The Baby Friendly Hospital Initiative

Implementing the Process in New Zealand

by

Christine Jackson

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ABSTRACT

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The Baby Friendly Initiative is a global initiative jointly with the World Health Organization (WHO) and the United Nations (UNICEF). The Baby Friendly Hospital Initiative has become the primary intervention strategy for strengthening the capacity of national health systems to protect and promote breastfeeding. WHO supports committees coordinating the BFHI process by placing particular emphasis on developing core groups of trainers, at national and regional levels developing reassessment and monitoring tools, to ensure the Initiative's continued integrity and credibility and broadening the Initiative.

This is a reflective paper that has documented the implementation of Baby Friendly Hospital (BFHI) in New Zealand. It describes the collaborative processes that were necessary to achieve such a goal and the sheer determinedness of a few. It demonstrates that with collegial passion and partnership, success and a political stance can be achieved from which health policy and reform can be directed.

The International context is outlined simplistically with an explanation of the important documents and global initiatives which underpin the implementation of BFHI. The scientific evidence supporting the Ten Steps to Successful Breastfeeding is documented so that the reader has an appreciation of the importance of BFHI and good health.

Background to the implementation of BFHI in New Zealand has been acknowledged. This process has been observed by the international community and seen as inspirational. With ministerial commitment and support the international documents have been rewritten to fit our unique maternity system, presented to the New Zealand community and instituted into health reforms.

To conclude this paper looks to the future, the establishment of a National Breastfeeding Committee, and implementation of the Baby Friendly Initiative into the community.

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CONTENTS

Glossary

World Health Organization (WHO): An organization established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's prime functions is to provide objective and reliable information and advice to those working globally in health. This is fulfilled by it's publications which include practical manuals, handbooks and training material that address and support national health strategies around the world.

United Nations Children's Fund (UNICEF): UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. (UNICEF, 2005)

International Code of Marketing of Breast-milk substitutes (WHO Code): In 1981 at the Thirty-Fourth World Health Assembly of the World Health Organization (WHO), in conjunction with the United Children's Fund, the WHO Code was adopted. The aim of this Code is

> "to contribute to the provision of sale and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (World Health Organization, 1981 p13)

New Zealand is a signatory to the WHO Code, so is committed to working towards meeting the WHO Code's aims (Ministry of Health, 2004). The WHO Code's aim is to protect infants' nutritional wellbeing. 'Implementing and enforcing the WHO Code are matters for individual countries and governments to determine in keeping with their own social and legislative frameworks (Ministry of Health, 2004).

Global Strategy for Infant and Young Child Feeding: In 1998, at the 101st session, the Executive Board of the World Health Organization called for the revitalization of the global commitment to appropriate infant and young child nutrition. The Global Strategy was endorsed by consensus on 18 May 2002 by the Fifty-fifth World Health Assembly.

The global strategy has built on past and continuing achievements the Baby Friendly Hospital Initiative (1991), The International Code of Marketing of Breast-milk Substances (1981) and the Innocenti Declaration (1990).

Convention on the Rights of the Child (1989): The Convention was adopted by the UN General Assembly. It came into force in September 1990 and became the most widely- and rapidly-accepted human rights treaty in history. UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

World Summit for Children (1990): This was a first-time meeting between the Heads of State and Government at the United Nations in New York City. At this meeting the 10 year goals for children's health, nutrition and education were set.

Innocenti Declaration: The Innocenti Declaration, for the protection, promotion and support of breastfeeding was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s. The Innocenti Declaration was adopted in 1990 and was subsequently endorsed by the World Health Assembly and UNICEF's Executive Board.

There were four Innocenti Targets:

1. Appointment of a national breastfeeding coordinator of appropriate authority, and establishment of a multisectoral national breastfeeding committee;
2. Ten Steps to Successful Breastfeeding (the Baby-Friendly Hospital Initiative) practised in all maternity facilities;
3. Global implementation of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly Resolutions in their entirety;
4. Enactment of imaginative legislation protecting the breastfeeding rights of working women; and establishment of means for enforcement of maternity protection.

Baby Friendly Hospital Initiative (BFHI): The Baby Friendly Hospital Initiative (1991) is a global movement of the World Health Organization and the United Nations Children's Fund. The goal is to increase breastfeeding rates by which BFHI promotes optimal infant feeding practices in hospitals throughout the world, providing comprehensive guidelines and ensuring hospitals and maternity centres support breastfeeding. This organization recognised the importance of implementing best practice in the health service would be crucial to the success of it programme. The Ten Steps to Successful Breastfeeding demonstrates best practice and was first published in a joint WHO/UNICEF statement in 1989 – 'Protecting, Promoting and Supporting Breastfeeding: The Special Role of the Maternity Service'. The initiative focuses on the initial and continued breastfeeding support mothers receive in hospitals. It includes guidelines to reflect and improve midwifery care that is both educational and relational, providing skills to communicate to mothers and their families and the importance of exclusive breastfeeding.

New Zealand Breastfeeding Authority (NZBA): The NZBA was formed in 1998 by a number of groups involved in the breastfeeding field to work towards the establishment of BFHI in New Zealand. It was incorporated in 1999 and contracted by the Health Funding Authority to develop BFHI for New Zealand. Although NZBA has advocated for the implementation of all of the goals of the *Innocenti Declaration*, its primary focus has been on the establishment of the Baby Friendly Hospital Initiative (BFHI), together with the development of the Baby Friendly Community Initiative (BFCI). NZBA is a committee consisting of eight representative members from stakeholder groups which include consumer organizations, health professionals and Maori (Appendix II). NZBA is facilitating the process by which a National Breastfeeding Committee (NBC) will be established. Once the NBC is in place NZBA's core business will be BFHI and a name change will illustrate this.

Transitional Breastfeeding Committee (TBC): This committee was appointed by a nomination process from the stakeholder groups in June 2004. The committee's mandate was to develop the terms of reference and make recommendations to the Ministry of Health regarding the formation of a National Breastfeeding Committee in New Zealand.

National Breastfeeding Committee (NBC): At the point of writing this Committee has yet to be established. Currently nominations for committee members have been asked for. The NBC will reside with and have a Ministry of Health mandate. It will be an overarching committee whose role is to coordinate and facilitate contractual obligations and has a pivotal role in providing national guidance in all areas of health where breastfeeding support is required or policy will impact on breastfeeding. It is a multi-sectoral committee consisting of governmental representation, non-governmental organization representation, Maori, Pacific and consumer representation. In forming this committee New Zealand is fulfilling one of the four operational targets of the Innocenti Declaration (Appendix VII).

Baby Friendly Community Initiative (BFCI): This is a community based initiative where primary healthcare practitioners in the community adopt practices that aim to protect, promote and support mothers to initiate and continue breastfeeding whilst at the same time providing unbiased information and support for those choose not to breastfeed. BFCI is based on the "Seven Point Plan" for the protection, promotion and support of breastfeeding in the community (UNICEF UK Baby Friendly initiative, 2005). This is a new health initiative in New Zealand which is in its development stage. Documents are currently out for consultation to the wider New Zealand community. NZBA has employed a BFCI coordinator to develop this new initiative.

Exclusive breastfeeding: Breastfeeding where the infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breastmilk, from the breast or expressed, and prescribed medicines, defined as per Medicines Act 1981, have been given from birth.

Fully breastfeeding: Breastfeeding where the infant has taken breastmilk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.

Partial breastfeeding: Breastfeeding where the infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours.

Artificial feeding: Breastfeeding where the infant has had no breastmilk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

Section I: The International Context

Introduction

In 1990 the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), jointly sponsored a global initiative, of which New Zealand with 31 other countries became signatories. They helped to develop, sign and adopt the Innocenti Declaration, on the protection, promotion and support of breastfeeding (Appendix V1). The document clearly spelt out the benefits of breastfeeding. It called for policies that support a breastfeeding culture, enabling women to breastfeed their children exclusively for the first four to six months, and asked all national authorities to integrate breastfeeding programmes into overall health and development policies (World Health Organization & Wellstart International, 1993). WHO and UNICEF jointly developed the Global Strategy for Infant and Young Child Feeding to revitalize world attention to the impact that feeding practices have on the nutritional status, growth and development, health, and thus the survival of infants and young children (World Health Organization, 2003).

Although New Zealand was present and contributed to these momentous decisions, little action was taken in the New Zealand health sector until a taskforce was set up by the New Zealand College of Midwives (NZCOM) in 1997. A number of prior attempts by independent health professionals committed to having breastfeeding supported and various groups (such as New Zealand Lactation Consultants) were unsuccessful at both regional and national level. Finally in 1997 NZCOM decided it was time to invite all stakeholders involved with breastfeeding to attend a large forum. Many attempts were made to initiate the implementation of the Baby Friendly Hospital Initiative documents. But without a political foothold, undertaking new developments was very difficult in the political climate of the early 1990's.

This paper follows the journey of the Baby Friendly Hospital Initiative (BFHI) in New Zealand, and includes my perceptions and interpretations. My involvement in the BFHI process began with my midwifery background in providing support for women to initiate breastfeeding in the hospital, soon after birth. Anecdotal evidence demonstrated

to me the importance of having not only knowledge but also expertise to assist women with breastfeeding. Prior to returning to New Zealand from Australia in 1995, I was working in a maternity unit which had gained the BFHI accreditation. I had been part of that journey and saw first hand what a difference it made to breastfeeding outcomes. In Wellington there was an opportunity to attend some of the early meetings discussing BFHI in the New Zealand setting. From there I have been involved in the writing of the New Zealand BFHI documents, training as an assessor and subsequently becoming a trainer and I am now the Chair of the New Zealand Breastfeeding Authority. It is important to document the implementation of BFHI in New Zealand not only to record the factual accounts, but also to recognise the many committed and passionate participants, both health professionals and consumers, who have contributed to such an amazing success story in New Zealand.

The importance of breastfeeding as a health initiative has now been placed within policy and has become a fundamental and strategic cornerstone for the implementation of BFHI in New Zealand. Having breastfeeding and its benefits as an integral inclusion in vital health documents and a supportive Ministry of Health ensures that breastfeeding has gained the support and protection that it deserves. The Baby Friendly Hospital Initiative addresses the responsibility that policy makers have to improve breastfeeding rates in New Zealand and thereby improve the health of future generations.

In this paper I will discuss the importance of NZBA. It has evolved from a volunteer group to one with recognised political standing; from collegial passion to collaborative success. This paper provides insight in to the evolution of the Baby Friendly Initiative in New Zealand.

This section provides the background of the international setting of the development of baby friendly hospitals and I provide a summary of the evidence supporting the Ten Steps to Successful Breastfeeding, which underpins the implementation of BFHI.

Section two describes the New Zealand setting and the context in which BFHI has been implemented, demonstrating that there has been an increase in breastfeeding rates since the implementation of BFHI into the maternity facilities. It illustrates the influence of

the New Zealand Breastfeeding Authority and the diversity and commitment of the groups on the committee over the past seven years.

