Counties Manukau District Health Board

Breastfeeding Action Plan

Contents

Acknowledgements

This Breastfeeding Action Plan was prepared for Counties Manukau District Health Board (CMDHB) by Catherine Poutasi of Integrity Professionals, with the active support and assistance of the Counties Manukau DHB Breastfeeding Steering Group: Sue Dashfield (Programme Manager - Personal Health), Debra Fenton (Primary Maternity Service Manager - Women's Health), Louisa Ryan (Programme Manager – Pacific Health), Paula Sole (Programme Manager - Well Child), Mihi Tibble-Williams (Programme Manager – Maaori Health).

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Most importantly, CMDHB thanks the many mothers, fathers and wider whaanau who attended focus groups and so willingly shared their views and experiences. Their participation has been invaluable in developing a better understanding of their strengths, challenges, needs and aspirations, which need to be taken into full account every step of the way in developing and implementing our future plans.

18 June 2008

Executive Summary

Breastfeeding is best for mothers and babies in almost any area one cares to measure. Whilst recognising the wider range of benefits including such things as cost to families and mother baby bonding, there are specific short, medium and long term health gains. Therefore it has particular significance as a key preventative strategy to avoid many debilitating health diseases including a range of infections, cardiovascular disease, diabetes, breast and ovarian cancer, other benefits also accrue. As a result, improving breastfeeding rates has increased in priority for the Ministry of Health (MoH) and Counties Manukau District Health Board (CMDHB).

The Ministry of Health has set a range of key national targets with the aim of reducing health inequalities and improving health outcomes overall. Breastfeeding rates form one such target. Currently breastfeeding rates in Counties Manukau DHB region are relatively low, and fall well short of the both the target and the reported current national average.

The Ministry of Health breastfeeding target is to increase the proportion of infants exclusively breastfed at

- Six weeks to 74% or greater
- Three months to 57% or greater
- Six months to 27% or greater

As part of the process of improving breastfeeding rates, Counties Manukau DHB has developed this Breastfeeding Action Plan to help provide a co-ordinated approach to planning, funding and delivering the relevant health services to a high risk population. The plan is set out in the following manner:

Introduction – This sets out the vision and the key message.

The vision of Counties Manukau District Health Board in relation to breastfeeding is:

> *Breastfeeding is valued, encouraged, accepted and supported in any setting by whaanau and the wider community. The numerous benefits to mother and baby are well understood, in particular that it is the best way of meeting the full nutritional requirements of a baby up to the age of 6 months.*

The key message to the wider Counties Manukau community will be

"Breastfeeding - simply the best[1]!"

Context - The context outlines the strategic accountabilities – international, national and at the local district level. The New Zealand strategic framework is outlined along with Counties Manukau DHB's own strategic framework. It also covers our population profile and current services.

[1] Suggestion from CMDHB Maaori Health team endorsed by BFSG

…. Context continued

Key points:

- Despite a vast amount of policy and frameworks breastfeeding rates for Counties Manukau DHB population are low
- International, national and district accountabilities to be met
- Many priority population groups within Counties Manukau (e.g. high Maori, high Pacific, high fertility, poor socio-economic status and low breastfeeding rates)
- A range of services is provided by or contracted for by Counties Manukau DHB and the Ministry of Health - but not well connected
- 57% of Counties Manukau DHB women receive their maternity care from CMDHB employed staff compared to other areas in New Zealand where care is delivered predominantly by independent LMCs.
- If you birth at Middlemore you are less likely to exclusively breastfeed

Gaps issues and barriers - The plan details the gaps, issues and barriers specific to the Counties Manukau population.

Key points

- Acute workforce shortage, with Maaori and Pacific under-represented
- Fragmentation of services and lack of continuity
- Gap in transfer of maternity care to Tamariki Ora/Well Child providers and GPs
- Inconsistent and conflicting advice from the range of involved health workers
- Whaanau and community attitudes often unsupportive (including workplace and employers)
- Poor data
- Disparities/inequalities for Maaori and Pacific and between geographic areas – Asian also feature.

Addressing the Issues - How Counties Manukau DHB will address the issues to improve breastfeeding rates in the district, over the next two years is outlined in the last section.

Key Points:

- Ensure any service enhancements or new initiatives address the specific needs of the Counties Manukau Population –and reduce disparities
- Ensure Maaori are actively involved at all levels and initiatives which deliver services to Maaori should align with the He Korowai Oranga and The Whaanau Ora Plan
- Ensure Pacific are actively involved at all levels and initiatives which deliver services to Pacific align with Pacific Health and Disability Action Plan and the Tupu Ola Moui framework

Goals and Objectives - The most significant element in developing the proposed actions is acknowledging we need to work together with the community and all other stakeholders in order to be successful. With this in mind, the goals and objectives that have been developed were informed by the stakeholder services and community feedback, and are aimed at the following three settings:

1) Within the DHB;

2) Community health providers; and

3) Wider community (e.g. local councils, marae, churches, employers, schools, community leaders and champions).

