support for and knowledge about breastfeeding; and having to return to paid work.

There have been many years of effort to highlight and address the issue; however limited resources have meant limited results in improving Māori breastfeeding rates, and getting the issue on the agenda at local, regional and national level. In 1994 the Māori sudden infant death syndrome (SIDS) programme was established. This programme has always had a strong interest in improving breastfeeding rates because breastfeeding is associated with a lower incidence of SIDS. Although work on research, cultural safety, strategic developments, and awareness-raising have taken place; this has not progressed into the widespread establishment of breastfeeding services specifically for Māori. At present only two such programmes are available for Māori pepe, wahine and whānau: B4Baby in South Auckland and Mum4Mum in the Hutt Valley.

The success of B4Baby is demonstrated by a significant increase in breastfeeding rates. This programme is a good example of how access to an appropriately trained and skilled workforce can deliver effective programmes specifically designed for Māori and Pacific women and whānau. Despite positive results, B4Baby has struggled to retain funding and does not have sufficient capacity to meet the demand for its services.

Mum4Mum is a pilot peer support programme aimed at high needs mothers. It focuses on training women – including Māori and Pacific women – to provide peer support within their communities. While there is good evidence for the effectiveness of ethno-specific programmes overseas, there is limited research specifically looking at what constitutes effective breastfeeding support for Māori women and whānau.

3.5 Breastfeeding support for Pacific peoples¹¹

Pacific women and families, while coming from a range of different cultures, languages and histories, share a need for services that protect and preserve cultural traditions and support for breastfeeding. Current evidence before the Committee indicates that breastfeeding services for Pacific women are either a token or marginalised response to a known, but little understood, set of needs.

10. Riripeti Haretuku, personal communication.

11. There are more than 22 Pacific nations with communities in New Zealand. The largest of these groups include Tongan, Samoan, Niuean, Cook Island, Tokelauan, Tuvaluan and Fijian communities, both Island and New Zealand-born. The Plan of Action recognises that all Pacific Island nations have individual histories, languages and cultural practices. Services delivered by and for Pacific women and families need to reflect the needs of the individual nations within the diversity of the New Zealand Pacific community.

The youthful population, the cultural impact of migration from the Pacific Islands to New Zealand, and current employment patterns all influence breastfeeding rates of Pacific women in this country. There is little research on what influences Pacific women's decision to breastfeed.

An anecdotal example is the relatively high rates of smoking among Pacific women over 15 years of age (34 percent) who are also more likely to be mothers at a younger age. The knowledge that smoking around baby is harmful seems to lead young Pacific women to stop breastfeeding, rather than to stop smoking. There is a paucity of research into the influences on breastfeeding rates among Pacific peoples in New Zealand and it should be a priority for breastfeeding research in this country.

The experience of Committee members points to specific strategies that would support an improvement in both Māori and Pacific breastfeeding rates. These include:

- policy support that recognises the specific needs of Māori and Pacific communities;
- family-focused messages that are positive, strength-based and linked with community development (not delivered in isolation);
- Māori and Pacific input into and guidance of programmes and services;
- sustainable resources for Māori and Pacific breastfeeding services;
- supportive workplace policies where Māori and Pacific people are employed; and
- fully resourced education pathways for health workers, peer supporters, counselling, and community advocates to support their career development, including training and key messages on breastfeeding.

4. What works to protect, promote and support breastfeeding?

4.1 Protecting breastfeeding

There are a number of ways to protect breastfeeding, including legislative and policy approaches; however evidence suggests that policy and legislative measures alone will not create an environment that supports and promotes a breastfeeding culture (NICE 2005).

International legislation

Internationally, legislation tends to focus on two key legal issues:

- the right to breastfeed in a public place; and
- the right and ability to breastfeed while in paid employment.