In section three I reflect on the progress that has been made and the barriers and obstacles which have, at times, proved to be challenging. I discuss briefly the move from Hospital Initiative to The Baby Friendly Community Initiative and the impact this has on the current health care system. Lastly I have listed some recommendations that could support the continued implementation of BFHI and BFCI in New Zealand.

Innocenti Declaration

The first and most critical global understanding was the Inocenti Declaration. The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative, co-sponsored by the United States Agency for International Development (A.I.D.) and the Swedish International Development Authority (SIDA). This was held at the Spedale degli Innocenti, Florence, Italy, on 30 July 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions" (Palmer G & Kemp S, 1996). From the initial adoption by the policy makers, the Innocenti Declaration was then adopted by the Forty-fifth World Health Assembly in May 1992 in Resolution WHA 45.34 (World Health Organization, 1998).

The Innocenti Declaration recognises that breastmilk provides ideal nutrition and contributes to infants' healthy growth and development. It reduces the incidence and severity of infectious diseases which lowers infant mortality and morbidity. Breastfeeding adds to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies. Recent research has found that these benefits increase with exclusive breastfeeding during the first six months of life. (Byers T, Graham S, & Rzepka T, 1985; Rea M F, 2004; Rosenblatt KA & Thomas DB, 1993). The Innocenti Declaration therefore declares, that as a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond (Palmer G & Kemp S, 1996).

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

1. Appointed a national breastfeeding coordinator of appropriate authority and established a multisectoral national breastfeeding committee with representatives from relevant governmental departments, nongovernmental organizations and health professional associations.

2. Ensured that every facility providing maternity services fully practices the Ten Steps to Successful Breastfeeding set out by the WHO/UNICEF Taken action to give effect to the principles and aims of all articles of the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions in their entirety.
3. Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement (World Health Organization & UNICEF, 1989; World Health Organization/UNICEF, 1990), Appendix VI.

In 1998, at the 101st session, the Executive Board of the World Health Organization called for the revitalization of the global commitment to appropriate infant and young child nutrition. The Global Strategy was endorsed by consensus on 18 May 2002 by the Fifty-fifth World Health Assembly. The WHO/UNICEF Global Strategy for Infant and Young Child Feeding includes and supercedes the Innocenti goals, paying additional attention to support for mothers in the community. The Global Strategy includes five additional operational targets to those of the Innocenti Declaration.

1. Implementation of comprehensive government policies on infant and young child feeding
2. Full support from health and other sectors for two years of breastfeeding or more
3. Promotion of timely, adequate, safe and appropriate complementary feeding (addition of other foods while breastfeeding continues)
4. Guidance on infant and young child feeding in especially difficult circumstances, with related support for families and caregivers
5. Legislation or suitable measures giving effect to the International Code as part of the national comprehensive policy on infant and young child feeding (World Health Organization/UNICEF, 1990).

Baby Friendly Hospital Initiative

The Baby Friendly Initiative is a product of global collaboration between the World Health Organization (WHO) and the United Nations (UNICEF), WHO and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) in response to the declining breastfeeding rates in many parts of the world. This was reflected in the high infant mortality and morbidity rates, largely due to malnutrition, infections of the respiratory tract and diarrhoeal disease. The global movement aims to give every baby the best start in life by ensuring a health care environment where breastfeeding is the norm (Saadeh, 1996). The protection, promotion and support of breastfeeding is fundamental to achieving optimum health of the nation and therefore it is the responsibility of those who have the position to create policies to provide all the mechanisms necessary to do so. The Baby Friendly Hospital Initiative has become the primary intervention strategy for strengthening the capacity of national health systems to protect and promote breastfeeding. who supports committees coordinating the BFHI process, by placing particular emphasis on developing core groups of trainers at national and regional level and by developing reassessment and monitoring tools to ensure the initiative's continued integrity and credibility.

The BFHI was developed to promote the implementation of the second operational target of the Innocenti Declaration which was to ensure that every facility providing maternity services fully practices all of the Ten Steps to Successful Breastfeeding set out in the joint WHO/UNICEF statement 'Protecting, promoting and supporting breastfeeding: the role of the maternity services' (World Health Organization/UNICEF, 1990). In addition, to continue to protect the principles of breastfeeding, aspects of the third operational target were also included. It was suggested that the principles and aims of all articles of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions would be necessary to continue to protect breastfeeding.

The criteria for a Baby Friendly Hospital, applies equally in all countries, and to all health care facilities. Saadeh (1996) states that the adoption of each of the Ten Steps has been associated with increased breastfeeding initiation and duration rates. Whether

or not a country is ‘developing’ or ‘developed,’ the health of our nation relies on the health of newborn and infants. By reducing poor health outcomes as early as we can, we then endeavour to create a healthier society. It is imperative that we protect, promote and support breastfeeding for these reasons. In the developed nations we reduce neonatal readmissions to paediatric wards and reduce chronic illnesses such as otitis media, obesity and asthma, all of which have an impact on the country’s health purse (Armstrong J & Reilly JJ, 2002; Dewey KG, Heinig MJ, & LA., 1995; Gdalevich M, Mimouni D, & Mimouni M, 2001; Oddy W, 2002).

LiBassi (2001, p5)writes in his paper, “the importance of breastfeeding for infant health cannot be overstated in both developing and developed countries. Epidemiological evidence indicates that breastfed infants have a reduced risk of infection, particularly gastro-intestinal infection, respiratory infection, urinary tract infection and middle ear infections.” The health sector benefits from those mothers who breastfeed. In developed countries where infant mortality is low, artificially fed infants require hospital treatment up to five times more often than those infants fully or partially breastfed (Leung GM, Lam TH, Ho LM, & Lau YL, 2005). Anecdotally we are seeing a reduction in pediatric admissions in the larger hospitals. This will need to be supported by data collecting but the trend as seen in other countries will hopefully become more apparent here in New Zealand.

The World Health Organization (1992)stated that in our world of diversity and contrast, we believe that the role of Maternity services in promoting breast-feeding is striking for its universal relevance. The principles affirmed here apply anywhere maternity services are offered, irrespective of such labels as “developed” and “developing”, “North” and “South”, “modern” and “traditional”. The Health professionals and other workers responsible for these services are well placed to apply them by providing the leadership needed to sustain, or if necessary re-establish, a “Breast-feeding culture”.

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff
2. Train all health care staff in skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding within a half hour of birth
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants
6. Give newborn infants no food or drink other than breast milk unless medically indicated
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial 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.

Figure 1: Ten Steps to Successful Breastfeeding (World Health Organization & UNICEF, 1989)

The Ten Steps to Successful Breastfeeding and the supporting scientific documentationare an integral part of BFHI. These steps have been redefined and altered in many countries to fit the primary health targets of each country. The ten steps and how they are evaluated are seen as the gold standard in promoting, supporting and protecting breastfeeding in any country. They are the foundation of the Baby Friendly Hospital Initiative and summarise the maternity practices necessary to support breastfeeding mothers.

The following discussion provides an explanation of each of the ten steps, with supporting evidence, and shows how the standard is measured in New Zealand. The scientific evidence which underpins the Ten Steps is well documented, readily available

and accessible for all health professionals and health services (World Health Organization, 1998).

Step One: *Have a written breastfeeding policy that is routinely communicated to all health care staff.* Many reports have shown the advantages of robust, measurable and consistent policies within institutions. Hospitals exert tremendous influence over this crucial maternal-child health arena with the power to promote and model optimal breastfeeding practices, or to subtly undermine and sabotage the breastfeeding decision (Powers N, Naylor A, & Wester R, 1994 p517).

The process of developing a policy, in itself, becomes an educational exercise. After comprehensive consultation with representatives of cultural groups, consumers and health care staff, the policy then becomes accepted within the facility and within the community. In New Zealand this consultative process is inherent in the formation of most health care policies. This leads to a greater credibility and acceptance of the policy within the facility by the community. The contractual obligations of the Lead Maternity Carer (LMC) with Section 88, requires all Lead Maternity Carers caring for a woman in a Maternity Facility, to support the Maternity Facility in implementing the Baby Friendly Hospital Initiative BFHI (Ministry of Health, 2002 p12). Having a consultative process whereby LMC's are included results in a tangible and open discussion document in the maternity facility. Written policies are effective only when they are carefully written and consistently implemented (Vogel A & Mitchell E, 1998).

For a facility to meet this standard the policy must include the following six components:

- The policy must address all of the Ten steps to Successful Breastfeeding.
- The policy must be developed in consultation with Maori, other ethnic groups, consumer organizations and other providers using the facility.
- The policy must support the principles of the Treaty of Waitangi (Protection, participation and partnership).
- The policy is to available and accessible for staff and mothers using the facility
- The policy or summary of the policy is to be displayed in the dominant language and in Maori.

- The policy or it's summary will be visibly posted in all areas of the service which provide care for mothers and babies, particularly in the postnatal and antenatal ward, neonatal units, and in antenatal clinics (Implementation Advisory Group, 2005)

Step Two: *Train all health care staff in skills necessary to implement this policy.* All health care staff who have contact with mothers and babies are to receive training on the implementation of the breastfeeding policy. Education of health care staff is pivotal for the provision of consistent support for women who choose to breastfeed. It has been shown in many studies that inconsistency in information and support has caused conflict, lack of understanding and reduced longevity of breastfeeding after discharge (Perez-Escamilla R, Segura- Millan S, Pollitt E, & Dewey K, 1992; Vogel A & Mitchell E, 1998). Staff education in breastfeeding management is essential (Vogel A & Mitchell E, 1998). Improving knowledge may not be effective in changing practices if there is no underlying change in attitude or increase in skills. With appropriate education, many facilities have found that their exclusive breastfeeding rates increased significantly but that over all breastfeeding initiation remained unchanged (Martens, 2000). It is therefore important for health workers to have adequate continuing education in order to identify personal biases and knowledge deficits which hinder breastfeeding promotion within the maternity facility (Paton, Beaman, Csar, & C Lewinski, 1996).

To demonstrate that this step has been attained the facility must provide documentation which shows eighty percent of all health care staff in the maternity facility have completed the education hours specified by the BFHI Assessment Criteria (Implementation Advisory Group, 2005). The hours are dependent on the health care status and are as follows:

- *Midwives and Nurses* – At least 18 hours breastfeeding education within the last 5 years. This is to include a minimum of 3 hours clinical supervision.
- *Medical staff* – At least 4 hours of breastfeeding education within the last 2 years. Ongoing education should be a minimum of 2 hours annually.
- *Ancillary Staff/ Support Staff* – At least 3 hours of breastfeeding education within the last 3 years. Ongoing education should be a minimum of one hour annually.

Step Three: *Inform all pregnant women about the benefits and management of breastfeeding.* Many women need counseling and education on the management and benefits of breastfeeding. It makes sense that all women should be given the education that they may require to make a fully informed decision about their choice of feeding method. In traditional societies the skill is passed on from mother to daughter through the generations but many mothers are now unable to assist their daughters as they themselves did not breastfeed (Minchin M, 1989; Ministry of Health, 1997).

Pugin et al, (1996) and Wiles (1984)state that prenatal group education with hands-on skills is a significant and additive component of breastfeeding support, especially among those who have no previous breastfeeding experience. The educational effect was greatest among primiparous women.

