

National Breastfeeding Strategy for New Zealand Aotearoa | Rautaki Whakamana Whāngote

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Introduction | He whakatakinga

Whakamanahia te whāngote, ka ora whānau, ka ora hapū, ka ora te iwi e

Empower breastfeeding and whānau, hapū and iwi will flourish

The National Breastfeeding Strategy for Aotearoa has been developed to support the exclusivity and duration of breastfeeding. Increasing the exclusivity and duration of breastfeeding is a key determinant of public health and is one of the most significant and cost-effective ways to improve equity and increase the health and wellbeing of a population.

This National Breastfeeding Strategy was developed with the intention and commitment to protect, promote, and support breastfeeding in Aotearoa New Zealand. It has been designed as a resource for government, policy makers, stakeholder organisations, public and private health sectors, industry, researchers and academics, iwi, hapū, whānau and communities as a tool to protect, promote and support breastfeeding.

Global public health recommendations state that infants should be exclusively breastfed for the first six months of life, with continued breastfeeding to age two years and beyond, with nutritionally adequate, safe and age-appropriate complementary feeding starting at around six months of age (World Health Organization and United Nations Children's Fund 2003).

In Aotearoa New Zealand only between 17 and 22 percent of children are exclusively breastfed to around six months (Ministry of Social Development 2018). Rates of exclusive breastfeeding are consistently lower for Māori and Pacific people.

Achieving 'optimal infant feeding' is a complex and multidimensional challenge that requires strong government leadership and coordination, and a holistic, whole-of-system approach.

Improving breastfeeding rates in Aotearoa New Zealand will directly contribute to:

- achieving equitable health outcomes for Māori
- improving overall population health outcomes
- improving maternal and child mental wellbeing
- reducing health costs through prevention of illness
- sustainability and waste reduction

The Strategy presents a roadmap to action in two parts, guided by pae ora. The first part outlines the priorities for **Government** to ensure the foundations are set for the actions

and outcomes that follow. The second part outlines these **actions and outcomes**, which will build a solid structure for the protection, promotion and support of breastfeeding in Aotearoa New Zealand.

Overview | Tiro whānui

Increasing the exclusivity and duration of breastfeeding is one of the most significant and cost-effective ways to achieve equity and increase the health and wellbeing of a population. This Strategy was developed with the intention and commitment to protect, promote and support breastfeeding in Aotearoa New Zealand.

Objectives | Ngā whāinga

- Increase the exclusivity and duration of breastfeeding in Aotearoa for this and future generations.
- Government policies and frameworks protect, promote and support breastfeeding and optimal infant feeding.
- Breastfeeding is a public health priority, and the determinants and barriers to breastfeeding are understood and mitigated.
- Consistent, evidence-based breastfeeding and infant feeding education is provided to all people working with pregnant women, infants and children.
- The positive impact of breastfeeding on health, development and wellbeing is valued by communities whānau, hapū and iwi.
- Whānau have access to consistent, evidence-based, culturally responsive breastfeeding information and support.
- People feel comfortable and supported to breastfeed in any environment, including workplaces, health and education settings, and public spaces.

Strategic framework: Pae Ora

Healthy environments **Wai ora**

Acknowledge the environment as a significant determinant of health, including the importance of governance and regulatory frameworks.

Healthy families **Whānau ora**

Empower families within a community context, promoting health as joint endeavor as opposed to an individual pursuit.

Healthy individuals **Mauri ora**

Prevention and treatment that benefits all members of society, including specific goals for priority groups.

The pae ora model emphasises that action to protect, promote and support breastfeeding needs to address three interconnected and mutually reinforcing elements.

Read more about the pae ora strategic framework:

Pae Ora framework

Priority areas

Setting the foundations: Government priorities

Ngā whakaarotau a te Kawanatanga

1. **Reduce inequitable outcomes and improve the wellbeing of Māori whānau**
2. **Policies, guidelines, regulations and frameworks protect, promote and support breastfeeding and optimal infant feeding**

Building a solid structure: Protecting, promoting and supporting breastfeeding in Aotearoa

Hāpaingia te whāngote ki Aotearoa

- **Outcome 1: Breastfeeding parents and their whānau have equitable access to a range of culturally appropriate breast and infant feeding supports**
- **Outcome 2: Breastfeeding parents and their whānau are supported by increased community education, resources and awareness**
- **Outcome 3: The maternal and child health workforce has the training, capacity and support to actively protect, promote and support breastfeeding**
- **Outcome 4: All maternity facilities achieve and maintain Baby Friendly Aotearoa (BFHI) accreditation**
- **Outcome 5: System settings support the safe provision of donor breast milk for infants in need**
- **Outcome 6: A robust evidence base informs infant feeding policy decisions and commissioning activities**
- **Outcome 7: Workplaces, education and childcare settings support parents and caregivers to reach their breastfeeding goals**
- **Outcome 8: System settings support and protect optimal infant and young child feeding in cases of temporary or sustained parent-child separation**
- **Outcome 9: System settings support and protect optimal infant and young child feeding during emergencies**

Background | Whakamahuki

Developing the National Breastfeeding Strategy for New Zealand Aotearoa

In 2019 the Ministry of Health | Manatū Hauora instigated a project to review, revise and refresh the **National Strategic Plan of Action for Breastfeeding 2008–2012** as part of the Maternity Action Plan 2019–2023. The scope of the project was to review the lapsed plan, with the aim of producing an enduring strategy to address barriers to establishing and maintaining breastfeeding in Aotearoa New Zealand.

This process involved a comprehensive review of these strategies and guidelines:

- **National Strategic Plan of Action for Breastfeeding 2008–2012**
- **Australian National Breastfeeding Strategy (2019 and beyond)**
- **Midland Breastfeeding Framework**
- **Global Strategy for Infant and Young Child Feeding**

The review also drew on numerous other national and international documents that demonstrate effective and innovative approaches to strategy development, such as:

- **Child and Youth Wellbeing Strategy**
- **Review of effective strategies to promote breastfeeding**
- **Bridging Cultural Perspectives**
- **Te Toi Ahorangi Strategy public engagement**
- **The New Zealand Health Research Prioritisation Framework**
- **Becoming Breastfeeding Friendly Scotland**

Several different approaches were tested before agreeing on a **pae ora framework**. This Strategy is intended to provide an appropriate balance of national level commitments and responsibilities as well as providing useful tools and guidance for regional implementation.

Additional resources informing the Strategy include:

- **Te Tiriti o Waitangi | Treaty of Waitangi**
- **Wai 2575 Māori Health Trends Report**
- **Whakamaui: Māori Health Action Plan 2020–2025**

- **The Ministry of Health Work Programme 2019/2020**
- **He Korowai Oranga: Māori Health Strategy**
- **The Whānau Ora Health Impact Assessment tool**
- **Achieving equity in health outcomes: Summary of a discovery process**
- **Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025**
- **Well Child Tamariki Ora Quality Improvement Framework**
- **Child and Youth Wellbeing Strategy**
- **NZBA BFHI Documents**

Expert Advisory Group for the National Breastfeeding Strategy

An Expert Advisory Group consisting of representatives from relevant organisations and health professions was established to provide advice to the Ministry of Health | Manatū Hauora during the project.

Terms of Reference

View the Terms of Reference Expert advisory group in the appendices,

Expert Advisory Group members

The Expert Advisory Group included representation from a broad range of stakeholders tasked with providing sector viewpoints at various stages of the Strategy development process. Members were selected to ensure diverse perspectives were taken into consideration.

Dr Amanda Kvalsvig

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Māmā of three tamariki; General Manager Women's Health Action; Consumer Member of the National Maternity Monitoring Group; Member of Northern Breastfeeding Network; Co-Chair National Breastfeeding Networking Group; Member of Maternal and Child Health Service Alliance; National Induction of Labour Guidelines Group Consumer Advisor, ON TRACK Research Prioritisation Project Ranking Group; CertPubHlth

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Māmā of six tamariki; Kaiārahi Māori – Te Waka Pākākano | Office of the Assistant Vice-Chancellor Māori, Pacific and Equity at Te Whare Wānanga o Waitaha | University of Canterbury; Vice-Chair and Consumer Member of the National Maternity Monitoring Group; Māori community representative on the South Island Child Health Alliance; Trustee

of Brainwave Trust; Member of Aotearoa Midwifery Collective Reference Group; MMIL, BMD, Dip Te Reo o Te Pīnakitanga ki te Reo Kairangi.