Some jurisdictions, for example Scotland and many states in America, have legislation that protects a woman's right to breastfeed in any place she would otherwise legally be allowed to be. It is important to note that countries with much higher breastfeeding rates, for example Sweden and Norway, do not have such legislation. Explicit legislative protection is not necessarily indicative of an established breastfeeding culture.

Variations in legislative approaches are illustrated by implementation of the *International Code of Marketing of Breast-milk Substitutes* (WHO 1981) (the Code). The Code has been passed into law in 25 of the 166 countries surveyed by UNICEF in 2003, and many provisions have been passed into law in a further 32 countries.

Domestic legislation

The right to breastfeed in New Zealand

In 2005, the Human Rights Commission developed a report *The Right to Breastfeed* in response to questions about breastfeeding at work, and calls for stronger protection of breastfeeding mothers and babies in New Zealand. The report notes that "... although there is no specific law in New Zealand on the right to breastfeed apart from anti-discrimination measures, the right is given meaning in a variety of ways through measures to respect, protect and promote the right to breastfeed."

The Commission has developed a set of principles that it uses to guide the application of a broad, enabling approach to affirming the right to breastfeed in New Zealand. These principles are relevant to the development and implementation of legislation, regulation, policies and/or practices that directly or indirectly affect the right to breastfeed.

1. A woman has the right to breastfeed and is protected from discrimination for breastfeeding under the Human Rights Act and international law.
2. The Commission should support and promote the right to breastfeed.
3. When considering breastfeeding complaints, a broad analysis should be used for comparisons across groups.¹²

12. Comparator groups are used to help isolate the reason for different treatment and can be used to prove discrimination based on a specific ground.

4. A woman should be permitted to breastfeed where she and her child would otherwise be permitted to be.
5. The right to breastfeed should not be limited by any individual, group or party unless the intervention is based on evidence of significant detriment to the mother or the child.
6. Breastfeeding should, generally, be considered to be in the best interests of the child but in most circumstances parents should be allowed to determine what is in the best interests of their child with respect to infant-feeding.
7. The approach to breastfeeding discrimination should encompass the view that breastfeeding mothers and their babies form an inseparable biological and social unit.

Protection of breastfeeding through legislation in New Zealand

Given the international evidence around the impact of paid maternity/parental leave on breastfeeding, it is likely that employment-related legislation that protects breastfeeding would have a positive effect. For example, there is good evidence of a correlation between length of paid maternity leave and improvements in breastfeeding rates and duration (Galtry 2003).¹⁶

The Parental Leave and Employment Protection Act 1987 was amended in 2002 to introduce paid parental leave, first for 12 weeks, increased to 14 weeks in 2005. The Department of Labour carried out an evaluation on the effect of paid parental leave in New Zealand (Department of Labour 2007b). Eighty-four percent of those surveyed believed paid parental leave was important for establishing breastfeeding; however 20 percent believed 14 weeks was insufficient to fully establish breastfeeding.¹³

Two bills currently before the House seek to explicitly protect breastfeeding. They are the Corrections (Mothers with Babies) Amendment Bill, to allow babies to stay with imprisoned mothers for up to two years for the purposes of breastfeeding and bonding; and the Employment Relations (Breaks and Infant Feeding) Amendment Bill, which seeks to promote and protect infant feeding by requiring employers to provide facilities and breaks for employees who wish to breastfeed. If passed, the bill will be supported by a code of employment practice.

The policies and practices that flow from legislation are the mechanisms that give practical effect to the intent of the legislation. For example, in addition to the legal provision of paid parental leave, it is important that workplaces are supportive of any woman who chooses, or needs to, return to work while breastfeeding either before or after the end of her paid leave period. Supportive measures can include: breastfeeding or expressing breaks; provision of appropriate facilities for breastfeeding and/or expressing and storing breast milk; flexible working hours; on site crèches with policies that support breastfeeding, and arrangements such as care leave for partners of women who have a caesarean section, multiple birth, or need to stay in hospital with a sick infant.