If the health facility provides antenatal services, the person(s) responsible for midwifery or nursing services should be able to demonstrate that all pregnant women are being given breastfeeding counseling. The antenatal educational must include the Ten Steps to successful breastfeeding. To meet this standard, eighty percent of pregnant women over thirty two weeks attending antenatal clinics or are inpatients, should be able to verify that that have been given this information (Implementation Advisory Group, 2005).

Step Four: *Help mothers initiate breastfeeding within a half hour of birth.* This step focuses on the immediate postpartum period and it is the expectation that all normal healthy infants will have skin-to-skin contact with its mother within half an hour of birth. There are numerous studies that demonstrate the importance of this first hour after birth and its effect on the successful of breastfeeding (Carfoot S, Williamson P, & Dickson R, 2005; Christensson K et al., 1992). The study by Christensson et al (1992) demonstrated that skin-to-skin care in the immediate postpartum period was associated with higher body temperatures and more rapid metabolic adaptation and maintaining blood glucose levels. Crying was also reduced and it was noted that the newborn who was separated from its mother cooled down quicker than the newborn who had constant skin-to-skin contact.

Early skin-to-skin contact and the opportunity to suckle within the first hour or so after birth are both important (World Health Organization, 1998). Initiation of breastfeeding

and the skin-to-skin contact are closely interrelated and few researchers distinguish between them. Studies have shown that early contact resulted in a significant increase in breastfeeding rates at eight to twelve weeks (de Chateau P & B, 1977; Mikiel-Kostyra K, Mazur J, & Boltruszko I, 2002; Righard L & Alade M, 1990). The initial mother-baby contact, is vital in developing the mother-baby relationship with primparae showing behaviour much more like multiparae behaviour. Toussaint G, Casanueva E, Atkin LC, & Avila-rosas H, (1988) and Wallace H & Marshall D, (2001) demonstrated that early skin-to-skin contact resulted in a significantly greater milk production on the first day than those whose newborn had been removed and placed in a cot. De Chateau et al (1977) also found that suckling and skin-to-skin contact within the first hour following birth resulted in a mean duration of breastfeeding that was two and a half months longer than the duration in maternal-infant pairs not afforded the same early contact. Righard and Alade (1990) also stated that the harmful effects of early separation and the benefits of undisturbed early contact are well documented. Conclusions from their study clearly highlight the importance of skin to skin contact until the first completed breastfeed (Righard L & Alade M, 1990).

Baby friendly accreditation requires that all mothers, regardless of feeding intention, should have the opportunity for a period of unhurried skin-to-skin contact in the immediate postnatal period (Baby Friendly News, 1999). This is to be continued for at least thirty minutes and the mother should be supported to initiate breastfeeding when the infant is ready and the mother able to respond to her baby. In order to meet the standard, eighty percent of those women who had a vaginal birth and sixty percent who had caesarean delivery, should be able state that this practice did occur.

Step Five: *Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.* This step ensures that there is adequate ongoing support with breastfeeding within six hours of birth even if mothers are separated from their babies and that the health workers knowledge is then able to be transferred to the mothers. With comprehensive staff education and a supportive work environment, with adequate staff numbers, mothers and their new babies, will feel well supported and receive consistent advice. Kindness and support, even without the technical skills, can build the mothers' confidence and have a lasting effect on breastfeeding (Hofmeyr GJ, Nikodem VC, Wolman WL, Chalmers BE, & Kramer T, 1991).

In order to meet this step eighty percent of those health care staff who assist mothers with breastfeeding, are able to describe correct positioning and attachment of a newborn at the breast. They must also be able to describe an acceptable technique for hand expression and storing milk that they teach to mothers (Implementation Advisory Group, 2005).

Step Six: *Give newborn infants no food or drink other than breastmilk, unless medically indicated.* Supplements such as water, glucose water, formula and other fluids should not be given to breastfeeding newborn infants unless medically indicated (American Academy of Pediatrics, 1997, 2005). All health care staff caring for mothers and babies should be aware of the 'acceptable medical reasons' for complimenting the baby with breastmilk substitutes (World Health Organization, 1997). Just one bottle can have serious consequences for both mother and baby (Vnuk, 1993). "Human milk is species-specific, and all substitute feeding preparations differ markedly from it, making human milk uniquely superior for infant feeding" (American Academy of Pediatrics, 2005 p496). Healthy term newborns do not develop 'symptomatic' hypoglycaemia as a result of simple underfeeding. Prevention of hypoglycaemia, by early initiation of breastfeeding and maintaining a baby's temperature reduces the need to supplement with a breastmilk substitute (World Health Organization, 1997).

To meet the standard for step six the maternity facility needs to have at least eighty percent of all babies who have received food or drink other than breastmilk to have acceptable medical reasons for such treatment or mothers insistence needs to be demonstrated (Implementation Advisory Group, 2005).

Step Seven: *Practice rooming in – allow mothers and infants to remain together – 24 hours a day.* This step supports safe and responsible practice within the maternity facility. By having their baby with them at all times mothers can then be assured that their baby will not be abandoned by a staff member while attending an emergency. Critics of rooming-in believe that new mothers need more rest and that removing the infant to the nursery will allow them this rest. When this statement was examined, it was found that mothers with rooming-in infants actually had an equal quantity and quality of sleep compared with mothers whose babies went to the nursery during the night (Perez-Escamilla R et al., 1992). Keefe (1988) found that mothers separated at

night from their baby did not sleep any longer nor did they have a better sleep. The study also found that the baby rooming-in had more quiet sleep and cried less, and breastfed slightly more during the night.

The practice of rooming-in has reduced newborn infections such as staphylococcal skin and eye infections (Mustajab I & Munir M, 1986; Soetjiningsih & Suraatmaja S, 1986). With the implementation of rooming-in there is easy access for the baby to the breast, with mothers recognizing the breastfeeding cues earlier, therefore decreasing the likelihood of breastfeeding difficulties (Yamauchi Y & Yamanouchi I, 1990). Rooming in provides the mother with easy access to her own baby and the mother is able to respond to the needs of the baby.

With the removal of nurseries in the maternity facilities there has also been a reduction in staff numbers required and Buranasin (1991) found rooming-in has seen the reduction of time spent on infant care by health personnel.

The standard of this step is achieved when eighty percent of mothers, when interviewed, are able to state that their babies have not been separated from them since birth except for periods of up to one hour unless it is essential for medical procedures (Implementation Advisory Group, 2005).

Step Eight: *Encourage breastfeeding on demand.* It is important that mothers are supported to follow the babies' feeding cues. Scheduled feeds were introduced in the early twentieth century when it was thought that the stomach required a certain interval between feeds. Night time feeds were to be avoided at all times (World Health Organization, 1998). Generally most facilities have accepted that scheduling breastfeeds leads to breastfeeding problems and insufficient milk production (Salariya EM, Easton PM, & Cater JI, 1978; Yamauchi Y & Yamanouchi I, 1990). With early and unrestricted feeds there is an earlier passage of meconium which reduces the prevalence of jaundice (Yamauchi Y & Yamanouchi I, 1990). There is a lower initial weight loss and lactation is established earlier, with a larger volume of milk on day three (Yamauchi Y & Yamanouchi I, 1990). For mothers, demand feeding helps prevent engorgement, and breastfeeding is established more easily (Slaven S & Harvey D, 1981).

The standard is met when eighty percent of mothers reported that there have been no restrictions placed on the frequency or length of breastfeeds to meet the standard of this step (Implementation Advisory Group, 2005).

Step Nine: *Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.* Pacifiers are used to calm a baby without giving a feed. Infants who use pacifiers may have fewer daily breastfeeds (Victora CG, Tomasi E, Olinto MT, & FC, 1993). Both pacifiers and artificial teats can be harmful by carrying infection. The use of a pacifier may interfere with the establishment of breastfeeding, or be an underlying trigger to a breastfeeding problem (Kramer MS et al., 2001). This does not contraindicate pacifier use for nonnutritive sucking and oral training programmes for the preterm infant. Victora et al (1993) concludes, that the pacifier is associated with weaning. It reduces the times that the infant is put to the breast therefore reducing nipple stimulation and resulting in decreased milk production.

This step is achieved when eighty percent of the women interviewed report that their babies have not used a dummy or artificial teat.

Step Ten: *Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.* This step is becoming the most demanding after step one and two. Culturally appropriate groups will have been part of the consultation process when writing the hospital's breastfeeding policy therefore they should already be involved in the referral process for mothers. Some areas of New Zealand, due to locality and remoteness, do not have breastfeeding support networks and therefore the facilities have taken it initiated local network groups. For breastfeeding to continue a new mother needs the support of all around her (Woolridge M, 1996).

Galtry (2003) concludes in her findings that we must continue to promote and encourage positive societal attitudes towards breastfeeding, including the integration of breastfeeding into the employment environment.

To achieve breastfeeding longevity the facility is required to ensure that all mothers discharge from the hospital have adequate postnatal support. Most women in New Zealand have a midwife who will continue that support once at home in the following

four to six weeks and then by community child health nurses throughout the preschool years (Vogel A & Mitchell E, 1998). In this step the facility is required to have an awareness of the community support networks that are available for mothers and how that they may contact them. Eighty percent of the staff can report what community support networks are available in the area and how women are referred to these agencies on discharge (Implementation Advisory Group, 2005).

The World Health Organization (WHO) states that there is now sufficient and conclusive evidence supporting the effectiveness of the Ten Steps to Successful Breastfeeding, to fully justify the implementation of the BFHI into all maternity facilities. Breastfeeding lays a foundation for good health in infancy, childhood and into adult life. Maternity hospitals have a special role in supporting the establishment of breastfeeding. Failure to make maternity services baby-friendly can no longer be politically or morally defended with our current evidence. In New Zealand we have taken up the challenge. In the next section I have detailed this progress.

Section Two: New Zealand Context

Background

New Zealand has a unique maternity system in which the majority of women choose a Lead Maternity Carer (LMC) to provide their antenatal, birth and postnatal care. When caring for a woman in a maternity facility, the LMC has a contractual obligation to assist with the initiation of breastfeeding and to support the maternity facility in implementing the Baby Friendly Hospital Initiative (Ministry of Health, 2002). In 2002 53,037 women in New Zealand gave birth in a hospital (Ministry of Health, 2004). Therefore it is essential that the maternity facility provides a supportive breastfeeding environment, well informed staff and good breastfeeding practices to assist the initiation of breastfeeding. Up until 2000 Plunket was the only organization that consistently kept breastfeeding data. These data collected did not differentiate between exclusive breastfeeding rates and partial breastfeeding rates.

It should be noted that the drop-off in breastfeeding rates from 1997 corresponds with the changes in referring guidelines to the wellchild provider. The wellchild service was either Plunket or other community groups who were contracted by the Ministry of Health to provide care for babies from four to six weeks until commencing school. In 2002 Section 88 required midwives to provide postnatal care for four to six weeks. Since the early 1960's there was a dramatic decline in the breastfeeding statistics (Fig 2). There are many variables that could attribute to the decline in the breastfeeding rates such as, mothers going back into the workforce earlier and societal changes. Although there has been some improvement in the breastfeeding rates in the 70's there has been little since. It cannot be ignored that time has become precious and breastfeeding needs support and acknowledgement. This data confirms the need for BFHI in New Zealand.