Timeframe | Angawā

The Strategy is designed to be an enduring yet living document with no specific end date. The Ministry of Health | Manatū Hauora will review the evidence underpinning the key priority and action areas every five years.

Implementation partners | Ngā kōtuitanga

The implementation of the Strategy will require collaboration and coordination across a wide range of organisations and individuals:

- parents, caregivers and their whānau
- health sector
- iwi, hapū and Māori organisations and service providers
- employers
- businesses or enterprises providing breastfeeding and lactation support and aids
- early childhood education and care services
- peak bodies, non-government organisations and professional associations
- tertiary education and training institutions
- researchers and academics
- all levels of government.

Governance | Mana whakahaere

The National Breastfeeding Strategy is part of a programme of work to protect, promote and support breastfeeding within the Ministry of Health | Manatū Hauora Maternity Action Plan (MAP). The MAP, and therefore the Strategy, is ultimately governed by the Director-General of Health. Further description of the governance structure will follow once the Strategy is released.

Te Tiriti o Waitangi

The National Breastfeeding Strategy for Aotearoa recognises that Māori, as Tangata Whenua, are partners to Te Tiriti o Waitangi alongside Tangata Tiriti – peoples of non-Māori origin - who have a right to live in Aotearoa New Zealand under Te Tiriti.

This Strategy commits to upholding the mana of Te Tiriti o Waitangi by ensuring the breastfeeding needs and aspirations of wāhine Māori and their whānau are reflected in the Strategy's whāinga (goals), whakaarotau (priorities) and putanga (outcomes).

Improving Māori breastfeeding rates will support the reduction of inequalities between Māori and non-Māori, with the whāinga, whakaarotau and putanga in this Strategy focused on increasing health equity and improving the hauora (health) and wellbeing of parents, their pēpi and whānau in Aotearoa New Zealand.

Meeting obligations under Te Tiriti is necessary to realise the overall aims of **He Korowai Oranga: Māori Health Strategy. Whakamaua: Māori Health Action Plan 2020–2025** provides guidance for the government, and the health and disability system as a whole to give effect to He Korowai Oranga. It sets out a suite of outcomes, objectives and priority areas for action that will contribute to the achievement of **pae ora – healthy futures**, and achieve four high-level outcomes. These are:

- enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing
- ensuring that the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori
- addressing racism and discrimination in all its forms
- protecting mātauranga Māori throughout the health and disability system.

Government priorities | Ngā whakaarotau a te Kawanatanga

Effective action to protect, promote and support breastfeeding requires political commitment at the highest level, and government leadership and coordination (World Health Organization 2003; World Health Organization 2020). This includes purposeful and decisive public action through policies, programmes and legislation (McFadden et al 2015).

Certain building blocks must be in a place at a national level to lay the foundations for the actions and outcomes that follow. These building blocks are presented across two priority areas for government action.

Priority 1 | Whakaarotau 1

Improving equity and wellbeing for Māori

Action	Why we should do this: what the evidence says
Develop and implement breastfeeding measures with an emphasis on increasing Māori health equity.	Breastfeeding can be strengthened by robust measurement and reporting. This would support DHBs to prioritise breastfeeding support for Māori, aligning with their responsibility to Te Tiriti (Manhire et al 2018).
Work in partnership with whānau, hapū and iwi Māori in the co-design, co-development, planning, decision making and evaluation of breastfeeding innovation and support services, including co-designing a new programme to incorporate into maternity, Well Child Tamariki Ora (WCTO) and primary care services.	Proactively engaging with whānau, hapū and iwi Māori (at national and regional levels) will ensure Māori are partners in decision making on matters affecting their health and wellbeing (Tapera et al 2017). Strengthening successful kaupapa Māori services and realigning services that are not appropriate or relevant to Māori consumers ensures that these services are well-placed to meet the breastfeeding needs and aspirations of Māori whānau (Edwards and Rangipohutu 2014).

Priority 2 | Whakaarotau 2

Policies, guidelines, regulations and frameworks protect, promote and support breastfeeding and optimal infant feeding

Effective action to protect, promote and support breastfeeding requires political commitment at the highest level, and government leadership and coordination (World Health Organization 2003; World Health Organization 2020). This includes purposeful and decisive public action through policies, programmes and legislation (McFadden et al 2015).

Certain building blocks must be in a place at a national level to lay the foundations for the actions and outcomes that follow. These building blocks are presented across two priority areas for government action.

Action	Why we should do this: what the evidence says
Policy and decision makers commit to understanding and meeting maternal and child health obligations under the various relevant national and international treaties, conventions and charters ratified by Aotearoa New Zealand. <u>Read more about relevant conventions.</u>	Protecting breastfeeding is a public health priority and a human rights obligation (Ralston et al 2020).
Explicitly consider breastfeeding in the development of relevant policies, guidelines, regulations and frameworks across government. These should be developed with wide stakeholder consultation and be free from commercial influences and conflict of interest.	Greater collaboration between sectors is required to promote best practice in protecting breastfeeding parents and their children (Gribble et al 2011). Evidence has demonstrated that the food industry can be overly influential in advocating their interests to policymakers (Cullerton et al 2016).
Work with food banks and charitable entities to ensure appropriate distribution of milk formulas. If powdered milk	It is important to ensure interventions are needs-based rather than donor-driven; and to guarantee

Action	Why we should do this: what the evidence says
formula is required, donated supply should continue for as long as the infant needs.	adequate quality and safety of the diet (IFE Core Group 2017).
The Ministry breastfeeding lead and the Infant and Young Child Feeding Committee (IYCFC) work with other interested parties to establish and support <u>World Breastfeeding Trends Initiative (WBTi)</u> assessments in New Zealand Aotearoa.	The WBTi assessment tool was developed by the <u>International Baby Food Action Network</u> to assess countries' progress in implementing the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. The WBTi assessment results in a report card on each country's national practices, policy and programme indicators. As at October 2018, 97 countries, including Australia, have completed a WBTi report (Gupta, Nalubanga, Trejos et al 2020). <u>Read more.</u>
Establish a regular process to review Aotearoa New Zealand's interpretation of the International Code <u>(The Code in NZ).</u> The review process should be developed in collaboration with the Ministry breastfeeding lead and the IYCFC.	Aotearoa New Zealand is a signatory to the International Code of Marketing of Breastmilk Substitutes (the Code) and has a responsibility to ensure the Code is upheld (Ministry of Health 2007).
Update and simplify information available about The Code in NZ, giving particular attention to increasing understanding about the 'grey areas' and the self-regulation processes.	There is inconsistent knowledge among policy makers, health workers, the NGO sector, consumers and other relevant parties regarding implementation of The Code in NZ (Burgess and Quigley 2011).
Review the current <u>Code complaints procedure</u> and implement required changes to simplify the complaints process. This should be developed in collaboration with the Ministry breastfeeding lead and the IYCFC.	The 2011 review of the Effectiveness, Implementation and Monitoring of the International Code of Breast-Milk Substitutes in New Zealand concluded that the current process was unnecessarily onerous on complainants (Burgess and Quigley 2011).

Action	Why we should do this: what the evidence says
Work with the Ministry of Primary Industries and <u>Food Standards Australia New Zealand</u> to review evidence relating to the marketing, labelling and preparation of breast milk substitutes, particularly regarding the safe preparation of powdered milk formulas.	Work is needed to clarify standards and improve safe use and preparation of breast milk substitutes and improve ministerial policy guidance and alignment with international regulations (First Steps Nutrition Trust 2020; Food Standards Australia New Zealand 2017).
Review relevant legal measures currently in place to strengthen the <u>About the WHO Code</u> and to better align with the <u>WHO International Code</u> and subsequent WHA resolutions.	There is limited understanding about what legal measures are in place to uphold the Code in NZ (Burgess and Quigley 2011).

Key outcomes and actions | Ngā whāinga matua e ngā mahi

A **Pae ora** approach emphasises the interconnection between parents and caregivers, their whānau, and the environments, determinants and support structures that influence infant feeding. The following outcomes recognise the need for a holistic, whole-of-system approach to the protection, promotion and support of breastfeeding in Aotearoa.

For each outcome, actions and supporting evidence are presented.