13. It should be noted that the primary purpose of the Paid Parental Leave scheme is employment protection during a period of parental leave with the provision of payment. Any extension of paid parental leave for the purpose promoting and supporting breastfeeding would be balanced with the scheme's other objectives.

International conventions

There are a number of key international initiatives that directly or indirectly protect breastfeeding. Together these declarations and conventions provide international guidelines, standards and policy frameworks. The key documents are:

- *International Code of Marketing of Breast-milk Substitutes* (WHO 1981), and related World Health Assembly resolutions.
- Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (four operational targets 1990; revised and five additional targets added in 2005).
- The International Labour Organisation's Maternity Protection Convention 183 (2000).
- *Global Strategy for Infant and Young Child Feeding* (WHO and UNICEF 2003).
- United Nations Convention on the Elimination of All Forms of Discrimination Against Women.
- United Nations Convention on the Rights of the Child.

The Innocenti Declaration is a call to action to protect, promote and support breastfeeding. The Declaration calls on all parties to work to establish and strengthen a global breastfeeding culture.¹⁴

It should be noted that there are no sanctions associated with conventions or declarations of this kind. It is the responsibility of signatory countries to determine the ways in which domestic compliance is measured and enforced.

4.2 Promoting breastfeeding

Breastfeeding takes place within a social and cultural context. Evidence shows that there is a link between community attitudes toward breastfeeding and breastfeeding duration (McIntyre et al 2001; Scott et al 2003).¹⁹

While there is limited evidence about specific initiatives, the literature suggests that the promotion of breastfeeding within society is an important part of improving breastfeeding rates, provided measures to protect and support breastfeeding are also put in place.

Breastfeeding can be promoted in many ways, ranging from awareness-raising campaigns that target the whole population, to the way midwives and other lead maternity carers discuss feeding decisions with pregnant women and their families.

As with other public health initiatives, the literature indicates that changes in attitudes take time, and require a comprehensive approach using a range of ways of communicating key messages.

The WHO notes that social marketing campaigns are most likely to be successful if:

- women perceive the messages as being beneficial, feasible and socially acceptable; and
- the messages are targeted toward the breastfeeding mother, her family, the health providers involved in the care of the mother and infant, and the community where they live.

14. Parties identified in the Declaration include families, societies, communities, employers, governments, for manufacturers and distributors of breast-milk substitute and related products, multi-lateral and bi-lateral organisations and international financial institutions, and public interest non-government organisations.

There are a number of New Zealand initiatives designed to promote breastfeeding, ranging from World Breastfeeding Week activities, and local programmes that, for example, provide stickers for breastfeeding-friendly cafes, mother's rooms and other venues. The Ministry of Health's breastfeeding promotion campaign will add significantly to the level of activity in this area.

4.3 Supporting breastfeeding

New Zealand has high breastfeeding initiation rates; however there is a steep decline in breastfeeding rates during the first six weeks. Supporting breastfeeding is a key part of improving the duration of breastfeeding to meet the Ministry of Health's goals, and the WHO recommendation that infants be exclusively breastfed for the first six months of life, and continue to be breastfed up to two years and beyond while appropriate complementary foods are introduced. Providing accessible, appropriate support for breastfeeding for mothers, fathers/partners, families/whānau, communities and society is essential in meeting this goal. Promotion of increased duration of breastfeeding will not succeed if mothers, fathers/partners and families do not have access to services that will support their decision to breastfeed.

Support services include programmes that foster and encourage breastfeeding in healthcare facilities, among women and babies at home, and in the paid workforce.