The most significant steps are likely to be the Implementation of The Baby Friendly Hospital Initiative (BFHI) and the Baby Friendly Community Initiative (BFCI). These initiatives support antenatal, birthing, postnatal and primary care services to provide the best environment and consistent information to mothers and whaanau. This in turn will assist in improving breastfeeding rates for babies in Counties Manukau DHB.

Introduction

The vision of Counties Manukau District Health Board in relation to breastfeeding is:

Breastfeeding is valued, encouraged, accepted and supported in any setting by whaanau and the wider community. The numerous benefits to mother and baby are well understood, in particular that it is the best way of meeting the full nutritional requirements of a baby up to the age of 6 months.

The key message to the wider Counties Manukau community will be

"Breastfeeding - simply the best[2]!"

Counties Manukau DHB acknowledges that breastmilk is the preferred nutritional source for babies to develop and sustain positive and healthy life outcomes. Counties Manukau DHB supports the *"Baby Friendly Hospital and Community Initiatives"* as part of the development of this plan and anticipates additional promotion of breastfeeding together with an enhancement of services will assist in increasing the breastfeeding rates for the Counties Manukau population (this will involve a particular focus on Maaori, Pacific and Asian communities).

[2] Suggestion from CMDHB Maaori Health team endorsed by BFSG

Context

Related policies, strategies and plans

There are a number of national and district strategies policies and plans that relate to Breastfeeding (See Appendix 1). Of particular relevance to the development of the Counties Manukau Breastfeeding Action Plan are those which have important requirements that need to be met, and those which relate in particular to the health needs of the CMDHB population.

International

The World Health Organisation (WHO) recommends increasing both the proportion of infants that are exclusively breastfed to six months of age and the proportion of infants partially breastfed beyond six months of age. Relevant international accountability documents relating to breastfeeding include:

- International Code of Marketing of Breast-milk Substitutes (WHO 1981) and subsequent relevant WHA resolutions
- Ottawa Charter for Health Promotion (1986)
- Ten Steps to Successful Breastfeeding (WHO/UNICEF 1989)
- International Labour Conference Convention on Maternity Protection (ILO Convention NO 183) June 2000
- World Health Organisation/UNICEF Global Strategy on Infant and Young Child Feeding (2003)
- Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO 1990 updated 2005)

National

New Zealand Health Strategy

Breastfeeding contributes positively to five of the thirteen population health objectives outlined in the New Zealand Health Strategy. These include:

- Improving nutrition
- Reducing obesity
- Reducing the incidence and impact of cancer
- Reducing the incidence and impact of cardiovascular disease
- Reducing the incidence and impact of diabetes

National Strategic Plan of Action for Breastfeeding

The Ministry of Health released a draft National Strategic Plan of Action for Breastfeeding in March 2008. The focus is on the development of a strategic plan in which:

"Aotearoa New Zealand is a country in which breastfeeding is valued, promoted, protected and supported by the whole of society" (Ministry of Health, 2008[3])

The breastfeeding target is to increase the proportion of infants exclusively breastfed at

- Six weeks to 74% or greater
- Three months to 57% or greater
- Six months to 27% or greater

The four key priority settings identified in the draft national Breastfeeding Strategic Plan are:

1) Government;
2) Family and community;
3) Health services; and
4) Workplace, childcare and early childhood education.

Government

- Strengthening the leadership provided by the Ministry of Health
- Improving the scope, quality and timeliness of breastfeeding data
- Identifying gaps in research
- Monitoring and reporting on compliance with the International Code of Marketing of Breast-milk Substitutes

Family and community

- Improving access to ante-natal education (focus on Maori, Pacific and other high need groups)
- Developing or support existing peer support services
- Increasing capability of whaanau to support breastfeeding

Health services

- DHB facilities to become/maintain Baby Friendly accreditation
- Assessing impact of workforce shortages
- Increasing capacity and capability of Maori and Pacific workforce

Workplace, childcare and early childhood education

- Developing a labour market policy framework for the extension of paid parental leave entitlements

The national strategic plan of action for breastfeeding also proposes five critical strategic areas for action:

1. Services for Maori and Pacific women and Whaanau;
2. Cultural responsiveness;
3. Education and information;
4. Training and support; and
5. Collaboration and communication

[3] Ministry of Health (2008) National Strategic Plan of Action for Breastfeeding 2008 – 2012 (Draft)

He Korowai Oranga – Maori Health Strategy

He Korowai Oranga is the National Maori Health Strategy (2002). The aim of He Korowai Oranga is Whaanau Ora – Maori families supported to achieve their maximum health and wellbeing. He Korowai Oranga recognises the interdependence of people and the need to work with people in a social as well as medical context. The four pathways of He Korowai Oranga are:

- The development of whaanau, hapu, iwi and Maori communities;
- Maori participation in health and disability sector;
- Effective health and disability services; and
- Working across sectors.