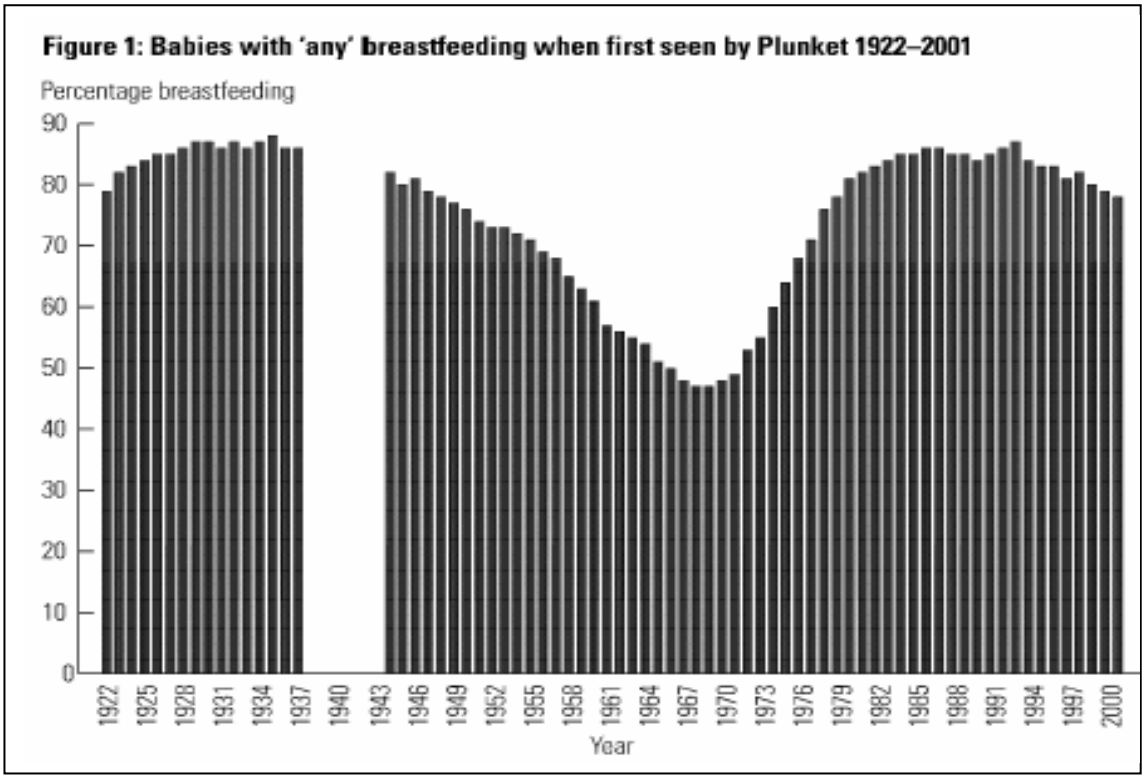

Figure 2: Babies with 'any' breastfeeding when first seen by Plunket 1922-2001

A national survey conducted in 1999 by the Health Funding Authority highlighted the need for consistent breastfeeding education within the maternity facilities. Twenty four percent of the respondents replied that their LMC had not explained clearly what kind of breastfeeding help and advice would be available whilst in hospital. Twenty nine percent said that were given conflicting advice about feeding (Health Funding Aurthority, 1999 p4). This survey provided further evidence for the Ministry of Health that consistent breastfeeding advice and support would improve consumer satisfaction and that the implementation of BFHI could have the desired effect. It would support the provision of consistent breastfeeding information to increase breastfeeding rates and improve the health of infants.

In the New Zealand Health Strategy 2000, it was stated clearly that supporting breastfeeding and the early initiation of breastfeeding would meet health objectives (Ministry of Health, 2000). The Health Minister further stated that this would also reduce childhood obesity, improve nutrition, decrease the incidence and impact of cancer, cardiovascular disease, diabetes and improve oral health. Of the eight priority

areas existing for Maori in this report five were noted that could be addressed by increasing the breastfeeding rates.

The Ministry of Health's Action Plan of 2002 set as one of the seven goals, 'to establish a national intersectoral breastfeeding committee' (Ministry of Health, 2002). In New Zealand this process has been facilitated by the New Zealand Breastfeeding Authority in conjunction with the Transitional Breastfeeding Committee. The Ministry of Health, in 2002, announced that funding would be made available for the establishment of a national breastfeeding committee in New Zealand. The New Zealand Breastfeeding Authority (NZBA) was contracted by the Ministry of Health to facilitate a process for the formation and establishment of the National Breastfeeding Committee.

In the Maternity Report published in 2003 it was documented that inaccurate data collection had made it "difficult to analyse breastfeeding rates at specific times following birth" (Ministry of Health, 2003, p9). Also, the breastfeeding definitions of exclusive, fully and partial breastfeeding varied, depending on their interpretation and this could alter the accuracy of the data collection. Coubrough (1999) stated that breastfeeding statistics and integrity were not recorded consistently and definitions were very ad hock adding to the lack of clarity. These problems have been rectified with the Section 88 Maternity Notice, effective from 1 July 2002 (Coubrough, 1999).

Without the scientific evidence and the implementation of BFHI the exclusive breastfeeding rates in New Zealand may have continued to fall further eroding New Zealand's breastfeeding culture.

The Journey

The New Zealand Breastfeeding Authority (NZBA) was established in November 1997 and has continued to strive to achieve higher breastfeeding rates in New Zealand. Prior to this date many groups had lobbied strongly for the formation of a national breastfeeding committee to promote breastfeeding within New Zealand, politically and socially. It was obvious that the implementation of BFHI was a solution to the problem, improving breastfeeding rates and health outcomes. There were however problems with 'meeting' the costs. International documents had to be adapted to fit within the New

Zealand maternity care system and at that time women's and children's health was not high on the priority list of the Ministry. In May 1997 the New Zealand Lactation Consultants and La Leche League put in a submission to the Transitional Funding Authority to implement BFHI. The New Zealand College of Midwives (NZCOM) had also been involved in lobbying and a decision was made to call a meeting of all those involved in breastfeeding. NZCOM set up a taskforce – the College Breastfeeding Initiative Taskforce (CBIT) with the aim of adapting the World Health Organization BFHI tool to the New Zealand context. In November 1997 another meeting was held, initiated by NZCOM, and at this meeting many groups were represented. NZCOM did not view themselves as "owning " BFHI and made this very clear at their meetings. There was a belief that the only way forward with BFHI was to have a shared commitment by all stakeholders. NZCOM offered the midwifery advisor to the College at the time as coordinator/facilitator and the New Zealand Plunket Society offered to provide secretarial support. This was the beginning of the New Zealand Breastfeeding Authority. In 1999 key stakeholder groups were asked by the New Zealand College of Midwives' Advisor, to nominate a representative member to the NZBA. Throughout this time funding was reliant on the goodwill of the organizations involved. The commitment by NZCOM ensured the NZBA continued to function.

The role of the NZBA was

- to coordinate the Ministry of Health contracts
- to consult with the NZBA Stakeholders
- to select the WHO Accredited BFHI trainers and assessors
- to run the training workshops for New Zealand assessors
- maintain a national database of accredited assessors, education and accredited hospitals
- to develop, monitor and evaluate the national accreditation process
- to assess and accredit hospitals as Baby Friendly

NZBA secured funding from the Ministry of Health to begin this process of adapting the BFHI international documents to fit into the New Zealand maternity system. This involved extensive consultation and debate including the recognition of the Treaty of

Waitangi and how this foundational document could be incorporated into the international audit tool.

Since 1997 NZBA has gained respect in the health sector both nationally and internationally. It has achieved and continues to achieve credibility throughout the BFHI arena. This is certainly the result of excellent coordination and leadership, the diversity of the representatives from stakeholder groups on the committee and their organisations' commitment. NZBA is an example of successful collaboration, where different groups come together with different skills, recognising each others skill and expertise. Through collaboration NZBA continues to develop.

Figure 3: Implementation Advisory Group (IAG) 1999

Back from left: Belinda Macfie (NZ Plunket Society), Julie Stufkens (NZBA Coordinator), Barry Twydle (Hospital Maternity Managers). Front from left: Bev Pownall (NZ Lactation consultants), Christine Jackson (NZ College of Midwives), Barbara Robson (Consumer Representative).

In 1999 the Implementation Advisory Group (IAG) was formed with representation from eight main stakeholder groups: the New Zealand College of Midwives, the New Zealand Lactation Consultants, the New Zealand Plunket Society, Maternity Managers,

Consumer representation, Pacific Peoples, Maori SIDS and the then coordinator of the New Zealand Breastfeeding Authority (Fig 3). The IAG was set up to review and amend the international BFHI documents so that they were relevant to the New Zealand context. It also aimed to integrate the principles of the Treaty of Waitangi. An action plan was developed for the implementation of BFHI into the New Zealand health system. This process took many hours and many meetings over a nine month period, from which a set of documents were developed for consultation and sent out in draft form. Once the submissions and comments had been received, collated and the changes were made ensuring that we had incorporated New Zealand's context, the documents were ready to be implemented. New Zealand has led the international BFHI arena in the way in which it has been inclusive of Maori, validating their culture. The Treaty of Waitangi's three principles partnership, participation and protection are an integral part of the BFHI document. The intent of the New Zealand document is to have consistent, evidence based, culturally appropriate practice where ever breastfeeding occurs. This is evaluated during the formal BFHI assessment of maternity units.

The three principles *protection, partnership* and *participation* are the foundation of the Treaty of Waitangi and are interpreted as follows. Breastfeeding data shows that Maori breastfeeding rates are lower than those of non-Maori and that this normal process needs to be protected. With all the documents there has been wide consultation with Tangata Whenua. This partnership model is the most important principle in the consultation process. A Maori representative has been present at each meeting held (representative has been from Maori SIDS) and through their networks and Iwi knowledge Maori have remained inclusive throughout consultation. Involving Maori and encouraging their support and advocacy, ensuring breastfeeding is seen as the cultural norm, addresses the third principle, participation. It is important to encourage Maori to be the teachers of Maori breastfeeding for those health workers working alongside mothers in the community and in the facilities. Part of this, is the inclusion and integration of the Treaty of Waitangi in BFHI assessment process.

Consumer representation has been another area where New Zealand has been has been at the forefront internationally. Many countries employ a professional audit team to fulfill the assessment requirements of BFHI and their teams do not include any

consumer representation. From the onset of BFHI in New Zealand consumers have been able to give a clear indication as to what the community would like for BFHI in New Zealand. Language is very important to the acceptance of change and challenge. Information sheets have been developed in consultation with consumer groups. These are comprehensive and easily understood by mothers and their families.