There is good evidence of the effectiveness of interventions in the following areas:

- Appropriate, accessible programmes that encourage family/whānau support for breastfeeding.
- Ante-natal education about breastfeeding that covers the importance of breastfeeding, the risks of not breastfeeding, and common problems and how to overcome them.
- Provision of information and services in the language of the woman and her family, and provision of translation services where required.
- Accurate education for health professionals about breastfeeding, covering the importance of breastfeeding and the risks of not breastfeeding, common problems and how to support mothers and families to overcome them.
- Hospital and health professional support for breastfeeding mothers, particularly consistent, ongoing advice and support.
- Training for health professionals to address psycho-social as well as physiological aspects of breastfeeding.
- Hospital and maternity facility environments that support and encourage breastfeeding, including the use of the Baby Friendly Hospital Initiative.
- Peer support programmes using trained counsellors.
- Parental leave policy with universal eligibility that supports and encourages women to take a period of leave following childbirth and supports exclusive breastfeeding for the recommended six months.
- Workplaces that support breastfeeding women to continue to breastfeed at work.
- Childcare centres and early childhood education facilities adopting breastfeeding friendly practices such as the provision of a suitable space, appropriate storage for expressed milk, and encouraging staff to breastfeed their own babies.

A recent New Zealand study (Quigley and Watts 2007) identified the following areas as key aspects related to supporting breastfeeding in this country:

- There is high awareness of the benefits of breastfeeding among New Zealand mothers. Breastfeeding is seen by most women as normal and natural, and, once established, is cheap, easy and convenient.
- Knowledge of what to expect, how to breastfeed, and access to hands-on, practical help with latching and general problem solving the early stages of breastfeeding.
- Household help is an important enabler of breastfeeding. Support from partners, family and close friends is particularly important.
- Cultural norms, role models, encouragement from others and learning from watching others breastfeed can all help enable breastfeeding.
- Supportive workplaces and education settings help women combine breastfeeding with paid work or study.

4.4 Barriers to breastfeeding

The literature indicates that the main barriers to breastfeeding are social, environmental and clinical.

Social and environmental barriers

- Partner and/or family beliefs that prefer artificial feeding (including the perception that artificial feeding enhances the father's opportunities to bond with the infant).
- Lack of family and broad social support, including the perception of breastfeeding as inconvenient, and attitudes that make breastfeeding embarrassing or uncomfortable for the woman.
- Community or societal expectations about the acceptable duration of breastfeeding.
- Insufficient knowledge about the normal course of breastfeeding, including common problems and the solutions.
- A culture that supports artificial feeding through promotion of images and language that portrays bottle-feeding as normal.
- Returning to work, by choice or through financial necessity,¹⁵ coupled with limited or absent workplace support for breastfeeding mothers.
- Inappropriate or lack of facilities to enable mothers to breastfeed wherever they may be.
- Societal attitudes about breastfeeding being inappropriate in public.
- Cultural beliefs and practices that limit breastfeeding duration and/or include early introduction of complementary foods, particularly among Māori and Pacific families.
- Media portrayal of artificial feeding as normal.
- Commercial promotion of formula through free or discounted formula and advertising.¹⁶

15. There is evidence that this issue particularly affects Pacific women, many of whom are the main breadwinners. See Galtry (1995). Higher percentages of Pacific people live in areas with the highest socioeconomic deprivation rating (Dep 10) than other groups in New Zealand.

16. Under the New Zealand interpretation of the WHO Code of Marketing of Breast-milk Substitutes (Ministry of Health 2007), free samples of artificial infant formula should not be provided to mothers in New Zealand.

- The desire to return to social and sporting activities, and to ‘get my body back’.
- Lower academic achievement and lower socioeconomic status.

Clinical barriers

Clinical barriers include specific conditions or situations that affect breastfeeding, and issues concerning service design and delivery. Clinical issues with a demonstrated effect on breastfeeding include the following:

- Lack of access to ante-natal education and post-natal support and information services, and/or prompt referral to specialist breastfeeding services.
- Perceived clinical issues, particularly insufficient milk, pain and exhaustion.
- Use of formula within the first month.
- The communication of negative or ambivalent attitudes to breastfeeding by health professionals to women and families, and inappropriate advice, for example standard recommendations on supplementary feeding with formula or advice that formula is a safe substitute for breast-milk.
- Lack of routine follow-up care and home visits for mothers.
- Twins and higher-order multiples.
- Premature and/or low birth weight infants.
- Infants who are separated from their mothers (most commonly unwell infants who are in intensive or special care units).
- Mothers who have had breast surgery that prevents or limits breastfeeding.
- Poor initiation of breastfeeding.
- Poor attachment at the breast.
- Disruptive hospital policies and procedures including, but not limited to, inappropriate interruption of breastfeeding, and early discharge in some populations.
- Low awareness among health professionals of the common problems around breastfeeding, and the solutions.