In the development of the Counties Manukau DHB breastfeeding action plan it is important to ensure the framework and aims of He Korowai Oranga are realised.

The Pacific Health & Disability Action Plan

The Pacific Health and Disability Action Plan (2002) focuses on the need for Pacific people to be involved in the development, management and implementation of health services within New Zealand. This is of particular relevance to Counties Manukau DHB given its high Pacific population. .The Counties Manukau DHB Pacific Tupu Ola Moui framework also prioritises strong community participation. The Counties Manukau DHB Breastfeeding Action Plan embraces this community approach.

Healthy Eating - Healthy Action (HEHA): Oranga Pumau Strategy

Improving breastfeeding rates is identified as a Ministry of Health target (number 8) within the Healthy Eating – Healthy Action (HEHA) strategy. HEHA is a high level framework to improve nutrition, increase physical activity and reduce obesity. It also focuses on reducing inequalities and improving health outcomes for Maori, Pacific and low socioeconomic groups.[4]

The breastfeeding target is to increase the proportion of infants exclusively breastfed at

- Six weeks to 74% or greater
- Three months to 57% or greater
- Six months to 27% or greater

The Counties Manukau DHB Breastfeeding Action Plan will address the following HEHA actions 9.3, 10.6, 13.2, 23.1, 24.1, and 25.2.

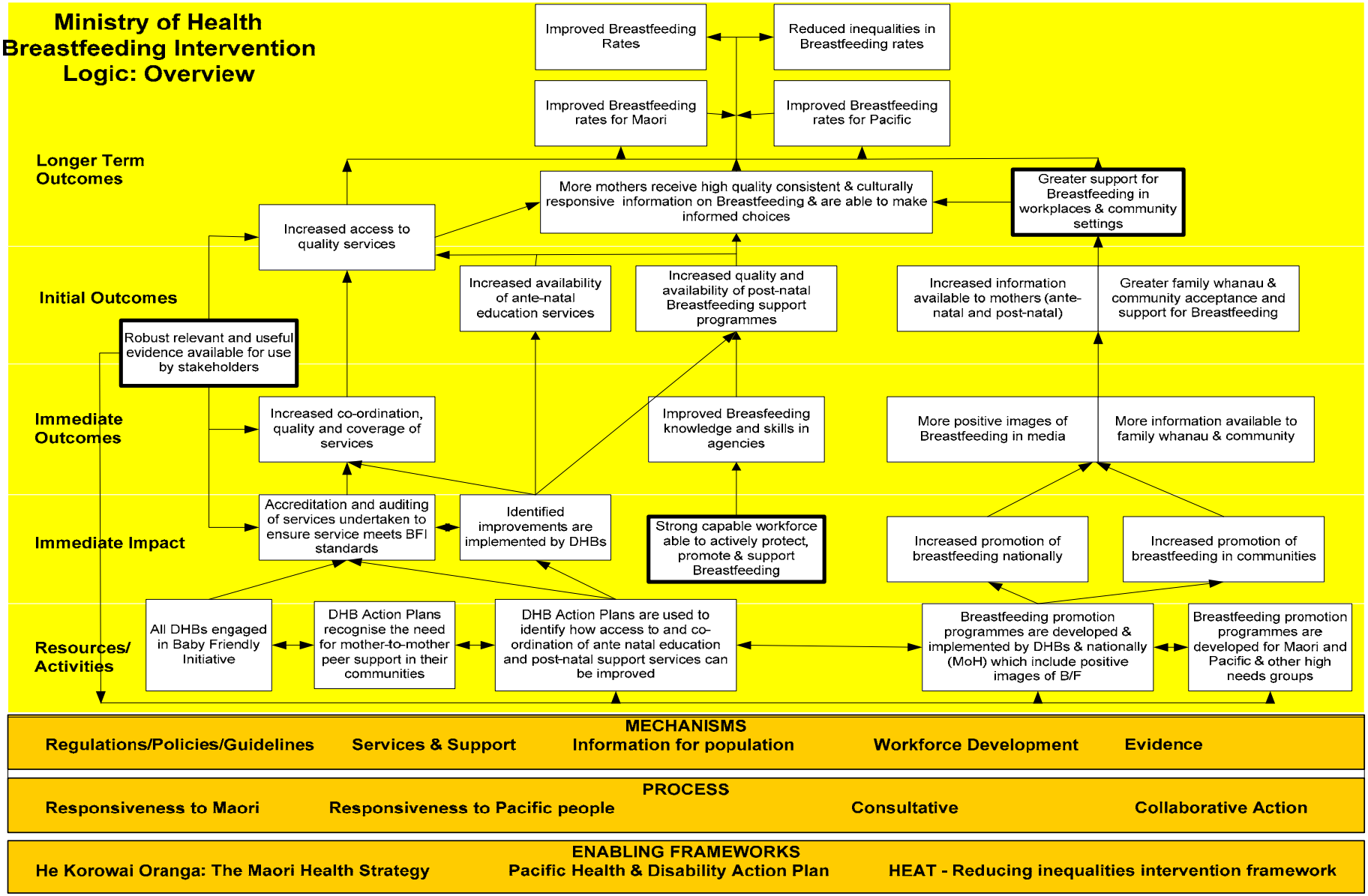
9.3	Promote consumption of vegetables and fruits in a variety of settings – schools, workplaces, rest homes, marae, community settings.
10.6	Develop and expand existing setting-based programmes promoting healthy food and physical activity. Settings include: early childhood centres, schools, workplaces, health care facilities, church groups, marae, shopping centres, markets. Prioritise settings for high-need groups.
13.2	Expand existing access and develop new community-based education programmes aimed at increasing knowledge and skills of community members, about nutrition and physical activities.
23.1	Build independent evaluation into all programmes funded by the health sector.
24.1	Develop and implement a communication plan to delivery clear, consistent messages about nutrition, physical activity and healthy weight for a variety of audiences and settings.
25.2	Extend existing and/or develop new training programmes that meet identified needs focusing particularly on the Maaori and Pacific workforce.