Outcome 1 | Putanga 1

Breastfeeding parents and their whānau have equitable access to a range of culturally appropriate breast and infant feeding supports

Action	Why we should do this: what the evidence says
Develop and maintain an up-to-date database of national and regional breastfeeding support services (both public and private). Identify service gaps and report these to the IYCFC.	Health and social services need national coordination to efficiently and effectively protect, promote and support breastfeeding, and to identify and address gaps and duplication in services (Women's Health Action and Point Research 2017; National Breastfeeding Advisory Committee of New Zealand 2009).
Increase the bicultural competence and confidence of the maternal and child health workforce, with particular attention to understanding and responding to the breastfeeding information and support needs of Māori and Pacific people.	Accessing breastfeeding support that is culturally safe, responsive and reflects cultural diversity can help address inequities in breastfeeding rates (Reinfelds 2015; Foaese 2019; Castro et al 2017).
DHBs work together with iwi, hapū and whānau, and existing breastfeeding support services, to address national and regional	A key aspect of effective breastfeeding support services is that they are tailored to the setting and the needs of population groups experiencing inequity (Public Health Unit, Taranaki DHB 2017).

Action	Why we should do this: what the evidence says
breastfeeding support service gaps. Report actions and progress to address gaps to the IYCFC.	
Increase the capacity of health providers (including <u>Well Child Tamariki Ora</u> providers and <u>Whānau Ora navigators</u>) to engage with partners and wider whānau to support and encourage breastfeeding parents.	Support from partners and wider whānau is consistently identified as key to establishing breastfeeding and increasing exclusivity and duration (Foaese 2019).
Identify current effective wānanga hapūtanga or kaupapa Māori breastfeeding and antenatal initiatives. Prioritise resources to support increased capacity and capability where need is identified. Report actions and progress to address gaps to the IYCFC.	Breastfeeding education is a central aspect of increasing breastfeeding initiation and duration. Ensuring that all whānau Māori have access to breastfeeding education is crucial, particularly education that honours Māori worldviews (Foaese 2019).
Embed effectively resourced kaiāwhina and peer supporters into wider community lactation services.	Use of tuakana-teina models and peer support interventions can result in improvements in the number of parents initiating breastfeeding (Balogun et al 2016). Those accessing peer support services were more likely to be breastfeeding at six months (Forster et al 2019). Peer support is particularly important for assisting younger parents to breastfeed (Public Health Unit, Taranaki DHB 2017).
Identify and action the breast/chestfeeding information and support needs of trans, non-binary, takatāpui and other gender-diverse parents and whānau.	Health workers and other support services involved in the care of breast/chestfeeding parents need to be knowledgeable about the specific lactation support required by trans, non-binary, takatāpui and other gender-diverse parents. Breast/chestfeeding support and information should be informed by the

Action	Why we should do this: what the evidence says
Report actions and progress to address gaps to the IYCFC.	principles of gender-inclusive care (MacDonald et al 2016).
Identify and action the breastfeeding information and support needs of parents and/or infants with disabilities and their whānau. Report actions and progress to address gaps to the IYCFC.	Health workers and other support services involved in the care of breastfeeding parents need to be knowledgeable about the specific lactation support required by parents and/or infants with disabilities and their whānau (Powell et al. 2018).
Increase the competence and confidence of the maternal and child health workforce to understand and respond to parents and caregivers who cannot, or choose not to, exclusively breastfeed.	Many health workers report having limited understanding on how to support appropriate use, preparation and storage of infant formula (Allen and Clarke 2018). Evidence indicates that interventions to increase breastfeeding that fail to address caregivers' needs in relation to formula feeding, particularly in a culture where mixed feeding is common, risk alienating potential beneficiaries, limit intervention reach and retention, and decrease the likelihood of achieving breastfeeding related outcomes (Jolly et al 2018).

Guiding documents and tools

- **Transgender parents and chest or breastfeeding**
- **Protecting, Promoting and Supporting Breastfeeding in Aotearoa New Zealand**

Outcome 2 | Putanga 2

Breastfeeding parents and their whānau are supported by increased community education, resources and societal awareness

Action	Why we should do this: what the evidence says
Ministry of Health Manatū Hauora works with the IYCFC and marketing experts to review the current status of national breastfeeding promotion.	Breastfeeding promotion campaigns provide encouragement for breastfeeding parents and also help normalise breastfeeding within wider communities (Skelton et al 2018).
The Ministry breastfeeding lead and the IYCFC work with the maternal and child health sector to strengthen existing successful breastfeeding promotion initiatives and support the development of new campaigns.	Mass media or social marketing campaigns can be effective in raising awareness but need to be sustained long enough to effect behaviour change (Brown 2017).
Review and update Ministry of Health Manatū Hauora consumer-facing breastfeeding resources with the aim of having culturally responsive, current, free resources available in digital format. Ensure that regionally developed breastfeeding resources are consistent with national key messages and included on individual DHB websites to assist breastfeeding parents and whānau to access local information.	The availability of high-quality, consistent information delivered in appropriate and manageable ways is imperative to achieving breastfeeding goals. This should include information available to whānau and support people (Reinfelds 2015).
Consider innovative ways to provide breastfeeding information and support, including on digital and virtual platforms.	The availability of peer support plus expert clinical advice that is timely and easily accessible, may improve maternal confidence and prevent early cessation of breastfeeding. The ability to adapt to virtual consultations quickly is particularly helpful for remote and rural clients, and for negotiating

Action	Why we should do this: what the evidence says
	environmental barriers like COVID-19, extreme weather conditions and road closures (Interim COVID-19 WCTO Clinical Governance Group 2020; Women's Health Action 2020).
Review and revise the <u>Baby Friendly Community Initiative (BFCI)</u> to ensure the programme is cost effective and aligns with relevant services and providers.	Achieving BFCI accreditation helps ensure best-practice standards for infant and young child feeding. It also supports the provision of factual information and support for those who are pregnant or breastfeeding, and parents who cannot or choose not to exclusively breastfeed.

Where are we now?

- The BFCI programme Aotearoa was discontinued in 2016. There is work underway to explore the viability of relaunching this programme.

Next steps and considerations

- A revised BFCI programme needs to engage health workers, and community and social service providers, particularly WCTO providers. It needs to be aligned with breastfeeding workplace initiatives and local/central government initiatives.

Guiding documents and tools

- Comprehensive plan to inform the design of a national breastfeeding promotion campaign**

Outcome 3 | Putanga 3

Maternal and child health workforce has the training, capacity and support to actively protect, promote and support breastfeeding

Action	Why we should do this: what the evidence says
Educational institutions, government and employers collaborate to include education on breastfeeding in pre- and post-registration curricula for all health	Educational curriculum or specialised training programmes for health professionals can improve breastfeeding knowledge and attitudes, and generate the

Action	Why we should do this: what the evidence says
professionals who care for parents/caregivers and children. This education includes the social, cultural, political and economic influences on infant feeding decisions.	confidence needed to support breastfeeding (Yang et al 2018).
Ministry of Health Manatū Hauora works with relevant health professional colleges, associations and regulatory authorities to increase the maternal and child health workforces' knowledge and understanding of their responsibilities under the Health Workers' Code.	There are significant gaps in health workers' knowledge and understanding of the Health Workers' Code (Allen and Clarke 2018), particularly relating to: - responsibilities to provide guidance on the use of infant formula, including safe preparation, use and storage - the complaints process for the Infant Nutrition Council Code of Practice for the Marketing of Infant Formula in New Zealand.
Revise education requirements for primary health organisations and providers (such as practice nurses and GPs), and promote breastfeeding-friendly policies in primary health care practices.	Many health care professionals lack the necessary knowledge, attitudes and skills to effectively address parents' breastfeeding concerns (Gavine et al 2016).
Support increased workforce capacity via updated funding models and referral pathways that improve integrated care and timely access to specialist breastfeeding support provided by professionals certified by the <u>International Board of Lactation Consultants</u> .	Collaborative approaches among health care professionals are essential for successful breastfeeding (Rosin and Zakarija-Grković 2016). Adequately resourced integrated care models optimise continuity, consistency and quality, while ensuring interdisciplinary cooperation and cost efficiency (OECD 2017).

Where are we now?

- Breastfeeding education is included in the curricula of pre-registration midwifery qualifications but is not routinely included in pre-registration nursing or medical qualifications. A growing number of health professionals and others hold the additional

International Board-Certified Lactation Consultant qualification (IBCLC), but there is a lack of Māori IBCLCs.

- Compulsory continuing education on breastfeeding was withdrawn from the Midwifery Council Annual Practising Certificate (APC) cycle in 2017.