Many of these factors are interlinked, and demonstrate the need for a comprehensive approach if breastfeeding rates in New Zealand are to be improved. Coordination and careful tailoring of services is essential. There is a need to make the most of available resources if breastfeeding rates are to improve in this country.

Breastfeeding in exceptionally difficult circumstances

In addition to the barriers identified above, there are other situations in which women and families will require special efforts to protect and support breastfeeding. The Global Strategy for Infant and Young Child Feeding identifies a variety of such circumstances.

The Strategy notes that in natural and human-induced emergencies, infants and young children are among the most vulnerable victims, particularly when the emergency causes interruptions to breastfeeding and/or the use of inappropriate complementary foods. New Zealand is prone to natural emergencies, and as such the Ministry for Civil Defence and Emergency Management recommends that families include infant feeding considerations when planning for an emergency.

The Strategy recommends that suitable and safe breast-milk substitutes should be part of emergency provisions to support any infants who cannot be breastfed as usual due to the emergency.

The Strategy also notes that children and mothers living in special circumstances will require extra attention and support. Examples include orphans and foster children; infants born to very young mothers; children of mothers with mental illness, physical or intellectual disabilities and/or drug or alcohol dependence; or mothers who are imprisoned, or part of a marginalised or otherwise disadvantaged population, including mothers and children who are the victims of family violence.

The Strategy recommends that:

‘... wherever possible in difficult situations, mothers and babies should remain together and be given the support they need to exercise the most appropriate feeding option under the circumstances.’

5. Key stakeholders

Protection, promotion and support of breastfeeding require action from a wide range of organisations, many of which are outside the health sector.

The key stakeholders for the National Strategic Plan of Action for Breastfeeding include (but are not limited to) the following:

Provider and consumer organisations

- Childbirth Education New Zealand
- Country Women's Institute
- Early childhood education and childcare providers
- Homebirth Aotearoa
- La Leche League New Zealand
- Infant Feeding Association of New Zealand
- Kindergarten Association
- Kohanga Reo National Trust
- Local breastfeeding networks
- Māori Women's Health league
- Māori Women's Welfare League
- New Zealand Childcare Association
- New Zealand Council of Women
- New Zealand Dietetic Association
- Parenting and family support groups (for example the Father and Child Trust; Young Parents Breastfeeding Group; Mother's Network)
- Parents Centre
- Playcentre Association
- Public Health Association
- Rural Women New Zealand
- Women's Health Action Trust

Health sector and health workforce groups

- Cook Island Health Network
- District Health Boards
- Iwi healthcare providers
- Midwifery Council of New Zealand
- Neonatal Nurses College of Aotearoa
- New Zealand Breastfeeding Authority
- New Zealand College of Midwives
- New Zealand College of Practice Nurses
- New Zealand Lactation Consultants Association

- New Zealand Nurses Organisation
- Nga Maia o Aotearoa me Te Waipounamu
- Pacific health providers
- Primary health organisations
- Private and publicly funded maternity and paediatric services workforce
- Public health services
- Royal New Zealand College of Obstetricians and Gynaecologists
- Royal New Zealand College of General Practitioners
- Paediatric Society of New Zealand
- Perinatal Society of Australia and New Zealand
- The Royal New Zealand Plunket Society
- College of Nurses Aotearoa
- Samoan Nurses Association
- Tongan Nurses
- Well Child providers