Ministry of Health Breastfeeding Intervention Logic

The following page displays Diagram 1 'Ministry of Health Breastfeeding Intervention Logic: Overview' has been developed by the Ministry of Health to guide the national Breastfeeding Strategic Plan and implementation. The diagram shows the overarching intervention logic and describes the resources and activities that will lead to immediate, medium and long term outcomes (Ministry of Health, 2008[5]). It was specifically developed for the national breastfeeding promotion campaign but is also applicable to the development and implementation of this Counties Manukau DHB Breastfeeding Action plan.

[4] Health Targets – Moving Towards Healthier Futures 2007/08

[5] Ministry of Health (2008).National Breastfeeding Promotion Campaign Intervention Logic – Healthy Eating – Healthy Action Project Team Sector Capability and Innovation Paper


Ministry of Health
Breastfeeding Intervention
Logic: Overview
Improved Breastfeeding Rates
Reduced inequalities in Breastfeeding rates
Improved Breastfeeding rates for Maori
Improved Breastfeeding rates for Pacific
Longer Term Outcomes
More mothers receive high quality consistent & culturally responsive information on Breastfeeding & are able to make informed choices
Greater support for Breastfeeding in workplaces & community settings
Increased access to quality services
Initial Outcomes
Increased availability of ante-natal education services
Increased quality and availability of post-natal Breastfeeding support programmes
Increased information available to mothers (ante-natal and post-natal)
Greater family whanau & community acceptance and support for Breastfeeding
Robust relevant and useful evidence available for use by stakeholders
Immediate Outcomes
Increased co-ordination, quality and coverage of services
Improved Breasfeeding knowledge and skills in agencies
More positive images of Breastfeeding in media
More information available to family whanau & community
Immediate Impact
Accreditation and auditing of services undertaken to ensure service meets BFI standards
Identified improvements are implemented by DHBs
Strong capable workforce able to actively protect, promote & support Breastfeeding
Increased promotion of breastfeeding nationally
Increased promotion of breastfeeding in communities
Resources/ Activities
All DHBs engaged in Baby Friendly Initiative
DHB Action Plans recognise the need for mother-to-mother peer support in their communities
DHB Action Plans are used to identify how access to and co-ordination of ante natal education and post-natal support services can be improved
Breastfeeding promotion programmes are developed & implemented by DHBs & nationally (MoH) which include positive images of B/F
Breastfeeding promotion programmes are developed for Maori and Pacific & other high needs groups
MECHANISMS
Regulations/Policies/Guidelines
Services & Support
Information for population
Workforce Development
Evidence
PROCESS
Responsiveness to Maori
Responsiveness to Pacific people
Consultative
Collaborative Action
ENABLING FRAMEWORKS
He Korowai Oranga: The Maori Health Strategy
Pacific Health & Disability Action Plan
HEAT - Reducing inequalities intervention framework