Next steps and considerations

- Include breastfeeding in the curricula of pre-registration nursing and medical qualifications.
- Reinstate compulsory continuing breastfeeding education for midwives as part of the APC cycle and ensure it is included in the Midwifery First Year of Practice programme.
- Facilitate opportunities for continuing education in breastfeeding through health professional postgraduate programmes and other educational institutions.

Guiding documents and tools

- Health worker's code

Outcome 4 | Putanga 4

All maternity facilities achieve and maintain Baby Friendly Aotearoa (BFHI) accreditation

Action	Why we should do this: what the evidence says
Maintain Baby Friendly Aotearoa (BFHI) accreditation as a contractual requirement for all private and public maternity facilities.	The BFHI has been effective in improving breastfeeding rates, both nationally and internationally. Globally, systemic reviews reveal the positive impacts of the BFHI, including improvements in breastfeeding initiation and duration (Pérez-Escamilla et al 2016).
Ensure maternity services staff attain the necessary skills to implement the BFHI criteria for New Zealand Aotearoa. All maternity services staff, irrespective of designation, should receive orientation to the service's breastfeeding policy when	All health workers who provide care during the antenatal and postnatal period and beyond have a key role to play in establishing and sustaining breastfeeding. Many health workers cannot fulfil this role effectively because they have not been trained to do so (World Health Organization and United Nations Children's Fund 2020).

Action	Why we should do this: what the evidence says
beginning employment and at each policy review.	
Investigate implementing Neo-BFHI into neonatal units to expand the current BFHI model. Expand the BFHI into paediatric wards and wider hospital facilities and ensure adequate specialty services are in place for breastfeeding parents, infants and children when admitted to a DHB setting.	Research demonstrates positive impacts for neonates, parents and facilities when Neo-BFHI steps are implemented. In addition, research indicates international readiness for expansion of baby-friendly standards to neonatal settings (Maastrup et al 2019).

Where are we now?

- The implementation of the BFHI in maternity services has produced a significant improvement in breastfeeding rates (Baby Friendly Aotearoa, 2020).
- BFHI Documents for New Zealand Aotearoa were revised in 2020. Pae ora and te ao Māori have been integrated into the BFHI Documents 2020.
- Annual breastfeeding data on discharge from all maternity services is collected online and reported back to the wider health sector.

Next steps and considerations

- Updated WHO/UNICEF criteria, training tools and advice will be integrated into the BFHI programme.
- Consider alignment of Baby Friendly Aotearoa with other health accreditation frameworks.

Guiding documents and tools

- **Protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018**
- **WHO/UNICEF Ten Steps to Successful Breastfeeding**
- **BFHI Documents**
- **Baby Friendly Aotearoa – Community**

Outcome 5 | Putanga 5

System settings support the safe provision of donor breast milk for infants in need

Action	Why we should do this: what the evidence says
Ministry of Health Manatū Hauora and other relevant parties work with the Human Milk Regulation Working Group to ascertain the status of the supply of and demand (including unmet demand) for donor human milk in New Zealand Aotearoa. Identify and action initiatives to improve access to donor milk.	There is evidence supporting the use of pasteurised donor human milk for hospitalised preterm or sick infants. A 2016 systematic review and meta-analysis found that the introduction of donor human milk increased any breastfeeding on discharge by about 20 percent (Williams et al 2016).
Develop resources to support safe peer-to-peer milk sharing, including pathways to access free screening, support systems and information about safe storage and transportation of donor milk.	Blood testing is part of the medical screening of potential milk donors and should be accessible for those donating and accessing human milk, along with evidence-based information about the risks and benefits (Perrin et al 2018; Gribble 2013).

Where are we now?

- There are two functioning human milk banks in New Zealand Aotearoa.
- There is no national regulatory framework for human milk banks, but the two existing milk banks follow international best practice guidelines.
- There is no food standard for the processing and/or pasteurisation of human milk.

Next steps

- Implementation of the Operational Guidelines for Milk Banks in Australia and New Zealand post document is release in 2020.

Guiding documents and tools

- **Strengthening Human Milk Banking: A Global Implementation Framework**

Outcome 6 | Putanga 6

How a robust evidence base informs infant feeding policy decisions and commissioning activities

Action	Why we should do this: what the evidence says
Invest in cross-sector activities to support innovative research on infant feeding among academics, iwi and community providers. Research explores the experiential, social, economic and cultural influences that contribute to infant feeding in New Zealand Aotearoa.	A strong evidence base for breastfeeding is recognised as a crucial component of ensuring that adequate resources are dedicated to breastfeeding (World Health Organization and United Nations Children's Fund 2003).
Ministry of Health Manatū Hauora continues to strengthen the accuracy and completeness of the existing data set on breastfeeding rates.	The Global Strategy recommends that data on breastfeeding trends is collected and used to evaluate the impact of interventions. Having a complete and accurate data set is essential to this goal (World Health Organization and United Nations Children's Fund 2003).

Where are we now?

- Some DHB breastfeeding activities are not informed by a comprehensive data set.
- Research initiatives are underway to identify breastfeeding intentions, outcomes, barriers and enablers in New Zealand Aotearoa and internationally, but more research specific to New Zealand Aotearoa is needed.
- Standard measures and indicators of breastfeeding do not capture the diversity of infant feeding practices in New Zealand Aotearoa.

Next steps

- Create a WCTO DataMart to improve the quality of breastfeeding data.
- Ensure data collected in Maternity Clinical Information Systems is able to be reported locally, nationally and to the Ministry of Health | Manatū Hauora.

Guiding documents and tools

- **HISO 10050.2:2020 Maternity Care Summary Standard**

Outcome 7 | Putanga 7

Workplaces, education and childcare settings support parents and caregivers to reach their breastfeeding goals

Action	Why we should do this: what the evidence says
Increase understanding of, and compliance with, the legislation protecting and supporting breastfeeding employees.	Evidence shows there is a lack of understanding regarding employer obligations to breastfeeding employees under the Employment Relations Amendment Act 2008 (Department of Labour 2010; Women's Health Action 2015).
Work collaboratively with national and regional providers to support the consistency and effectiveness of national and regional Breastfeeding Friendly Workplace (BFW) initiatives.	Combining breastfeeding and employment is difficult for many parents, and a perceived lack of employer support negatively impacts the success of breastfeeding employees (Lubold and Roth 2012). Breastfeeding support in workplaces improves breastfeeding initiation, duration and exclusivity, and increases job satisfaction and commitment (Atabay et al 2014).
Implement policy and training to ensure early childhood education (ECE) centres are breastfeeding friendly.	ECE centres influence breastfeeding practices and decision making (Bartle and Duncan 2009). Implementing policy is essential in supporting ECE centres to be breastfeeding friendly (Marhefka et al 2018).

Guiding documents and tools

- **BFW Employer tools and templates**
- **Breastfeeding & Work: Let's make it work!**
- **Breastfeeding and returning to paid work**
- **The Employment Relations Amendment Act 2008**
- **The Code of Employment Practice on Infant Feeding**

Outcome 8 | Putanga 8

System settings support and protect optimal infant and young child feeding in cases of temporary or sustained parent-child separation

Action	Why should do this: what the evidence says
Provide breastfeeding parents who have social, health or medical risk factors with targeted support to continue breastfeeding.	Breastfeeding parents experiencing multiple social or other medical risk factors that contribute to stopping breastfeeding may be assisted by additional or more intensive support (Johnson et al 2015).
Support the provision of full-time dedicated breastfeeding and lactation support in NICUs and special care nurseries, paediatric wards and mental health units.	Research demonstrates that providing dedicated NICU breastfeeding and lactation support can be cost effective and is associated with improved breastfeeding outcome measures for high-risk preterm infants (Gharib et al 2018; Renfrew et al 2009).
Review evidence to ensure breastfeeding recommendations for parents with HIV are in line with current best practice evidence.	WHO guidelines (World Health Organization and UNICEF 2016) recommend that infants should be exclusively breastfed for the first six months, regardless of the HIV status of the breastfeeding parent.
Ensure skilled breastfeeding and lactation support is available to breastfeeding parents who are incarcerated and those with children and infants in child protection services.	Supporting breastfeeding parents who are incarcerated is a cost-effective and promising approach to protect the health and welfare of parents and their children (Baxter, Cooklin and Smith 2009; McIntyre 2017). Evidence suggests that recidivism can be reduced by utilising a prison nursery/mother-baby unit model (Carlson 2018).
Work with the Ministry of Justice and Department of Corrections to review the practicality and implementation of <u>M.03.03 Feeding and bonding facilities</u> and <u>M.03.02 Female and pregnant prisoners</u> . Assist with appropriate updates to	Supporting prisoners to have regular contact visits, or be co-located with their children in feeding and bonding facilities, minimises the impact of their imprisonment on their children and actively contributes to a reduced likelihood of intergenerational criminality (Department of

Action	Why should do this: what the evidence says
support national and international best practice, especially in the area of Mothers with Babies Units.	Corrections 2018; Elliott-Hohepa and Hungerford 2013).
Work with Oranga Tamariki, Ministry of Justice and Ministry of Social Development to review the practicality and implementation of the Oranga Tamariki <u>Maintaining family/whānau relationships</u> <u>polices</u> (Maintaining breastfeeding).	When an infant is removed from a birth parent, it is generally deprived of its right to the nutritional and immunological benefits of breast milk, which research shows has a long-term impact on healthy development (The Paediatric Society and Children's Hospitals Australasia 2018; Ministry of Children and Family Development and Representative for Children and Youth 2018). In addition, breastfeeding may be a protective factor against maternal neglect (Report of the Health Committee 2013; Strathearn et al 2009).