Government agencies

- The Commissioner for Children
- Department of Corrections
- Department of Labour
- Education Review Office
- Equal Employment Opportunities Trust
- The Families Commission
- The Family Court
- Food Standards Australia New Zealand
- The Human Rights Commission
- Local government, including public facility designers and managers
- Ministry of Education
- Ministry of Health
- Ministry of Justice
- Ministry of Pacific Island Affairs
- Ministry of Social Development
- Ministry of Women's Affairs
- New Zealand Food Safety Authority
- Office of Ethnic Affairs
- Te Puni Kōkiri
- Work and Income New Zealand

Community and society

- Advertising and media, including the Advertising Standards Authority, the Broadcasting Standards Authority and Communication Agencies Association of New Zealand
- Community groups, including (but not limited to) runanga, churches (particularly Pacific churches), community social service and support groups and networks; mothers' groups.
- Employers
- Retailers
- Researchers and research and data users
- Trade unions

Affected parties

- Industry (manufacturers, importers and retailers of artificial infant formula, follow-on formula, teats and bottles)

References

- American Academy of Pediatrics. 2005. Breastfeeding and the use of human milk. *Pediatrics* 115(2): 496–506.
- Arora S, McJunkin C, Wehrer J, Kuhn P. 2000. Major factors influencing breastfeeding rates: mother's perception of father's attitude and milk supply. *Pediatrics* 106(5): E67.
- Basire K, Pullon S, McLeod D. 1997. Infant feeding: the thoughts behind the statistics. *New Zealand Medical Journal* (1997) 110, 184–7.
- Britton JR, Britton HL, Gronwaldt V. 2006. Breastfeeding, sensitivity and attachment. *Pediatrics* 118(5): 1436–43.
- Butler S, Williams M, Tukuitonga C, Paterson J. 2004. Factors associated with not breastfeeding exclusively among mothers of a cohort of Pacific infants in New Zealand. *New Zealand Medical Journal* 117(1195).
- Cattaneo A, Yngve A, Koletzko B, Gusman L. 2005. Protection, promotion and support of breastfeeding in Europe: current situation. *Public Health Nutrition* 8(1), 39–46.
- Callister P, Galtry J, unpublished. 'Baby bonus' or paid parental leave – which one is better? Submitted to the *Social Policy Journal of New Zealand*, November 2007.
- DeSouza R. 2006. New spaces and possibilities: the adjustment to parenthood for new migrant mothers. Wellington: Families Commission/Kōmihana ā Whānau (Blue Skies Report 13/06).
- Department of Labour. 2007a. *A Guide for Employers: Breastfeeding in the workplace*.
- Department of Labour. 2007b. *Parental Leave in New Zealand: 2005-2006 evaluation*. Wellington: Department of Labour.
- Dignam D. 1998. Breastfeeding, Intimacy and Reconceptualising the Breast. *Breastfeeding in New Zealand: Practice, problems, and policy*. Beasley A and Trlin A (eds). Palmerston North: Dunmore Press.
- Ellison-Loschmann L. 1997. Māori women's experiences of breastfeeding. A thesis in partial fulfilment of the requirements for the degree of Master of Arts (applied) in Midwifery. Wellington: Victoria University of Wellington.
- EU Project on Promotion of Breastfeeding in Europe. 2004a. *Protection, Promotion, and Support of Breastfeeding in Europe: A blueprint for action*. Luxembourg: European Commission Directorate for Public Health.
- EU Project on Promotion of Breastfeeding in Europe. 2004b. *Protection, Promotion, and Support of Breastfeeding in Europe: Review of interventions*. Luxembourg: European Commission Directorate for Public Health.
- Farquhar S, Galtry J. 2003. *Developing Breastfeeding-friendly Childcare to Support Mothers in Paid Employment and Studying*. Equal Employment Opportunities' Contestable Fund Project. Accessed at <http://www.womens-health.org.nz/breastfeed/downloads/childcarereport.doc>.
- Ferreira-Rea M, Morrow A. 2004. Protecting, promoting, and supporting breastfeeding among women in the labour force. *Protecting Infants through Human Milk: Advancing the scientific evidence, advances in experimental medicine and biology*. Pickering et al (eds). New York: Kluwer and Associates/Plenum Publishers.