The New Zealand Breastfeeding Authority (Figure 4), is central to the National Breastfeeding strategic plan in New Zealand. The NZBA has a contractual obligation to the Ministry of Health, with specific reporting indicators and output measures. These are presented to the Ministry of Health quarterly. The NZBA is a national committee consisting of representatives from both professional and consumer organizations. The committee provides information, support and assessment for maternity facilities and health services which are working towards BFHI and towards the implementation of best practice in relation to breastfeeding.

Further to a growing body of evidence supporting the implementation of BFHI throughout the world and the continued challenges made by the World Health Organization, NZBA continues to facilitate the consultation process. The Innocenti Declaration calls upon all governments to appoint a "national breastfeeding committee of appropriate authority" and to establish "a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional associations" (Palmer G & Kemp S, 1996p19).

NZBA facilitated the public forum and nomination process alongside the Ministry of Health to establish the Transitional Breastfeeding Committee (TBC). The TBC's objective was to write the Terms of Reference for the National Breastfeeding Committee which would have a Ministry of Health mandate. The Transitional Breastfeeding Committee contained a broad range of expertise and perspectives which included, public health, breastfeeding and employment research, women's health, midwifery, children's health, Maori and Pacific experience, health promotion, consultation and networking. Once the process was completed the TBC's role and existence was terminated. The National Breastfeeding Committee (NBC) is to be the

overarching body, determining a breastfeeding strategic plan for New Zealand. NZBA whose name will change once the NBC has been established, will sit below the National Breastfeeding Committee as will the Baby Friendly Community Initiative Committee.

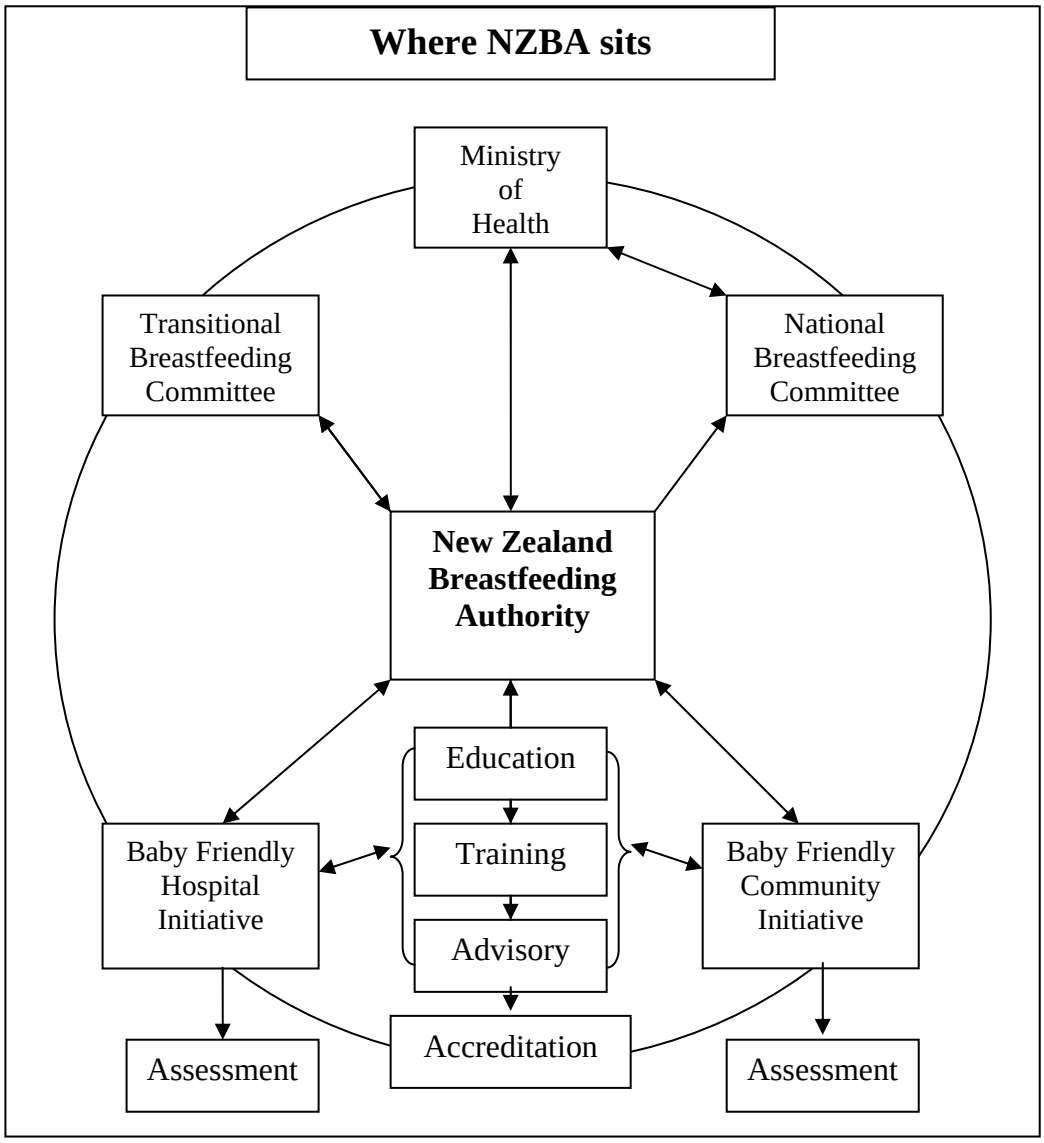

Figure 4: New Zealand Breastfeeding Authority

Currently NZBA is responsible for providing all of the BFHI assessor training. Assessors must complete a workshop every 3 years to remain active as National BFHI assessors. NZBA is also contracted to provide BFHI workshops for regions that continue to struggle with this assessment process. Understanding the BFHI accreditation process and the importance that each facility plays in supporting exclusive breastfeeding on discharge is crucial to the ongoing breastfeeding relationship. Changing a hospital culture is never easy but the education supported by the scientific evidence gives credibility to the change. When breastfeeding statistics are collected and the evidence shared the majority of health care workers realise the importance of their participation. NZBA also works in an advisory capacity, sharing the expertise that it has amongst the stakeholder groups. The Authority is invited to many forums to provide updated statistics or an expert viewpoint. Attendance and presentations at conferences contributes to, and allows for, the dissemination of current breastfeeding information, barriers and successes and updates on the BFHI accreditations.

Initial assessments

Hospitals must meet the BFHI Global Criteria for each of the Ten Steps to Successful Breastfeeding to achieve accreditation as a Baby Friendly Hospital. The appraisal is a rigorous process carried out by a team of trained assessors from outside the facility. The team report the results of the assessment to a national authority that decides on designation and certification. The Ten Steps to Successful Breastfeeding are pivotal to the implementation of the BFHI in the maternity facilities and are seen as the minimal requirement for health facilities to become recognized as “baby friendly”.

The Ten Steps are the gold standard from which all facilities can base their breastfeeding policy. Saadeh (1996) is quoted as saying,

> “Adoption of the Ten Steps should enhance care for all women, whether or not they are breastfeeding. Properly implemented, they favor informed decision making about infant feeding, individualised advice about infant feeding, humane care during labour and delivery, support for mothers after discharge, and independence from commercial influences. Increasing the autonomy of mothers in the maternity unit is important for enhancing maternal competence and confidence after discharge” (p157).

In 2000 a BFHI assessor-training workshop was held over two days which was attended by many who were committed to having BFHI implemented in New Zealand. The South Pacific representative for BFHI, Ros Escott, attended as a trainer educator. Four maternity hospitals were assessed as part of the training in the Auckland area. Whilst this was daunting for those facilities, it was a great opportunity for the assessors to try out their interviewing skills and familiarise themselves with the new documents. It was also a learning experience to see how far some facilities were away from being ready to be assessed.

In 2001 NZBA was contracted by the Ministry of Health to assess thirty maternity facilities in New Zealand. This was the first big contract that the NZBA had been given. It posed a few problems as it was required in a very short time frame and the need for consistency was a necessity. This meant that only a few of the assessors that had been trained could be used for these particular assessments, so not all could have a full compliment of assessors. The thirty facilities which were assessed gave a clear indication as to where New Zealand facilities were placed and this has been used as a baseline for breastfeeding data collection.

Implementation

NZBA is responsible for the coordination and preparation of facility assessments. Teams are selected from a wide range of professions and expertise. Each assessment team is made up of a Maori and a consumer representative. The team also consists of a Lead assessor who coordinates the assessment and documents all the information, according to the BFHI documents.

In 2002 the first three New Zealand Baby Friendly facilities were accredited and by March 2005, there have been twenty two facilities which have achieved the prestigious award and gained global recognition.

Figure 5: The Honorable Steve Chadwick presenting the first BFHI Accreditation Certificates 2002

For each facility that achieves the Baby Friendly Hospital Accreditation there is a presentation process. The BFHI presentation (Fig 5) was held in Parliament to mark the first event in New Zealand. The collegial work and implementation of the BFHI process is an event to be celebrated. The NZBA pride themselves in ensuring that each facility's accreditation is validated and celebrated.

Outcomes

Since BFHI New Zealand has been introduced, breastfeeding rates have improved. With consistent and a better understanding of the breastfeeding definitions, enforcement of accurate and accountable data collecting statistics will have some international meaning. Up until 2001 the data had not shown any significant increase in breastfeeding rates. It has only been over the past three years, with all health carers

required to report breastfeeding data, that we are now seeing an increase in exclusive breastfeeding rates. When the LMC passes care of the mother and baby to Plunket or other Wellchild providers, there is another breastfeeding point of data collecting. This can aid in identifying breastfeeding trends in New Zealand.

Facility	2001 Audit % Exclusive	When Accredited % Exclusive	Births in year
Birthcare Parnell	-	91.0	239
Botany Downs	-	83.5	319
Burwood Birthing Unit	-	84.0	177
Christchurch Women's	59	78.0	4274
Dunedin	80	81.4	1715
Hawera	-	75.0	103
Huntly	95	96.5	172
Kenepuru	-	93.2	252
Levin	-	80.0	145
Lincoln	-	87.0	76
Nelson	70	81.6	847
Palmerston North	84	89.0	2118
Paraparaumu	-	94.4	92
PUKekohe	-	84.0	370
Rangiora	-	80.0	
St George's	56	83.3	627
Taranaki	70	77.9	1094
Tauranga	54	81.0	1722
Timaru	-	89.4	581
Wairau	55	78.0	458
Wanganui	85	76.0	656
Wellington	52	75.3	3546
Whakatane	52	82.0	634

Table 1: Change in Exclusive Breastfeeding Rates in New Zealand BFHI Hospitals

From the initial Ministry of Health audits that took place in 2001, there has been an improvement in quality of breastfeeding data collection on discharge from the maternity facilities. There have been increases in exclusive breastfeeding from as little as 1% to as much as 30% (Table 1). In June 2005 there were 20,000 babies born in Baby Friendly hospitals, of which a minimum of 75 percent were exclusively breastfed. This compared to 67 percent in 2001 is an incredible achievement in just four years.

There has been no change in the use of formula (breastmilk substitutes), but there has been a four percent rise in the exclusive breastfeeding rates from 46% in 2002 to 50% in 2004 at six weeks (Fig 6). There has also been a four percent rise in exclusive breastfeeding rates at three months from 33% in 2002 to 37% in 2004 (Fig 7).