Guiding documents and tools

- **M.03.03 Feeding and bonding facilities**
- **M.03.02 Female and pregnant prisoners**
- **Promoting Access to Breastfeeding in Child Welfare Matters: Joint Special Report**
- **Rights of Children in Relation to Breastfeeding in Child Protection Cases**

Outcome 9 | Putanga 9

System settings support and protect optimal infant and young child feeding during emergencies

Action	Why we should do this: what the evidence says
Ministry of Health Manatū Hauora works with relevant stakeholders to ensure policies and procedures are in place to effectively implement the National Health Emergency Plan in regard to Appendix 11 – Position statement on infant feeding in an emergency. <u>National Health Emergency Plan - Ministry of Health</u>	Greater collaboration between sectors is required to promote best practice in protecting breastfeeding parents and their children in emergencies (Gribble et al 2011). Strengthening policies on, and planning for, infant and young child feeding in emergencies will help to protect the health and feeding of all infants and young children in disasters and emergencies (COAG Health Council 2019; IFE Core Group 2017).
Ensure that breastfeeding parents have access to support and information that will enable them to initiate, maintain and reinstate (if necessary) breastfeeding during an emergency.	Lack of support for infant feeding in emergencies places infants and young children at serious risk of adverse health consequences (Gribble, Peterson and Brown 2019).

Guiding documents and tools

- **Position Statement: Infant Feeding in an Emergency for Babies Aged 0–12 Months - Ministry of Health**
- **Infant Feeding in an Emergency: Guide for DHB Emergency Management Staff and Roles and Responsibilities - Ministry of Health**
- **Emergency preparedness for those who care for infants in developed country contexts - International Breastfeeding Journal**
- **Infant feeding in disasters and emergencies: Breastfeeding and other options**
- **Providing breastfeeding support during the COVID-19 pandemic: Concerns of mothers who contacted the Australian Breastfeeding Association - medRxiv**
- **Infant feeding during the coronavirus (COVID-19) crisis: A guide for local authorities - Unicef**

Pae Ora: A strategic framework

Increasing the exclusivity and duration of breastfeeding requires that whānau can access the technical, financial, emotional, cultural and public support they need to:

- **breastfeed exclusively for six months**
- **continue breastfeeding, along with offering complementary foods, for two years or beyond.**

(World Health Organization 2020)

Meeting these **global recommendations for optimal infant feeding** cannot be achieved through singular actions. Rather, the protection, promotion and support of breastfeeding in Aotearoa New Zealand requires a holistic, whole-of-system approach that adopts **pae ora** as a framework for co-design, co-development and implementation. This framework acknowledges the interconnectedness of the breastfeeding parent and child to their whānau, and the wider context of environments, determinants and support structures that influence infant feeding.

Specifically, pae ora emphasises that action to protect, promote and support breastfeeding needs to address three interconnected and mutually reinforcing elements.

1. Wai ora: Healthy environments

The concept of wai ora encapsulates the importance of the environments in which we live and that have a significant impact on the health and wellbeing of individuals, whānau and communities. This includes improving the governance and regulatory framework that underpins the protection, promotion and support of breastfeeding.

2. Whānau ora: Family health

The core goal of whānau ora is to empower whānau to control the services they need to work together, build on their strengths and achieve their aspirations. Whānau have their own capability and they can work to achieve their potential and their moemoea/aspirations. Breastfeeding support services should be inclusive and integrated. There is no one-size-fits-all approach; breastfeeding support should be flexible to meet family needs.

3. Mauri ora: Healthy individuals

Mauri ora focuses on the individual in the context of their reality. Mauri describes the vitality, energy and wellness that lies within every individual. Mauri ora emphasises that comprehensive health systems, from prevention to treatment, must be responsive to the needs all members of society. This includes providing information on how breastfeeding protection, promotion and support will assist all of Aotearoa New Zealand, including specific goals for priority groups.

The case for breastfeeding | Tūāhua mō te whāngote

Breastfeeding protects the health of children and whānau, as well as offering economic and environmental benefits (Victora et al 2016; Smith 2019; Walters et al 2019). Increasing breastfeeding rates positively contributes to performance against many systems level measures, in particular preventing ambulatory sensitive (avoidable) hospital admissions (ASH) in children aged 0–4. Breastfeeding is also key to achieving the sustainable development goals by 2030 (World Alliance for Breastfeeding Action 2016).

Look at ASH data on the [here](#).

WABA | World Breastfeeding Week. Breastfeeding: A Key to Sustainable Development



WABA | World Breastfeeding Week. Breastfeeding: A Key to Sustainable Development

1. Breastfeeding is a natural and low-cost way of feeding babies and children. It is affordable for everyone and does not burden household budgets compared to artificial feeding. Breastfeeding contributes to poverty reduction.
2. Exclusive breastfeeding and continued breastfeeding for two years and beyond provide high quality nutrients and adequate energy and can help prevent hunger, undernutrition and obesity. Breastfeeding also means food security for infants.
3. Breastfeeding significantly improves the health, development and survival of infants and children. It also contributes to improved health and wellbeing of mothers, both in the short and long term.
4. Breastfeeding and adequate complementary feeding are fundamentals for readiness to learn. Breastfeeding and good quality complementary foods significantly contribute to mental and cognitive development and thus promote learning.
5. Breastfeeding is the great equaliser, giving every child a fair and best start to life. Breastfeeding is uniquely a right of women and they should be supported by society to breastfeed optimally. The breastfeeding experience can be satisfying and empowering for the mother as she is in control of how she feeds her baby.
6. Breastfeeding on demand provides all the water a baby needs, even in hot weather. On the other hand, formula feeding requires access to clean water, hygiene and sanitation.
7. Breastfeeding entails less energy when compared to formula production industries. It also reduces the need for water, firewood and fossil fuels in the home.
8. Breastfeeding women who are supported by their employers are more productive and loyal. Maternity protection and other workplace policies can enable women to combine breastfeeding and their other work or employment. Decent jobs should cater to the needs of breastfeeding women, especially those in precarious situations.
9. With industrialisation and urbanisation the time and space challenges become more prominent. Breastfeeding mothers who work outside the home need to manage these challenges and be supported by employers, their own families and communities. Creches near the workplace, lactation rooms and breastfeeding breaks can make a big difference.
10. Breastfeeding practices differ across the globe. Breastfeeding needs to be protected, promoted and supported among all, but in particular among poor and vulnerable groups. This will help to reduce inequalities.
11. In the bustle of big cities, breastfeeding mothers and their babies need to feel safe and welcome in all public spaces. When disaster and humanitarian crises strike, women and children are affected disproportionately. Pregnant and lactating women need particular support during such times.
12. Breastfeeding provides a healthy, viable, non-polluting, non-resource intensive, sustainable and natural source of nutrition and sustenance.
13. Breastfeeding safeguards infant health and nutrition in times of adversity and weather-related disasters due to global warming.

14. Breastfeeding entails less waste compared to formula feeding. Industrial formula production and distribution lead to waste that pollutes the seas and affects marine life.
15. Breastfeeding is ecological compared to formula feeding. Formula production implies dairy farming that often puts pressure on natural resources and contributes to carbon emissions and climate change.
16. Breastfeeding is enshrined in many human rights frameworks and conventions. National legislation and policies to protect breastfeeding mothers and babies are needed to ensure that their rights are upheld.
17. The Global Strategy for Infant and Young Child Feeding (GSIYCF) fosters multi-sectorial collaboration, and can build upon various partnerships for support of development through breastfeeding programs and initiatives.