- Galtry J. 1995. Breastfeeding, labour market changes and public policy in New Zealand: is promotion of breastfeeding enough? *Social Policy Journal of New Zealand* 5: 1995.
- Galtry J. 2002. Child health: an underplayed variable in parental leave policy debates? *Community, Work, and Family*. 5(3): 257–78.
- Galtry J. 2003. The impact on breastfeeding of labour market policy and practice in Ireland, Sweden, and the USA. *Social Science and Medicine* 57 (2003): 167–177.
- Gerrard A. 2000. Breastfeeding in Norway: Where did they go right? *British Journal of Midwifery*: 9(5): 294–300.
- Glover M, Manaena-Biddle H, Waldon J. 2007a. Influences that affect Māori women breastfeeding. *Breastfeeding Review* 15(2): 5–14.
- Glover M, Manaena-Biddle H, Waldon J. 2007b. The role of whānau in Māori women’s decisions about breastfeeding. *Alternative*: 143–159.
- Hector D, King L, Webb K. 2004. *Overview of Recent Reviews of Interventions to Promote and Support Breastfeeding*. Sydney: University of Sydney and NSW Health.
- Innocenti Declaration 2005 on Infant and Young Child Feeding. Adopted by participants of the event *Celebrating Innocenti 1990–2005: Achievements, Challenges and Future Imperatives* 22 November 2005, Florence Italy. Accessed at: <http://innocenti15.net/declaration.pdf.pdf>
- International Labour Organisation Maternity Protection Convention 183 (2000).
- León-Cava N, Lutter C, Ross J, Martin L. 2002. *Quantifying the Benefits of Breastfeeding: A summary of the evidence*. PAHO: Washington DC.
- McInerney Z. 2002. Lactation and the workplace. *Reclaiming Breastfeeding in the United States*. Cadwell C (ed). Massachusetts: Jones and Bartlett Publishers.
- McIntyre E, Hiller E, Turnbull J. 2001. Community attitudes to infant feeding. *Breastfeeding Review* 9(3): 27–33.
- McLeod D, Pullon S, Basire K. 1998. Factors affecting infant feeding: reflections and perceptions of Hutt Valley mothers. *Breastfeeding in New Zealand: Practice, problems, and policy*. Beasley A and Trlin A (eds). Palmerston North: Dunmore Press.
- Minister of Health. 2001. *Primary Health Care Strategy*. Wellington: Ministry of Health.
- Minister of Health. 2002. *Pacific Health and Disability Action Plan*. Wellington: Ministry of Health.
- Minister of Health. 2007. *Health Targets: Moving towards healthier futures*. 2007/08. Wellington: Ministry of Health.
- Minister of Health and Associate Minister of Health. 2002. *He Oranga Korowai: Māori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 1997. *Infant Feeding: Guidelines for New Zealand health workers*. Wellington: Ministry of Health.
- Ministry of Health. 1998. *Child Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2002a. *Breastfeeding: A guide to action*. Wellington: Ministry of Health.
- Ministry of Health. 2002b. *Maternity Services Satisfaction Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2002c. *Well Child Framework*. Wellington: Ministry of Health.
- Ministry of Health. 2003a. *Achieving Public Health for All People: Whakatutuki te Oranga Hauora Mo Nga Tangata Katoa*. Wellington: Ministry of Health.