District

Counties Manukau District Health Board Strategic and District Annual Plan

The Counties Manukau District Health Board District Strategic Plan for 2006-2011 specifies an outcome area entitled 'Child and Youth Health' under which strategies and initiatives to encourage and support breastfeeding would fall. In addition, the District Annual Plan (DAP) for 2007/08 focuses on a number of key child health related initiatives and on improving care from conception through to adolescence. This includes an emphasis on support for breastfeeding[6]. In addition, the DAP specifies strategies and initiatives to increase the number of breastfed Maori and Pacific babies; identify current breastfeeding policies and guidelines; and develop a Counties Manukau perspective, in consultation with the community, on how these policies and guidelines should be implemented at a local level to complement and enhance existing services and programmes.

Let's Beat Diabetes (LBD)

The ten action areas that will support an improvement in diabetes identified as part of the Lets Beat Diabetes Plan are all relevant and link with improving breastfeeding rates. The LBD aims to prevent and/or delay the onset of diabetes, slow disease progression, and increase the quality of life for people with diabetes. This includes a focus around:

- Supporting Community Leadership and Action
- Promoting Behaviour Change Through Social Marketing
- Changing Urban Design to Support Healthy, Active Lifestyles
- Supporting a Healthy Environment Through a Food Industry Accord
- Strengthening Health Promotion Co-ordination and Activity
- Enhancing Well Child Services to Reduce Childhood Obesity
- Developing a Schools Accord to Ensure Children are 'Fit, Healthy and Ready to Learn'
- Supporting Primary Care-based Prevention and Early Intervention
- Enabling Vulnerable Families to Make Healthy Choices
- Improving Service Integration and Care for Advanced Disease

The action area focusing on 'enhancing Well Child services to reduce childhood obesity' highlights the importance of encouraging exclusive breastfeeding for the first six months. In addition, Primary Care Prevention and Enabling Vulnerable Families to Make Healthy Choices could involve parental education that formula fed babies have increased rates and risks of Type 1 and Type 2 Diabetes.

[6] Counties Manukau District Annual Plan 2007/08 (pg 14)

Whaanau Ora Plan – Maaori Health Strategy (2006-2011)

The Whaanau Ora framework is central to the Counties Manukau DHB approach to Maaori Health and Disability and articulates the vision, values, key themes, strategies and Maaori health and disability priority areas.

The plan is underpinned by a range of key values those being, tika, pono, aroha (correctness honesty and compassion), whai kaha (empowerment), mooka tika (changing attitudes, behaviours), tino rangatiratanga (self determination and autonomy), manaaki tangata (support in improving outcomes) and finally mahi tahi (working together and ensuring Maaori are informed).

The vision is based on the premise of Whaanau Ora - Maaori Ora, that Healthy Whaanau equals Healthy Maaori. This acknowledges both the dynamic and diverse nature of whaanau and supports multiple concepts including inspiring whaanau to be educated, knowledgeable and motivated and to encourage the adoption of a healthy lifestyle. In the reducing of inequalities maternal health is recognised as a key priority area within Whaanau Ora.

In alignment with the Whaanau Ora framework, and in recognising the short and long term benefits of breastfeeding, the B4Baby service continues to be delivered in the community and to support breastfeeding education and promotion.

Tupu Ola Moui – Pacific Health Action Plan (2008)

To further support and enhance health outcomes for Pacific people within Counties Manukau, the DHB is committed to reducing inequalities and this is reflected in the Tupu Ola Moui – Pacific Health Plan. Specifically, the Breastfeeding Action Plan will contribute to the implementation of the Tupu Ola Moui goal of “Well Pacific Mothers and Caregivers” and objective 2.3.2 which refers to:

“Improved access to an integrated continuum of care spanning maternity services, antenatal, postnatal, primary care and Well Child handover”

Due to the significant inequalities experienced by Pacific people in Counties Manukau, an improvement in breastfeeding rates as a preventative measure will reduce the likelihood of more Pacific people experiencing diabetes and obesity later in life. Utilisation of Lotu Moui’i and other ethnic group settings in which to provide further breastfeeding promotion and education is recommended.

Counties Manukau DHB Population

The Auckland region had the highest number of births in New Zealand - March 2007 (36% of all live births were registered in Auckland)[7]. In Counties Manukau district Pacific are the most fertile ethnic group in comparison to 'Other' in Counties Manukau DHB, followed by Maaori.