Read more about the health, economic and environmental benefits of breastfeeding:

- **[Reduction in illness | Kia heke te taumaha](#)**
- **[Reduction in health costs | Kia heke te utu hauora](#)**
- **[Societal and environmental benefits | Ngā hua mō te hapori me te taiao](#)**

Breastfeeding in a national and global context | Whāngote ki Aotearoa, ki tāwāhi

Indigenous breastfeeding cultures in New Zealand Aotearoa and globally have been undermined by colonisation and other global economic and political influences. Breastfeeding has been identified as a human right, and efforts to improve breastfeeding exclusivity and duration are articulated through a global health equity lens.

Read more about the national context for breastfeeding:

- **[Breastfeeding in New Zealand | Whāngote ki Aotearoa](#)**

Read more about the global context for breastfeeding:

- **[Breastfeeding in the international context | Whāngote ki tāwāhi](#)**

Breastfeeding support services | Ratonga tautoko whāngote

In New Zealand Aotearoa, a wide range of supporters work collaboratively to assist whānau to achieve their breastfeeding goals and desired intentions. The acquisition of knowledge and skills, support by health care providers, and a parent's self-efficacy and self-confidence in their ability to breastfeed are all important influences (Bartle and Harvey 2017; Wood et al 2016; Entwistle et al 2010).

Read more about breastfeeding support services in New Zealand Aotearoa:

- [Breastfeeding support services | Ratonga tautoko whāngote](#)

Structural influences and barriers | Awenga ā-pūnaha, taero ā-pūnaha

Infant feeding decisions are influenced by the society and environment in which parents and caregivers live, and the level of support they are able to access to achieve their breastfeeding goals (Rollins et al 2016). Rates of exclusive breastfeeding in New Zealand Aotearoa are influenced by a wide range of factors, including whānau and partner support, socioeconomics, social pressure, cultural influences, and mental health and wellbeing. The availability of support in various settings such as workplaces, education, health care and community spaces also plays an important role.

Read more about the structural influences on breastfeeding:

- [Structural influences and barriers | Awenga ā-pūnaha, taero ā-pūnaha](#)

Breastfeeding policy and legislation in New Zealand | Herenga me ngā ture whāngote i Aotearoa

Globally, the right to breastfeed and to be breastfed is well-documented in international conventions and treaties related to health and human rights. In New Zealand Aotearoa, the legislative framework for protecting, supporting and promoting breastfeeding is covered in key pieces of policy and legislation designed to address the barriers to breastfeeding across infancy and early childhood.

Read more about breastfeeding policy and legislation:

- [Breastfeeding policy and legislation in New Zealand | Herenga me ngā ture whāngote i Aotearoa](#)

Further reading | Panui atu

The case for breastfeeding | Tūāhua mō te Whāngote

Information on the benefits of breastfeeding in reducing illness and improving health, reduction in health costs, and societal and environmental

Reduction in illness and improved health | Kia heke te taumaha, kia piki te ora

Information on the benefits of breastfeeding in reduced illness and improved health.

For infants, breastfeeding supports the development of a healthy immune system, and works as a protective factor against sudden unexplained death in infancy (Victora et al 2016). Breastfeeding can reduce respiratory, gastrointestinal and acute ear infections, type 1 and 2 diabetes and obesity (Stuebe 2009). Women who breastfeed are less likely to experience postpartum haemorrhage, postpartum weight retention and depression (Victora et al 2016; Stuebe 2009). Additionally, breastfeeding works as a protective factor against many chronic illnesses, including invasive breast cancer, ovarian cancer, hyperlipidaemia, hypertension, cardiovascular disease and type 2 diabetes (Victora et al 2016).

Recent epidemiological and biological research expands on the known benefits of breastfeeding for parents and children (Benjamin 2011; Victora et al 2016). These include epigenetic benefits, reducing vulnerability to chronic illness and conditions (Binns et al 2016; Eidelman 2019), and supporting gut microbiota in health and diseases such as allergies (Van den Elsen et al 2019).

Children | Tamariki

Increasing breastfeeding exclusivity and duration may reduce the risk of a range of poor health outcomes (Victora et al. 2016; Stuebe 2009), such as:

- respiratory infections
- type 2 diabetes
- gastroenteritis
- otitis media
- obesity
- sudden unexpected death in infancy.

Additional resources | He rauemi anō

- **Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect**
- **Perspective: Should Exclusive Breastfeeding Still Be Recommended for 6 Months?**
- **Benefits of Breastfeeding – NZBA resource**
- **Breastfeeding and the risk of respiratory tract infections after infancy: The Generation R Study**
- **Shaping the Gut Microbiota by Breastfeeding: The Gateway to Allergy Prevention?**

Breastfeeding parent | Ūkaipō

Breastfeeding promotes maternal health. Women who breastfeed experience lower rates of postpartum haemorrhage, postpartum weight retention and depression (Victora et al. 2016; Stuebe 2009). Benefits to mental health include increases in maternal sensitivity, the ability to cope with stress and improved sleep (Kendall-Tackett 2017).

Breastfeeding positively contributes to maternal mental health and wellbeing, and protects against many chronic illnesses, such as:

- invasive breast cancer
- uterine cancer
- ovarian cancer
- type 2 diabetes
- osteoporosis and reduced bone density in later life.

Additional resources | He rauemi anō

- **Maternal and economic benefits of breastfeeding**
- **Maternal, newborn, child and adolescent health**

Societal and environmental benefits | Ngā hua mō te hapori me te taiao

Information on the benefits of breastfeeding for society and the environment

The benefits of breastfeeding reach far beyond health, and in the face of a climate crisis the case for breastfeeding is strengthened. Breast milk is a naturally renewable resource that requires no packaging, shipping or disposal. Furthermore, it does not require intensive dairy farming or the use of non-renewable and polluting technology (Smith 2019; Karlsson et al 2019).

The economic benefits of breastfeeding for whānau are substantial. Breastfeeding is inexpensive when compared to using breast milk substitutes (milk formulas), and whānau may save on health costs due to reduced incidence of illness. The financial impacts of infant feeding can be significant, particularly for those in low socioeconomic or minority populations who are most likely to formula feed in New Zealand Aotearoa (Manhire et al 2018).

In addition, breastfeeding improves productivity in the workplace and benefits employers (Ministry of Health 2020) by reducing staff absenteeism and contributing to a more stable workforce. Employers who support their employees (through maternity benefits, breastfeeding breaks) note improved staff morale, reduced staff turnover and increased loyalty.

Additional resources | He rauemi anō

- **A commentary on the carbon footprint of milk formula: harms to planetary health and policy implications**
- **No one is talking about the environmental impacts of the baby formula industry**
- **The carbon footprint of breastmilk substitutes in comparison with breastfeeding**

Breastfeeding in New Zealand | Whāngote ki Aotearoa

Information on the history of breastfeeding in Aotearoa New Zealand

Breastfeeding practices in Aotearoa New Zealand have been compromised by various external influences. Colonisation, medicalisation, sexualisation of breasts, and the commercialisation of breast milk substitutes have contributed to environments that have undermined breastfeeding as a normal cultural practice.

Before colonisation, all Māori infants were breastfed (Papakura 1938). In pre-colonised Aotearoa New Zealand, breastfeeding was viewed as an imperative in maintaining and sustaining a child's development and wellbeing. A well-fed child was reflective of the health status of the whānau, hapū and iwi, and ensured the continuance of future generations. Breastfeeding was so valued that its benefits were recognised through normalised practices such as wet nursing (Lusk et al 2000). If the birth parent was unavailable or could not breastfeed, the baby would be breastfed by another woman in the whānau or hapū (Glover et al 2008). Post-colonisation policies and culture saw the unjust loss of many Māori practices and the introduction of, often detrimental, westernised practices into Māori society. Lower breastfeeding rates are one of the indicators that Māori health and wellbeing has declined as a result of colonisation.

During the 19th and early 20th centuries, industrialisation and the growing authority of medical professionals resulted in substantial shifts away from breastfeeding towards commercial products (Minchin 2018) both internationally and within the New Zealand context. In the early decades of the 20th century, childbirth, mother care and baby feeding practices were heavily medicalised. This shift, along with unrestricted marketing of infant feeding products, the sexualisation of breasts in Western societies, and major transformations in gender relations and family dynamics that saw women shift into the paid workforce, contributed to rapidly declining breastfeeding rates (McBride-Henry and Clendon 2010).