- Ministry of Health. 2003b. *Healthy Eating–Health Action Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2003c. *Māori Public Health Action Plan*. Wellington: Ministry of Health.
- Ministry of Health. 2006. *Food and Nutrition Guidelines for Pregnant and Breastfeeding Women: A background paper*. Wellington: Ministry of Health.
- Ministry of Health. 2007. *Implementing and Monitoring the International Code of Marketing of Breastmilk Substitutes in New Zealand: The code in New Zealand*. Wellington: Ministry of Health.
- Ministry of Health. 2008. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (aged 0 – 2): A background paper*. Wellington: Ministry of Health.
- Ministry of Social Development. 2000. *New Zealand’s Agenda for Children: Making life better for children*. Wellington: Ministry of Social Development.
- National Breastfeeding Advisory Committee. 2008. *Protecting, Promoting and Supporting Breastfeeding in New Zealand: A review of the context of breastfeeding in this country and of the evidence for successful interventions supporting breastfeeding*.
- National Institute for Health and Clinical Excellence (NICE). 2005. *The Effectiveness of Public Health Intervention to Promote the Duration of Breastfeeding*. London: NICE.
- New Zealand Breastfeeding Authority. 2007. *Baby Friendly Hospital Initiative and Baby Friendly Communities Initiative*.
- Quigley and Watts Ltd. 2007. Comprehensive plan to inform the development of a national breastfeeding promotion campaign. Viewable on [http://www.moh.govt.nz/moh.nsf/pagesmh/6791/\\$File/comprehensive-plan-inform-design-national-breastfeeding-campaign.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6791/$File/comprehensive-plan-inform-design-national-breastfeeding-campaign.pdf)
- Scott JA, Mostyn T, Greater Glasgow Breastfeeding Initiative Management Team. 2003. Women’s experiences of breastfeeding in a bottle-feeding culture. *Journal of Human Nutrition* 19(3): 270–7.
- United Nations. 1989. U.N. Convention on the Rights of the Child. UN General Assembly Document A/RES/44/25. Accessible at: <http://www.cirp.org/library/ethics/UN-convention>
- World Health Organization (WHO). 1981. *International Code of Marketing of Breast Milk Substitutes*. Geneva: WHO.
- World Health Organization (WHO). 1991. *Indicators for Assessing Breastfeeding Practices*. WHO: Geneva.
- World Health Organization. 2003. *Global Strategy for Infant and Young Child Feeding*. World Health Organization: Geneva.

Appendix One

Baby Friendly Hospital Initiative (BFHI) and Baby Friendly Communities Initiative (BFCI)

Baby Friendly Hospitals and Baby Friendly Communities are World Health Organization initiatives designed to strengthen the protection, promotion and support of breastfeeding.

In New Zealand, the majority of maternity facilities are Baby Friendly Hospitals. Implementation and assessment of Baby Friendly Hospitals is a primary focus of the New Zealand Breastfeeding Authority. The NZBA is also a leader in the development of Baby Friendly Communities in New Zealand, a project currently in the pilot stage.

A **Baby Friendly Hospital** is a health care facility where the practitioners who provide care for women and babies adopt practices that aim to protect, promote and support **exclusive** breastfeeding from birth. At the same time, Baby Friendly facilities ensure that women who choose not to breastfeed are supported in their decision and provided with unbiased information and advice.¹⁷

Part of being a baby friendly hospital is implementing the ten steps to successful breastfeeding. 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. Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats 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 the hospital or clinic.

The Baby Friendly Communities Initiative works toward a vision where breastfeeding is the cultural norm in society. It is based on a seven point plan for the protection, promotion and support of breastfeeding in the community, whereby relevant agencies and providers will:

1. Have a written breastfeeding policy that routinely is communicated to all staff and volunteers.
2. Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy.

17. New Zealand Breastfeeding Authority website: <http://www.babyfriendly.org.nz/page.php?5#60>.

3. Inform pregnant women and their families about the benefits and management of breastfeeding.
4. Support mothers to establish and maintain exclusive breastfeeding to six months.
5. Encourage sustained breastfeeding beyond six months, to two years or more, alongside the introduction of appropriate, adequate and safe complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote collaboration among health services, and between health services and the local community.