Fertility

While fertility rates in New Zealand have been relatively stable in the last decade, in Counties Manukau District the birth rate remains high[8] and is increasing. In 2001 there were 6,982 births in Counties Manukau DHB facilities compared to 8,707 in 2007. At least 1,200 of the 2007 births are domiciled elsewhere (e.g. a large proportion live in the adjacent suburb Otahuhu which is within Auckland District Health Board's region and are largely from high deprivation areas with a poor socio-economic status). In addition some women who are domiciled in Counties choose to birth in Auckland DHB's National Women's Hospital. These figures exclude home births.

Diagram 2. Fertility Rate for Counties Manukau Population and the Rest of New Zealand

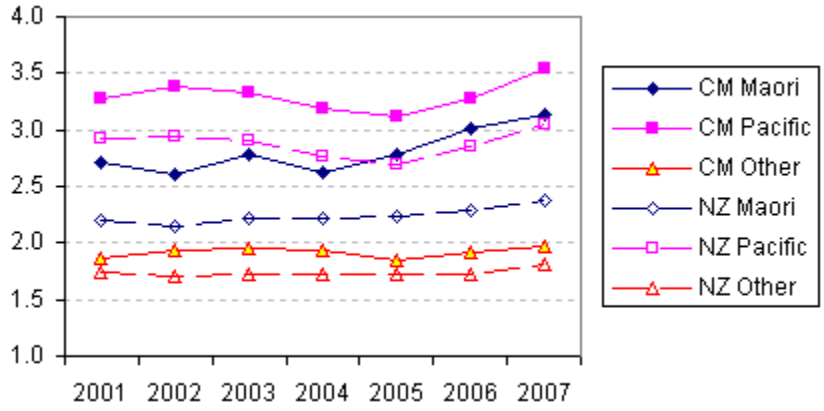


Diagram 2 indicates the fertility rate for all ethnic groups from 2001 – 2007 for Counties Manukau DHB population in comparison to the rest of New Zealand. The Counties Manukau DHB Maaori, Pacific and Other populations have higher fertility rates compared to the national rates.

Socio-economic Status

The NZDep2006 deprivation index measures relative socioeconomic deprivation by dividing New Zealand into tenths of the distribution, with decile 1 representing the areas with the least deprived scores and decile 10 representing the areas with the most deprived scores.[9] Nearly thirty-four percent of the Counties Manukau population are living in areas that have

[7] http://www.stats.govt.nz/store/2007/11/births-and-death-sep07qtr.hotp.htm?page=para002Master
[8] Counties Manukau District Health Board (2007). About Counties Manukau District Health Board: Population Profile. www.cmdhb.org.nz/Counties/About_CMDHB/Overview/population-profile.htm
[9] Clare Salmond, Peter Crampton, June Atkinson, *NZDep2006 Index of Deprivation*, Department of Public Health, University of Otago, Wellington, August 2007.

the most deprived NZDep scores. Furthermore, forty-three percent of the 0-14 year olds living in the Counties Manukau area reside in areas that have the most deprived NZDep scores (decile 9 and 10).[10] Maaori and Pacific residents are also overrepresented in those areas that have the most deprived NZDep scores decile 9 and 10 areas.

Table 1. Ethnicity Breakdown and Socio-Economic Status (SES) for all Deliveries in Counties Manukau[11]. (SES1 – Least Deprived, SES5 – Most Deprived [Deciles 9 & 10])

Socio-economic status (SES)	Maaori	Pacific	Chinese	Indian	Asian	Other
SES1	6%	4%	12%	6%	5%	66%
SES2	14%	7%	10%	8%	6%	56%
SES3	14%	13%	10%	7%	6%	51%
SES4	25%	29%	3%	11%	5%	27%
SES5	30%	46%	1%	5%	3%	16%
Total	**23%**	**32%**	**4%**	**6%**	**4%**	**30%**

A large proportion of women delivering in Counties Manukau facilities are from decile 9 and 10 areas (as shown in Table 1). As a result these mothers may have additional resource barriers and may be less likely to breastfeed[12] without appropriate and effective support. For example, focus groups and stakeholders identified issues such as: poverty; family violence; alcohol and substance use and having more than one child; as factors that may decrease the likelihood of some mothers breastfeeding.

Current Breastfeeding Rates

The current national breastfeeding targets identified by the Ministry of Health are[13]:

Table 2: National Breastfeeding Targets

Age	Breastfeeding Target
6 weeks	74%
3 months	57%
6 months	27%

[10] http://www.cmdhb.org.nz/About_CMDHB/Overview/population-profile.htm
[11] Includes Middlemore, Botany, Papakura and Pukekohe data for 2007 domiciled deliveries
[12] *Moore (unpublished) cited in Ministry of Health (2008) Background Report: Protecting, Promoting and Supporting Breastfeeding in New Zealand states that women from higher socio-economic groups and who have a higher education are more likely to breastfeed.*
[13] Ministry of Health (2007). Health Targets – Moving towards healthier futures 2007/08. Pg28

…..Current Breastfeeding Rates continued

The following are full breastfeeding (including exclusive and fully[14]) rates according to available 2006 statistics for New Zealand[15]:

Table 3: Breastfeeding Rates for New Zealand by Ethnicity

Age	All	Maori	Pacific	Asian	European/Other
6 weeks	66%	59%	57%	55%	70%
3 months	55%	45%	48%	53%	60%
6 months	25%	17%	19%	25%	29%

Breastfeeding rates for Maaori, Pacific and Asian communities within New Zealand are lower than the rates for European/New Zealanders as indicated in Table 3.