DHB	**6wks**	**11-15wks**
	%	**%**
Northland	70.22	56.42
Waitemata	64.99	49.40
Auckland	65.44	51.35
Counties Manakau	58.78	43.77
Waikato	68.50	52.45
Lakes	72.99	58.59
Bay of Plenty	68.06	57.41
Tairawhiti	55.84	44.00
Taranaki	74.07	59.27
Hawkes Bay	60.49	47.45
Whanganui	60.12	46.18
Midcentral	63.59	51.97
Capital and Coast	76.57	56.85
Hutt Valley	62.44	46.67
Wairarapa	58.87	34.45
Nelson Malborough	69.88	61.32
West coast	53.85	47.83
Canterbury	67.54	53.76
South canterbury	68.67	57.09
Otago	60.40	52.88
Southland	62.11	43.10
New Zealand	**65.63**	**50.98**

Table 2: Full Breastfeeding Rates by DHB July to December 2001

The above table shows that nationally there were 65% of infants fully breastfeeding (this includes exclusive and full breastfeeding numbers) at six weeks with an increase to 67% in 2004.

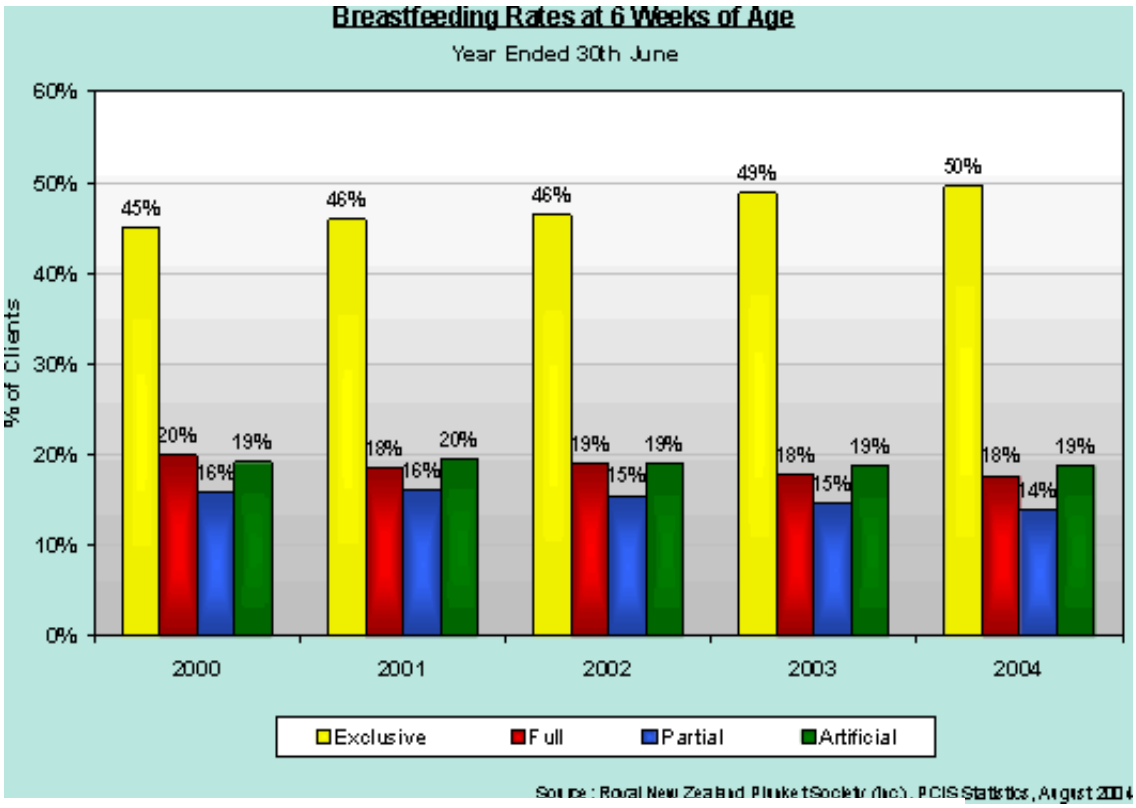

Figure 6: Data from Royal New Zealand Plunket Society August 2004

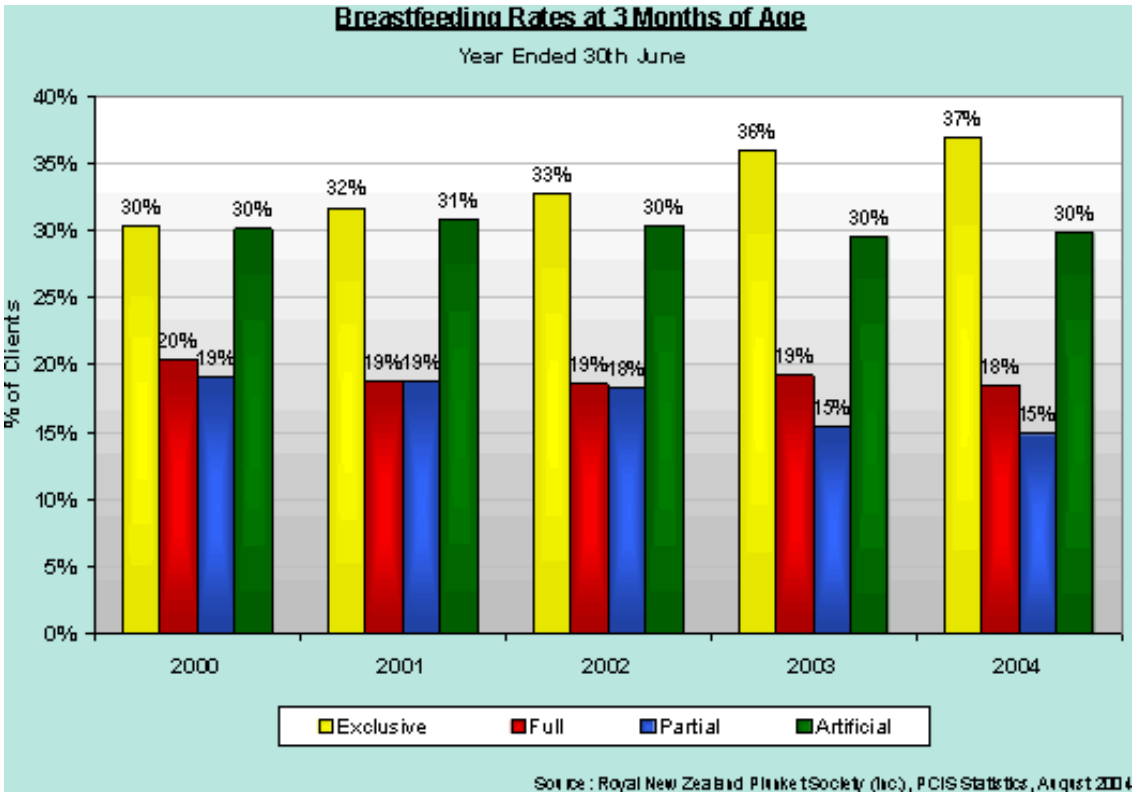

Figure 7: Data from Royal New Zealand Plunket Society August 2004

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In table 3 the Ministry of Health provides full breastfeeding rates according to regions and these figures also provide useful data as to the type of breastfeeding.

Breastfeeding Rates at 6 weeks				
DHB	**01/01/2004 - 31/12/2004**			
	Exclusive	Full	Partial	Artificial
Auckland	53%	18%	17%	13%
Bay of Plenty	53%	14%	8%	25%
Canterbury	54%	15%	13%	17%
Capital and Coast	53%	20%	14%	13%
Counties ManUKau	40%	15%	23%	22%
Hawkes Bay	45%	22%	10%	23%
Hutt	49%	12%	17%	21%
Lakes	59%	15%	10%	15%
MidCentral	44%	18%	15%	23%
Nelson Marlborough	50%	22%	10%	18%
Northland	53%	22%	11%	14%
Otago	54%	14%	10%	23%
South Canterbury	50%	14%	12%	24%
Southland	46%	20%	9%	25%
Tairawhiti	59%	10%	13%	19%
Taranaki	61%	4%	9%	27%
Waikato	60%	11%	9%	21%
Wairarapa	44%	17%	20%	19%
Waitemata	47%	19%	17%	17%
West Coast	48%	12%	11%	29%
Whanganui	50%	12%	9%	29%
Total	**50%**	**17%**	**14%**	**19%**

Table 3: Breastfeeding Rates at 6 weeks in regions.
Source: Royal New Zealand Plunket Society (Inc.), PCIS Statistics, April 2005

With the implementation of BFHI, exclusive breastfeeding data has gradually increased at discharge and at six weeks. With more maternity facilities working towards this accreditation this percentage of babies exclusively breastfed will further improve. This then will impact on the breastfeeding rates at three and six months which continue to decline. Once again New Zealand has taken on the breastfeeding challenge. With the implementation of the Baby Friendly Community Initiative (BFCI) it is hoped that further community breastfeeding education and support will address most areas and we will then see an increase in exclusive breastfeeding rates after six weeks.

Section III: The Next Step

Moving into the community

The next step for New Zealand is the emphasis placed on the development of Step Ten of the Ten Steps to Successful Breastfeeding. *Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.* This breastfeeding initiation, takes the breastfeeding support and education seamlessly from the hospital into the community. Many new mothers are discharged from the maternity facility within 48 hours post birth and it is assumed that on discharge from a BFHI accredited facility a minimum of seventy five percent of mothers will be exclusively breastfeeding their babies. Breastfeeding status on discharge is a specific reporting indicator for the Ministry of Health.

NZBA has been given a Ministry of Health contract to develop the Baby Friendly Community Initiative (BFCI). A BFCI coordinator was employed late 2004 and the developments of draft documents were commenced. The BFCI objectives are a continuation of the BFHI into the community. They include improving the health of mothers and their infants by supporting exclusive breastfeeding beyond discharge from the maternity facility and to improve the parent/child relationship with a good start to the parenting experience by supporting community networks to provide quality care. BFCI will also measure through an assessment process that ensures consistent information is given to mothers. Through accurate data collection potential cost savings can be reported back to the Ministry of Health and the New Zealand public. In addition and complimentary to the New Zealand Ministry of Health strategies and Action Plans, *The Seven Point Plan* includes the following guiding principles:

- Informed decision making
- Promoting and sharing evidence-based and best practice
- Promoting and sharing across the continuum of service through collaboration
- Working toward empowerment and public participation.

The NZBA anticipates that any health service in the community working towards Baby Friendly designation will work within these principles (New Zealand Breastfeeding Authority, 2005).

In 2002, 73% of women had a midwife as their Lead Maternity Carer present at birth (Ministry of Health, 2004). It is important that midwives continue to provide breastfeeding support as it is required in order that mothers continue to exclusively breastfeed their babies until four to six weeks. At this stage the care of the mother and her baby is handed over to the Wellchild services. It is required by Section 88 that for each individual LMC midwife reports their breastfeeding data at two and six weeks postpartum (Ministry of Health, 2002).