The feminist movement of the 1960s and the establishment of community networks, such as the La Leche League and the Parents' Centre, began to change the way that many women valued and understood their own bodies and knowledge (Else 2019). Despite changing perceptions among women, only 47 percent of babies were breastfed by the end of the 1960s, as opposed to the 87 percent breastfed during the 1920s (McBride-Henry and Clendon 2010).

Rates began to steadily increase in the 1970s and continued to rise with the implementation of the International Code of Marketing of Breast Milk Substitutes in 1981 (Reinfelds 2015). However, breastfeeding rates in Aotearoa New Zealand have now plateaued for both Māori and non-Māori.

Health promotion | Whakatairanga hauora

Information on the Ottawa Charter for Health Promotion and how it can be applied to support breastfeeding.

Health promotion aims to enable people to gain control over, and improve, their own health. The Ottawa Charter for Health Promotion provided the first international framework for health promotion based on five components (World Health Organization 1986):

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

On a global scale the approaches vary considerably depending on context. In many developing countries there are continued attempts to stop formula companies from marketing to vulnerable parents. In addition, in developed countries issues of inadequate breastfeeding services, maternal isolation, lack of community support for parents, discrimination in various environments and lack of paid parental leave frequently prove to be barriers for parents to achieve their breastfeeding goals.

Applied to breastfeeding, the five components from the Ottawa Charter can be used to:

- tackle breastfeeding prevalence, duration, and intensity from many angles
- set out evidence-based expectations relating to a government's performance in relation to promoting, supporting and protecting breastfeeding
- provide frameworks for addressing breastfeeding prevalence-related issues

- contribute to an environment that supports or, in some cases, requires involved nations to commit to develop and maintain policies, structures and services that support, promote, and protect breastfeeding.

Breastfeeding support services | Ratonga tautoko whāngote

Information on breastfeeding support services, including postnatal care in maternity facilities, Lead Maternity Carers, IBCLCs (lactation consultants)

The importance of evidence-based breastfeeding support provided in a sensitive, culturally appropriate and individualised manner is well-established in research (Blixt et al 2019). Breastfeeding support services should be multidimensional, introduced at different points during the childbirth and postpartum journey, and offered by a range of providers, in different settings and using different modalities including online support innovations and culturally diverse services (Alberdi et al. 2017; Manhire et al. 2018; Bridges 2016)

In Aotearoa New Zealand, whānau can access breastfeeding support through community groups, private providers and DHBs, such as:

- postnatal care in maternity facilities
- Lead Maternity Carers
- IBCLCs (lactation consultants)
- peer support/kaiāwhina services.

Postnatal care in maternity facilities

The Ministry of Health currently funds a 48-hour postnatal stay following labour and birth. Longer stays are possible for women experiencing breastfeeding problems. During the postnatal stay the skilled support of midwives and other health professionals is offered to initiate and support breastfeeding.

Lead Maternity Carers

In Aotearoa New Zealand, Lead Maternity Carers are required to provide a minimum of seven postnatal visits, at least five of which need to be in the home in the six weeks following birth (Ministry of Health 2019). This postnatal care is the final stage of the continuity of care relationship that begins during pregnancy, continues throughout the labour and birth, and concludes six weeks following birth.

IBCLCs (often called lactation consultants)

International Board Certified Lactation Consultants (IBCLCs) have undertaken an education programme and gained a qualification in lactation consultancy. They may be employed in maternity facilities or community settings, or may be self-employed. They are

often also nurses, midwives, GPs or other health professionals. IBCLCs work with more complex breastfeeding and lactation issues such as preterm babies; babies with cardiac or other medical conditions; and mothers with mastitis, breast abscess, breast cancers, delayed lactation and more. They often work in conjunction with midwives, Well Child Tamariki Ora Providers, doctors, breastfeeding advocates, kaiāwhina and breastfeeding peer supporters.

Peer support/kaiāwhina services

Peer support programmes such as those offered by La Leche League are available countrywide, working to increase breastfeeding knowledge, confidence and enjoyment (Ministry of Health 2015). Mother-to-mother, parent-to-parent and peer-to-peer groups have demonstrated significant success in sharing information, providing avenues for questions and discussions, empowering decisions, establishing support groups and enduring friendships, and teaching health professionals (La Leche League International; WABA 2016; Rossman 2011; Brown 2018; McFadden 2019).

Kaiāwhina are an essential part of the Aotearoa New Zealand health and disability sector workforce. Kaiāwhina are qualified Māori community health workers and use Māori models of health to work collaboratively with whānau. Many kaiāwhina can understand and speak te reo Māori and have a strong knowledge of local iwi and Māori health groups. This can help whānau to stay or become connected to local Māori support.

Kaiāwhina offer support services for mothers and their pēpe/tamariki that is designed to generate a warm, therapeutic, non-judgemental and culturally safe environment for the whānau and their pēpe. Kaiāwhina who have received breastfeeding education can help by supporting breastfeeding, encouraging parenting skills, and building self-esteem and confidence in a supportive environment for responsible and positive care of the tamariki.

Other supporters

Other sources of support range from those who provide wai rakau rongoa, complementary therapies, herbalists, and other registered therapists and health professionals, including physiotherapists, cranio-sacral therapists and more.

Successful community breastfeeding support programmes

Services that raise awareness of breastfeeding are important support systems for breastfeeding as they both provide individual support and normalise breastfeeding (World Health Organization and United Nations Children's Fund 2003).

In 2018/19 Bay of Plenty DHB Planning and Funding led a procurement process to seek providers for Kaupapa Māori Breastfeeding Support services for the region. The two selected providers have been delivering services since March 2019. Ngā Kakano works in the Western Bay of Plenty, and the Eastern Bay iwi alliance (service lead iwi – Ngati Awa Iwi Social and Health service) with Plunket covers the Eastern Bay of Plenty. The models

are similar in that they provide open referral pathways into the service and operate a multi-tiered service, with kaiāwhina providing the parent-to-parent support and lactation consultants for clinical support. These services provide a kaupapa Māori service underpinning, with a big focus on manaakitanga, whānau ora and supportive traditional practices.

Breastfeeding policy and legislation in New Zealand | Herenga me ngā ture whāngote i Aotearoa

Information on breastfeeding policy and legislation in New Zealand, including our international commitments.

Human Rights Act 1993

There is no specific law in Aotearoa New Zealand that deals with the right to breastfeed, but legal protection for the right is available in some circumstances, such as proven disadvantageous treatment based on direct or indirect sex discrimination.

Other relevant conventions and charters include:

- **United Nations Convention on the Rights of the Child**
- **Convention on the Elimination of all Forms of Discrimination Against Women**
- **The Universal Declaration of Human Rights**
- **International Covenant on Economic, Social and Cultural Rights**
- **International Covenant on Civil and Political Rights**

Implementing The Code in NZ

Aotearoa New Zealand is a signatory to the International Code of Marketing of Breastmilk Substitutes (the Code). Effective and full implementation of the Code and subsequent World Health Assembly resolutions is a complex and resource-intensive process. Implementation is influenced by the political will to legislate and enforce the Code (World Health Organization et al 2016).

The current Code in NZ was set up as voluntary and self-regulatory because the government directed that the Code was to be implemented and monitored through consensus and discussion, not through legislation. Article 5 of the Code specifies that products within its scope are not advertised. In New Zealand, at the time, it was believed that it was not possible to legally restrict the advertising of products without contravening the Commerce Act 1986 and the Fair Trading Act 1986. Following a review of the voluntary, self-regulatory implementation and monitoring process for the Code in NZ in 2001, the Ministry of Health | Manatū Hauora decided to continue with the same approach. However, the Ministry acknowledged that attention needs to be paid to raising awareness of the Code in NZ, and to the marketing of follow-on formula (Ministry of Health 2012).

Further reading | He rauemi anō

- [The Health Workers' Code](#)
- [FSANZ Standard 2.9.1 Infant formula products](#)
- [FSANZ Standard 2.9.2 Food for infants](#)
- [Children and Young People's Advertising Code](#)
- [Review of the NZ interpretation WHO International Code of Marketing of Breast-milk Substitutes](#)
- [International Code of Marketing of Breast-milk Substitutes](#)
- [Implementing and monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand](#)
- [Key stakeholder consultation to complete the evaluation of the effectiveness of the WHO International Code of Marketing of Breast-Milk Substitutes in New Zealand](#)
- [Marketing of breast-milk substitutes: National implementation of the international code – Status Report 2016](#)
- [INC Code & Health Workers Code of Practice*](#)

* INC represents the major manufacturers, marketers and ingredient suppliers of infant formula and toddler milk in Australia and New Zealand as well as local manufacturers who are producing product for export.