Please note: This data is based on information provided by Plunket and not any of the other Maaori or Pacific Tamariki Ora/Well Child providers. Mothers who do not attend any Tamariki Ora/Well Child provider, as well as those that attend a Maaori or Pacific Tamariki Ora/Well Child provider will not be included in this data. Accurate conclusions (for the whole of CMDHB population) cannot therefore be drawn; and CMDHB believe that the true rate may be even lower for Maaori and Pacific.

While the breastfeeding rates in New Zealand at birth are consistent with the rates evident in other OECD countries, the proportion of babies exclusively breastfed at six weeks of age is relatively low. From six weeks of age breastfeeding rates continue to decline as partial and artificial feeding becomes more common.[16] Counties Manukau DHB has low rates of exclusively breastfed babies at six months of age compared to the Ministry of Health national targets[17].

[14] The following are definitions of breastfeeding provided by the Ministry of Health: Exclusive: 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. Fully: 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: The infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours. Artificial: 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.

[15] Ministry of Health (2008) National Strategic Plan of Action for Breastfeeding (Draft)

[16] Comprehensive plan to inform the design of a national breastfeeding promotion campaign. Quigley and Watts Ltd (31 July 2007)

[17] Data provided by the Ministry of Health from July – December 2001 shows that Counties Manukau rates are lower than the national rate. E.g. Counties Manukau DHB's rate at 6 weeks is 58.78 compared to the national 65.63; and at 11-15 weeks Counties figures are 43.77 compared to the national rate of 50.98. (Breastfeeding: A Guide to Action; Ministry of Health 2002)

Table 4: Counties Manukau DHB Breastfeeding Rates (Plunket Data)

Counties Manukau DHB	6 weeks				3 months				6 months			
Ethnicity	Exclusive	Full	Partial	Artificial	Exclusive	Full	Partial	Artificial	Exclusive	Full	Partial	Artificial
Maori	29%	17%	23%	31%	17%	19%	20%	45%	4%	8%	31%	57%
Pacific	34%	12%	31%	23%	25%	12%	25%	38%	9%	7%	36%	48%
Asian	15%	27%	38%	20%	10%	27%	30%	32%	7%	16%	35%	42%
Other	39%	19%	23%	18%	27%	20%	22%	31%	9%	12%	36%	43%
Total	**33%**	**17%**	**27%**	**23%**	**23%**	**18%**	**23%**	**36%**	**8%**	**10%**	**35%**	**48%**

The percentage of babies exclusively, fully, partially and artificially breastfeeding at 6 weeks, 3 and 6 months according to Plunket data from July – December 2007. At six weeks there are more exclusively breastfed babies; by three months this situation has been reversed and there are more artificially fed babies; and finally at six months there is an even larger gap between exclusively breastfed and artificially fed with 48% of babies being artificially feed compared to only 8% being exclusively breastfed.

In addition, at six weeks and three months those identified as Asian are the least likely to exclusively be breastfed; at six months it is Maaori who are least likely to be exclusively breastfed.

Breastfeeding rates in 2000 indicated only 51.6% of women on discharge from Counties Manukau facilities were exclusively breastfeeding[18]. More recent data collected by Middlemore Hospital indicate that those women domiciled in Counties Manukau DHB region who birthed at and were then discharged from Middlemore had only a 52% exclusive breastfeeding rate. This shows a very small increase in the number of women exclusively breastfeeding on discharge from Middlemore Hospital between 2000 and 2007.

The majority of women give birth at Middlemore Hospital (primary and secondary facility). Mothers who gave birth and were discharged from any of the primary Community Maternity Units are more likely to be exclusively breastfeeding compared to mothers who birthed at Middlemore Hospital; this further highlights the need to implement the Baby Friendly Hospital Initiative within Middlemore Hospital.