The New Zealand Maternity facilities have achieved so much and our society's health can only but benefit. The future is very exciting for the Baby Friendly Hospital Initiative in New Zealand as it moves into the community. Ministerial support and funding will help this initiative succeed. With the help of the local community networks and community support groups, exclusive breastfeeding rates can be increased, thereby reducing the infant admissions to the paediatric and emergency rooms (American Academy of Pediatrics, 1997; Yngve A & Sjostrom M, 2001). The community is now ready to see that BFCI is implemented.

Reflection

Looking back on the past six years much has been achieved. Many midwives and health care staff have gained breastfeeding knowledge to assist new mothers in initiating breastfeeding. Over the past six years I have seen maternity staff resist the change. But then they get caught in the momentum and find that they too are supporting women to breastfeed. Although challenged along the way, they themselves have felt well supported. With change comes anxieties and fear of change itself. No one is comfortable when their practices are challenged nor their ideas shaken when the routines of yesterday become obsolete.

Today, in our small secular community of New Zealand the 'tall poppy' syndrome is very evident and as NZBA's profile becomes even more apparent there are more critics that appear to tear down what has been achieved. With the collaboration of many different stakeholder groups there are always challenges of mind set and organizational

and personal agendas that are to be addressed. These at times have been difficult, and sometimes they remain unresolved.

The New Zealand Breastfeeding Authority has played a significant role in the implementation of the Baby friendly Hospital Initiative in New Zealand. Its prime role has been to coordinate contractual obligations with the Ministry of Health, to provide educative workshops for health professionals and interested consumers. It has provided a forum for consultation and discussion in a collaborative manner. The NZBA has contributed to the resources that are now available and has become the facilitator of new breastfeeding initiatives. Its beginnings were voluntary, but today the NZBA is viewed as an authoritative body, which facilitates and coordinates several breastfeeding contracts and continues to be funded to support, protect and promote breastfeeding in New Zealand.

The strength of the NZBA's membership is fundamental to the integrity of its continued success. The commitment of all committee members to the improvement of breastfeeding rates and to the development of breastfeeding as the cultural norm remains strong. With this at its core, NZBA will not fail to act as a political force that will continue to address relevant issues, provide support for maternity facilities and expert knowledge for the Ministry of Health when required.

Perception

The BFHI has not come without its difficulties, both politically and personally. As with many new health initiatives there are many personal agendas that surface and at times cause conflict. Those community groups who have worked tirelessly to promote breastfeeding and who have contributed hundreds of volunteer hours are now watching the object of their passion slowly come to fruition. This does not come without issues of letting go of control and ownership, sharing of philosophies and developing a collaborative approach, where progress now belongs to New Zealand's mothers and babies and to the health of a nation. Many of the stakeholder groups have watched the development of BFHI, not always agreeing with its outcomes. But they have observed

the evolving initiative and the formation of a national breastfeeding committee. With this in the forefront it has been crucial to the development of BFHI in New Zealand, to have remained an open, transparent and honest process. Consultation with the stakeholder groups has been seen as an informative and open process, that has supported the initiatives which have been implemented with integrity, as it was intended. With consultation there is always a possibility of complaint and criticism. Managing the process has not always been smooth.

Unique to New Zealand is our partnership with Maori. In the development of BFHI in New Zealand and within the health arena, this has been integral to policy and the writing of the BFHI documents. Over the past 8 years this process has provided a platform for breastfeeding amongst the Maori peoples of New Zealand. Once again it cannot have succeeded without the dedication of the Maori SIDS Programme who have provided not only expertise in breastfeeding, but also in Maori cultural appropriateness and Maori consultation. This relationship between process and the community and iwi has been viewed very positively by many nations internationally who have ethnic disparity and inequality amongst their peoples.

At times there have been persons selected for some positions to support the main structure of baby friendly because of their expertise, but in the main representation on various committees has been through a nomination process from the main stakeholder groups. Consultation throughout the formation and implementation of BFHI in New Zealand has been pivotal in maintaining a fair and equitable process and continuing the BFHI momentum. Political commitment has also given us the funding to continue to implement this health initiative. Internationally New Zealand has become more credible and enviable.

The BFHI in New Zealand would not have gained so much ground and achieved so much if it were not for the political positions held by women. At the launching of the BFHI documents in Wellington at Parliament, the Minister of Health, Hon Annette King, spoke of her support for this initiative and the importance of breastfeeding for health. This has been our strength, and without their tenacity and political influence the implementation of neither BFHI nor the improvement in our national breastfeeding rates

would have gained so much ground in such a short period of time. Valuing mothers and supporting women to continue to exclusively breastfeed to 6 months has seen the development of paid parental leave entitlements (Department of Labour, 2004). Discussion has also occurred between many community groups, Government Ministers and with the Human Rights Commission on the right to breastfeed in a public place (Human Rights Commission, 2005). Work towards breastfeeding in the workplace is currently being included into the maternity specifications

Recommendations

There are three areas of recommendation which I would like to emphasise.

- *To have health workers who support breastfeeding at health policy level.* Encouragement should be given in support of health workers to sit on pertinent committees within the District Health Boards so that their advocacy can be heard. Where there is a primary health strategy being developed the importance and benefits of breastfeeding as a basic human right would be included. When submissions are called for, more encouragement and assistance is required to support health workers to participate in primary health meetings or to table their concerns about the lack of breastfeeding support and awareness of its contribution to improved health outcomes. The long term effects on society are obvious and well supported by the evidence (Yngve A & Sjostrom M, 2001). Breastfeeding support should be recognized as not just another inconvenience but an integral part of every health policy such as reducing obesity (Kries R et al., 1999), reducing the incidence of diabetes (Yngve A & Sjostrom M, 2001, p634) and decreasing the incidence of otitis media (Heinig MJ, 2001) to name a few. To make a difference in the health of future generations, exclusive breastfeeding for six months needs to be included in health policy.
- *To ensure that all District Health Board's allocate funds within budget to staff education, work force planning, and innovative breastfeeding initiatives appropriately.* The maternity specifications indicate to all maternity facilities that they are required by the Ministry of Health to be working towards the implementation of BFHI. Breastfeeding rates are also a reporting indicator.

Without funding there is little commitment by management to support the health workers both in the facility and in the community in their endeavours to support exclusive breastfeeding. As most babies are born in a maternity facility in New Zealand, hospital practices need to demonstrate that they protect, promote and support breastfeeding. It is without a doubt that continued funding to support staff education, staff numbers and breastfeeding initiatives is a necessity (Vogel A & Mitchell E, 1998).

- *To circulate amongst health workers and community support networks latest scientific evidence that supports exclusive breastfeeding to six months.* It is important to have ongoing credible and valid breastfeeding research to support that which has already been published nationally and internationally. With the development of a National Breastfeeding Committee it is hoped that this will be their role. Individual research projects and multi-centred research with other sectors should continue to be supported.

The NZBA will continue to place breastfeeding at the forefront of the Ministry of Health documents and will continue to assist facilities to gain the BFHI accreditation. It is necessary to have the support of the Ministry of Health both financially and within ministerial portfolios, to be able to progress to ensure all maternity facilities will achieve the Baby friendly Status by the 2006. With breastfeeding definitions now consistent throughout the health arena, breastfeeding rates are accurately collected and disseminated to policy makers. There will be many more challenges for BFHI in New Zealand as there is always changing personal within the Ministry and within NZBA itself.

With the development and formation of the National Breastfeeding Committee we will see more strategic planning for breastfeeding, incorporating objectives and goals as well as funding at government level. Above all breastfeeding has gained recognition and is seen as a very important health issue, one which impacts on our children initially and on the future health of all New Zealanders. Through continued consultation and collaboration, honesty and integrity, passion and direction to make a difference, breastfeeding will once again become the cultural norm.

Appendix I

Development of Baby Friendly Hospital Initiative in New Zealand: Time Line

1983 - Adoption of the WHO Code and Monitoring Committee established

1990 - Policy makers from 32 govts,10 persons from United Nations and other agencies at the World Summit for Children, developed and adopted the Innocenti Declaration' the Protection, Promotion and Support of breastfeeding.

- Monitoring Committee disbanded.

1991 - The World Health organisation (WHO) and the United Nations Children's Fund launched the Baby Friendly Hospital Initiative (BFHI)

1992 - The New Zealand College of Midwives "Breastfeeding Handbook, *Protecting, Promoting and Supporting Breastfeeding"* was published

1994 - The Ministry of Health and the New Zealand Committee for UNICEF held an Inaugural National Baby-Friendly Hospital Initiative Workshop. Following this there was a formation of a BFHI taskforce – no funding

1994-5 - Public Health Commission documents set breastfeeding targets.

1995 - Public Health Commission published Guidelines for Healthy Infants and Toddlers.

1997 - Ministry of Health published Infant Feeding: Guidelines for New Zealand Health Workers. The Code of Practice for the Marketing of Infant Formula was published by the New Zealand Infant Formula Marketers' Association.

- Participants of the New Zealand Lactation Consultants Association (NZLCA) Conference including NZCOM, LLLNZ and Plunket, submitted a proposal to the Transitional Health Authority to implement BFHI – no funding

- The NZCOM established a BFHI Taskforce to produce the first four New Zealand BFHI documents. These were launched at the inaugural NZCOM national BFHI workshop.

1997 - The New Zealand College of Midwives convened the second national BFHI workshop. The delegates became the "New Zealand Breastfeeding Authority'

1998 - Meeting held in Wellington facilitated by New Zealand College of Midwives.
- Ministry of Health published Progress on Health Outcome Targets. Breastfeeding targets rates set for 1997 were not achieved.

1999 - NZBA became an incorporated society
- Contracted by the Health Funding Authority to develop BFHI for New Zealand.
- Formed the Implementation Advisory Group (IAG) to rewrite the global documents, to fit the unique New Zealand maternity system and to incorporate the treaty of Waitangi.

2000 - BFHI documents were launched with the launch of the Baby Friendly Hospital Initiative in Aotearoa/NZ during World Breastfeeding Week at the Millenium Hotel in Christchurch.

2001 - Ministry of Health contracted BFHI audit of 30 of the 87 maternity facilities.
- The Nutrition toolkit

2002 - Breastfeeding: A Guide to Action
- 3 Hospitals gained the BFHI accreditation

2003 - Global Strategy for Infant and Young Feeding

2004 - WHO/UNICEF Seminar – the Baby Friendly Hospital Initiative in Industrialised Countries held in Barcelona

2004-5 - Review of the BFHI documents

2005 - Implemented the reviewed documents

2005-6 - A working group formed and charged with the writing up of the Baby Friendly Community Initiative documents. Preparation is required for public consultation, implementation and piloting the community assessment tool.