Baby Friendly Hospital Initiative (BFHI)

The BFHI is an international programme launched in 1991 by the World Health Organization and the United Nations Children's Fund to ensure all maternity services become centres of breastfeeding support worldwide. Mothers receive immediate breastfeeding support through the BFHI. In Aotearoa New Zealand the Ministry of Health | Manatū Hauora contracts the New Zealand Breastfeeding Alliance (NZBA) to facilitate the Baby Friendly Aotearoa Programme, of which the BFHI is a part. The BFHI works to improve exclusive breastfeeding rates by providing evidence-based breastfeeding support to parents, and ensuring maternity providers employ best-practice standards of care. The BFHI also requires services to support mothers who choose not to or cannot breastfeed. It is a requirement in New Zealand Aotearoa that all maternity facilities are BFHI accredited, and as a result 99.85 percent of infants are born in BFHI-accredited facilities.

Read more about:

- [Baby Friendly Aotearoa](#)
- [WHO/UNICEF 10 Steps to Successful Breastfeeding](#)

Baby Friendly Community Initiative (BFCI)

Families and communities are indispensable resources for breastfeeding parents. Evidence has shown that parent-to-parent support groups, peer counsellors and community-based workers can be very effective in helping parents to initiate exclusive breastfeeding and sustain breastfeeding for up to two years or beyond. In 2019, 78 percent of infants were exclusively breastfed on discharge from maternity services. However, this percentage drops significantly to 49 percent six weeks after birth, and then 16.7 percent at six months.

The BFCI is part of the Baby Friendly Aotearoa Programme and strives to create supportive breastfeeding services in the community. Like the BFHI, it aims to protect, promote and support breastfeeding for healthy parents and babies through the implementation of best-practice standards based on current scientific evidence and set guidelines. The BFCI programme includes a broad focus on:

- providing community support for the initiation of breastfeeding to improve exclusive breastfeeding rates
- supporting mothers to increase the duration of breastfeeding alongside the appropriate introduction of complementary foods.

Read more about [**BFCI**](#).

Paid parental leave (PPL)

PPL has a significant influence on exclusive breastfeeding by providing parents greater opportunity to establish and maintain breastfeeding (Nandi et al 2018; Lucas and McCarter-Spaulding 2012; Grandahl et al 2020; Mirkovic et al 2016). Current evidence suggests the availability of unpaid leave has little impact on parents' breastfeeding practices (Nandi et al 2018).

Previously, parents in Aotearoa New Zealand were entitled to 18 weeks of PPL, which increased to 26 weeks in July 2020. Parents are also entitled to a further 30 weeks unpaid parental leave.

Read more about [**Paid parental leave**](#).

Workplace regulation

Breastfeeding while working is protected in Aotearoa New Zealand via [**The Employment Relations Amendment Act 2008**](#). The Act specifies that employers have to give breastfeeding breaks and appropriate facilities for employees who want to breastfeed or express milk for their babies at work or during the working day, if this is reasonable and realistic in the circumstances (taking into consideration the employer's operational environment and resources). The breaks are unpaid and in addition to rest and meal breaks (unless the employee and employer agree otherwise). If employers don't do this, the Employment Relations Authority could make them comply or apply a penalty.

The **Code of Employment Practice on Infant Feeding** provides information about 'appropriate facilities' for employees to breastfeed or express. **Breastfeeding in the Workplace – A guide for employers** also has practical information about how facilities can be provided in a workplace.

Read more about the **Employment Relations Amendment Act 2008**.

Breastfeeding in emergencies | Whāngotea i ngā wā ohotata

Information on breastfeeding in emergencies, such as a natural disaster or pandemic

During an emergency, such as a natural disaster or pandemic, breastfeeding can save lives (Gribble and Berry 2011; American Academy of Pediatrics 2020) by:

- protecting infants from the risks of an unclean water supply
- helping protect infants against respiratory illnesses and diarrhoea
- providing milk that is always at the right temperature for infants
- being available without needing other supplies.

Further reading | He rauemi anō

- **Emergency preparedness for those who care for infants in developed country contexts**
- **Infant feeding in disasters and emergencies: Breastfeeding and Other Options**
- **Providing breastfeeding support during the COVID-19 pandemic: Concerns of mothers who contacted the Australian Breastfeeding Association**

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Appendices

Appendix 1: Advisory Group for the refresh of the National Strategic Plan of Action for Breastfeeding 2008-2012 - Terms of Reference

Terms of Reference

1.	Establishment	The Advisory Group is established by the Ministry of Health.
2.	Introduction	The Advisory Group will provide representation from different organisations and health professions and assist in the refresh of the National Strategic Plan of Action for Breastfeeding 2008-2012.
3.	Purpose	The Advisory Group is to provide advice to the Ministry of Health during the project to refresh the National Strategic Plan of Action for Breastfeeding 2008-2012. The scope of the project is to review, revise and refresh the National Strategic Plan of Action for Breastfeeding 2008-2012 with the aim of producing an enduring strategy to address barriers to women establishing and maintaining breastfeeding in Aotearoa New Zealand.
4.	Governing Principles	The following principles are proposed as governing the approach, purpose and interactions of members of the Advisory Group: i. In all interactions, the values of trust, honesty, respect, reliability and integrity will be upheld ii. The Treaty of Waitangi is recognised as a founding document for New Zealand and the Treaty principles of partnership, protection and participation will be promoted iii. True woman-centred care and partnering with consumers leads to better outcomes iv. We will apply an equity and continual quality improvement lens to all we do

5.	Responsibilities and Activities	Key tasks of the Advisory Group members are to: • contribute constructively to meetings and have good communication and team-working skills; this should include a commitment to the needs of women and whānau • use their background knowledge and experience of the topic to provide guidance to the Ministry of Health project team • read all relevant documentation and make constructive comments and proposals at (and between) meetings • with other members of the Advisory Group, consider implementation issues arising from the updated recommendations • with other members of the Advisory Group, agree the minutes of meetings
6.	Communication with Stakeholders	It is expected that members will provide leadership and act as key communicators within the professional groups they represent. They will routinely provide feedback on issues discussed at meetings and from circulating documents to their own professional groups.
7.	Membership	The Advisory Group will have up to 10 members. Type and number: • Midwife - 1 • Well Child Provider - 1 • Lactation Consultant - 1 • DHB Midwifery Leader - 1 • DHB Planning & Funding - 2 • Maori - 1 • Non-Governmental Organisation - 2 • Consumer - 1 • Researcher/Policy - 2 Membership will include representation from a range of stakeholders including but not limited to:

8.	Register of Interests	All members of the Advisory Group will be required to declare all relevant interests. Declarations of interest and associated actions should be recorded to ensure transparency in the way the interest is handled.
9.	Chair	The Advisory Group Chair will be elected at the first full meeting of the Group.
10.	Term	Membership will be for the duration of the project which will be completed within the 2019/2020 financial year.
11.	Meetings	As series of face-to-face, video and tele conference meetings will be held. These will be coordinated by the Ministry of Health with support from the group appointed chair/co-chair and the secretariat. Meeting agendas and papers will be published no less than five working days prior to a meeting. The Advisory Group will endeavour to operate on the basis of consensus, however where this is not possible, the majority view will prevail. Meeting minutes will be finalised within 2 weeks of a meeting.
12.	Coordination and secretariat support	The Ministry of Health will provide management and resources for the Advisory Group. Women's Health Action will provide secretariat support.
13.	Remuneration	Work carried out as part of the Advisory Group will be reimbursed on a pro rata basis at the rate of \$325.00 per day (exclusive of GST), on receipt of invoice. Public servant/state servants/employees of Crown bodies are not paid for work carried out for the Advisory Group. A public servant/state servant/employee of a Crown body should not retain both the fee and their ordinary pay where the duties of the outside organisation are undertaken during ordinary department or Crown body hours. Payment of meeting and other fees will be in accordance with the latest Cabinet circular on fees and guidelines for appointments for statutory bodies, which can be found at:

		<u>https://dpmc.govt.nz/publications/co-12-6-fees-framework-members-appointed-bodies-which-crown-has-interest</u>
14.	Quorum	A quorum shall be half the membership.