Appendix II

NZBA Stakeholders

- Allergy New Zealand
- Childbirth Educators of New Zealand
- Diatrict Health Board Women's Health Managers Network
- Education for Change
- Federation of Women's Health Councils Aotearoa New Zealand
- Fertility New Zealand
- Health Star Pacific
- Healthcare Aotearoa
- Home Birth Associations
- La Leche League New Zealand
- Ministry of Health
- Maori SIDS Programme
- New Zealand College of Midwives
- New Zealand Association of Neonatal Nurses
- New Zealand College of Practice Nurses
- New Zealand Cot Death Association
- New Zealand Dietetic Association, Paediatric Specialist Interest Group
- New Zealand Lactation Consultants Association
- New Zealand Paediatric Society
- Nga Mia O Aotearoa me Te Wai Pounamu
- Parents Centre New Zealand
- Perinatal Society of Australia and New Zealand
- Royal College of Obstetricians and Gynaecologists
- Royal New Zealand College of General Practitioners
- Royal New Zealand Plunket Society
- The Office of the Commissioner for Children
- The Pharmacy Guild
- UNICEF New Zealand
- Womens Health Action

Associate Member

- Judith Galtry

Appendix III

Facilities WHO have achieved Baby Friendly Hospital Accreditation

PRIMARY UNITS

1. Birthcare Parnell
   www.birthcare.co.nz
2. Botany Downs Maternity Unit
   www.cmdhb.org.nz
3. Burwood Birthing Unit
   www.cdhb.govt.nz
4. Kenepuru Maternity Unit
   www.ccdhb.org.nz
5. Lincoln Maternity Unit
   www.cdhb.govt.nz
6. Paraparaumu Maternity Unit
   www.ccdhb.org.nz/
7. Rangiora Maternity Unit .
   www.cdhb.govt.nz
8. Horowhenua Maternity Unit
   www.midcentral.co.nz
9. Hawera Maternity Unit
   www.tdhb.org.nz
10. St George's Maternity Unit
    www.stgeorges.org.nz

SECONDARY UNITS

1. Palmerston North Women's Health Service
   www.midcentral.co.nz
2. Tauranga Maternity Unit
   www.bopdhb.govt.nz
3. New Plymouth Maternity Unit
   www.tdhb.org.nz
4. Wanganui Maternity Unit
   www.midcentral.co.nz
5. Whakatane Maternity Unit
6. Timaru Maternity Unit
   www.timaruhospital.co.nz

TERTIARY UNITS

1. Christchurch Women's Hospital
   www.cdhb.govt.nz
2. Queen Mary Maternity Centre Dunedin
   www.otagodhb.govt.nz
3. Wellington Hospital Maternity Service
   www.ccdhb.org.nz

August 2005

Appendix IV

Ten Steps to Successful Breastfeeding

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

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

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

4. Help mothers initiate breastfeeding within a half hour of birth

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

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

7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day

8. Encourage breastfeeding on demand

9. Give no artificial 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.

From: Protecting, Promoting and Supporting Breastfeeding:
The Special Role of Maternity Services A joint WHO/UNICEF Statement.
Published by the World Health Organisation,1211 Geneva 27,Switzerland.

Appendix V

The WHO/UNICEF International Code of Marketing of Breastmilk Substitutes

Summary of Main Points

1. No advertising of breastmilk substitutes in the health care system or to the public.

2. No free samples to be given to mothers or pregnant women.

3. No free or subsidised supplies to hospitals.

4. No contract between company marketing personnel and mothers

5. Materials for mothers should be non-promotional and should carry clear and full information and warnings.

6. Companies should not give gifts to health workers.

7. No free samples to health workers, except for professional evaluation or research at the institution level.

8. Materials for health workers should contain only scientific and factual information.

9. No pictures of babies or other idealising images on infant formula labels.

10. The labels of other products must provide the information needed for appropriate use, so as not to discourage breastfeeding.

Appendix VI

The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings

All providers of community health care should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Support mothers to initiate and maintain breastfeeding
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods
6. Provide a welcoming atmosphere for breastfeeding families
7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community

UUNICEF UK Baby Friendly Initiative, 1999

Appendix VII

Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding

Recognising that:

Breastfeeding is a unique process that:

Provides ideal nutrition for infants and contributes to their healthy growth and development Reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality Contributes to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies Provides social and economic benefits to the family and the nation Provides most women with a sense of satisfaction when successfully carried out

and that Recent Research

has found that: these benefits increase with increased exclusiveness of breastfeeding during the first six months of life, and thereafter with increased duration of breastfeeding with complementary foods, and programme intervention can result in positive changes in breastfeeding behaviour

We therefore declare that:

As a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner.

Attainment of this goal requires, in many countries, the reinforcement of a "breastfeeding culture" and its vigorous defence against incursions of a "bottle-feeding culture". This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life.

Efforts should be made to increase women's confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding, often by subtle and indirect means. This requires sensitivity, continued vigilance, and a responsive and comprehensive communications strategy involving all media and addressed to all levels of society. Furthermore, obstacles to breastfeeding within the health system, the workplace and the community must be eliminated.

Measures should be taken to ensure that women are adequately nourished for their optimal health and that of their families. Furthermore, ensuring that all women also have access to family planning information and services allows them to sustain breastfeeding and avoid shortened birth intervals that may compromise their health and nutritional status, and that of their children.

All governments should develop national breastfeeding policies and set appropriate national targets for the 1990s. They should establish a national system for monitoring the attainment of their targets, and they should develop indicators such as the prevalence of exclusively breastfed infants at discharge from maternity services, and the prevalence of exclusively breastfed infants at four months of age.

National authorities are further urged to integrate their breastfeeding policies into their overall health and development policies. In so doing they should reinforce all actions that protect, promote and support breastfeeding within complementary programmes such as prenatal and perinatal care, nutrition, family planning services, and prevention and treatment of common maternal and childhood diseases. All healthcare staff should be trained in the skills necessary to implement these breastfeeding policies.

Operational Targets

All governments by the year 1995 should have: Appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations

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

Taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety;

and enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement

We also call upon international organizations to:

Draw up action strategies for protecting, promoting and supporting breastfeeding, including global monitoring and evaluation of their strategies

Support national situation analyses and surveys and the development of national goals and targets for action;

and Encourage and support national authorities in planning, implementing, monitoring and evaluating their breastfeeding policies

The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative, co-sponsored by the United States Agency for International Development (A.I.D.) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July - 1 August 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions. (1)

Four targets of the Innocenti Declaration are:

1. Appointment of a national breastfeeding coordinator of appropriate authority, and establishment of a multisectoral national breastfeeding committee;

2. Ten Steps to Successful Breastfeeding (the Baby-Friendly Hospital Initiative) practiced in all maternity facilities;
3. Global implementation of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly Resolutions in their entirety;
4. Enactment of imaginative legislation protecting the breastfeeding rights of working women; and establishment of means for enforcement of maternity protection.

The challenge of how to improve breastfeeding, with an overview of breastfeeding patterns in the 1990s, is summarised among the World Summit for Children goals.

The Global Strategy includes five additional operational targets:

1. Implementation of comprehensive government policies on infant and young child feeding;
2. Full support from health and other sectors for two years of breastfeeding or more;
3. Promotion of timely, adequate, safe and appropriate complementary feeding (addition of other foods while breastfeeding continues);
4. Guidance on infant and young child feeding in especially difficult circumstances, and related support for families and caregivers; and
5. Legislation or suitable measures giving effect to the International Code as part of the national comprehensive policy on infant and young child feeding.

NZCOM CONSENSUS STATEMENT
Breastfeeding

This Consensus Statement was ratified at NZCOM AGM, July 2002

The New Zealand College of Midwives is committed to protecting, promoting and supporting breastfeeding.

Midwives:

- **are the health professionals with a primary role in the initiation and the establishment of breastfeeding**
- **are committed to the health and well-being of women and acknowledge that breastfeeding has health benefits for women.**
- **are committed to the health and well-being of babies, and believe that human milk is the optimum food for human babies. Breastfeeding also provides immunological benefits that promote healthy growth and development of infants.**
- **have a responsibility to provide evidence-based research and culturally appropriate information about breastfeeding that supports women to develop and maintain the art of successful breastfeeding.**
- **have a responsibility to provide evidence-based research and culturally appropriate information about infant feeding to women during pregnancy and the postpartum.**
- **have a responsibility to protect and support the breastfeeding woman and her baby**
- **support the World Health Organisation recommendation that babies should be exclusively breastfed until six months of age and with added solids continue breastfeeding into the second year and beyond.**
- **support the principles of the Baby Friendly Hospital Initiative (BFHI).**

Definitions:

The following definitions should be used when describing breastfeeding:

- ***Exclusive breastfeeding*:** The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breastmilk, from the breast or expressed, and prescribed* medicines have been given from birth.
  *Prescribed as per the Medicines Act 1981

- ***Fully breastfeeding:*** The infant has taken breastmilk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.

- ***Partial breastfeeding:*** The infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours.

- ***Artificial feeding:*** The infant has had no breastmilk but has had alternative liquid such as infant formula with or without food in the past 48 hours.

Source: Breastfeeding Definitions for Monitoring the National Health Outcome Targets in New Zealand. MOH. New Zealand. Feb 1999.

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Title: Protecting, Promoting and Supporting Breastfeeding
Author: New Zealand College of Midwives Breastfeeding Sub-Committee, 1992.
Source: New Zealand College of Midwives, P O Box 21106, Edgeware, Christchurch.
ISBN 0-478-01691-5

Title: Evidence for the Ten Steps to Successful Breastfeeding
Author: World Health Organisation, Geneva. 1998.

Title: International Code of Marketing of Breastmilk Substitutes
Author: World Health Organisation
Source: WHO – Geneva, 1991.

Title: Food and Nutrition Guidelines for Healthy Breastfeeding Women: A background paper
Author: Ministry of Health. New Zealand. 1997.

Title: Infant Feeding: Guidelines for New Zealand Health Workers
Author: Ministry of Health, New Zealand. 1997.

Title: A Guide to Effective Care in Pregnancy and Childbirth
Author: Enkin, M. Keirse, M. Renfrew, M. Neilson, J.
Source: Oxford University Press. 1995.
ISBN 0-19-262326-5 Hardback ISBN 0-19-262324-9 Paperback

Title: Breastfeeding Pure and Simple
Author: Gwen Gotsch
Source La Leche League International, Revised edition 2000

Title: Breastfeeding Matters
Author: Minchin, Maureen. 4th Edition
Source: Alma Publications and George Allen and Unwin (1998).
ISBN 0-86861-810-1

Title: Baby Friendly Hospital Initiative Documents for Aotearoa
Author: New Zealand Breastfeeding Authority (NZBA)
Source: Julie Stufkens, Coordinator NZBA Stufj@cpublichealth.co.nz

Title: Evidence Based Guidelines for Breastfeeding Management during the First Fourteen Days
Author: International Lactation Consultants Association
Source: International Lactation Consultants Association

Title: The Womanly Art of Breastfeeding
Author: La Leche League International
Source: Angus and Robertson, 1997. (6th Revised Edition)

Breastfeeding 2002

The purpose of New Zealand College of Midwives Consensus Statements is to provide women, midwives and the maternity services with the profession's position on any given situation. The guidelines are designed to educate and support best practice.

All position statements are regularly reviewed and updated in line with evidence-based practice.

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