[18] Ministry of Health 2002 Breastfeeding: A Guide to Action

Counties Manukau DHB has three primary maternity facilities: Botany, Papakura and Pukekohe that have achieved Baby Friendly Hospital Accreditation. Middlemore Hospital has not received Baby Friendly Hospital status but is planning to implement the initiative (the 10 steps, and the code of compliance etc) over the next two years, with an intention to undertake BFHI pre- assessment (by June 2010). The barriers faced by Counties Manukau DHB in implementing BFHI include acute midwifery workforce shortage and the need for additional funding to fulfil the workforce training requirements.

Table 5. Breastfeeding Rates on Discharge by Facility in 2007 for Births Where CMDHB Employed Midwives Managed LMC Care

	Birthed and discharge from **MMH***	Birthed **MMH** and discharged from **Botany**	Birthed **MMH** and discharged from **Papakura**	Birthed **MMH** and discharged from **Pukekohe**	Birthed and discharged from **Botany**	Birthed and discharged from **Papakura**	Birthed and Discharged from **Pukekohe**
Exclusive	52%	76%	78%	82%	95%	93%	93%
Fully	7%	2%	8%	7%	1%	2%	2%
Partial	29%	16%	6%	4%	1%	1%	2%
Artificial	12%	6%	8%	7%	3%	4%	3%

Diagram 3. Counties Manukau in Comparison to National Breastfeeding Rates at 6 Weeks, 3 Months and 6 Months (Plunket Data)

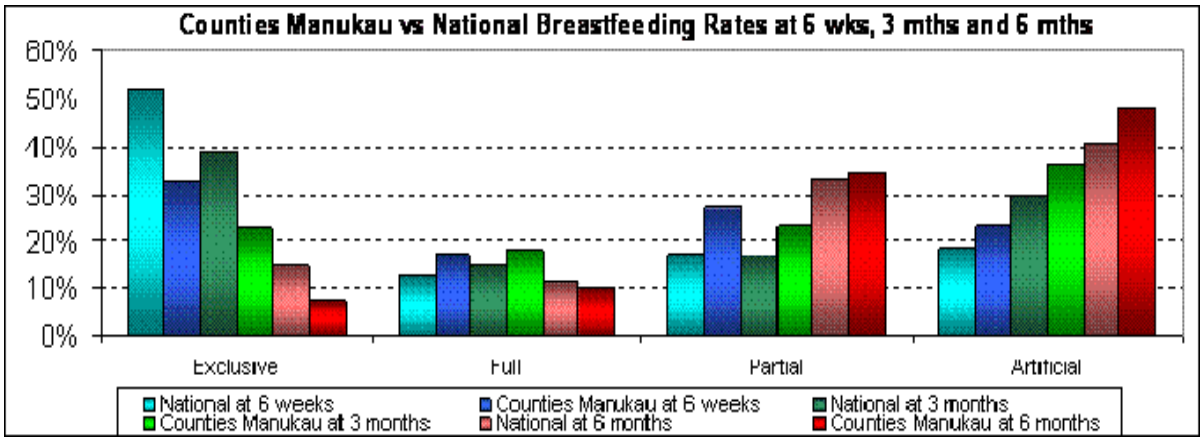


Diagram 3 shows a comparison between the national and Counties Manukau DHB breastfeeding rates. The diagram indicates the partial breastfeeding rates in Counties Manukau are higher than the national rates, this indicates that mothers in Counties Manukau DHB are more likely to be supplementing breastmilk with formula, but are still maintaining some level of breastfeeding and may indicate a level of understanding of the value of breastmilk.

Key Points

- Despite a vast amount of policy and frameworks breastfeeding rates for Counties Manukau DHB population are low
- International, national and district accountabilities to be met
- Priority population groups within Counties Manukau (e.g. high Maori, high Pacific, high fertility, poor socio-economic status and low breastfeeding rates)

Current Services

Counties Manukau DHB funds a range of maternity services and specialist facilities within the hospital and the community. Services include antenatal and postnatal education and care, breastfeeding support services, lactation specialists, and pregnancy and parenting courses. In addition to funded services within the Counties Manukau DHB district there are other initiatives not funded by the DHB, which impact on breastfeeding such as Section 88 Lead Maternity Carers, La Leche Peer Support Groups and Family Start. See Appendix 2 which has a list of complementary services that currently support breastfeeding or where women can gain access to breastfeeding advice within the Counties Manukau district[19]. Note the Ministry of Health manages the Section 88 contractual agreement with independent midwives not Counties Manukau DHB.

Utilisation of Counties Manukau DHB maternity services & facilities

Table 6: Service Delivery Models

Different Types of Service Delivery	Percentage of mothers utilising types of service
Independent Lead Maternity Care (LMC)	43%
CMDHB employed midwives (community midwives antenatally & postnatally, and core midwives at delivery)	32%
As above with GP sharing antenatal care	22%
CMDHB employed LMC midwives provides antenatal, delivery and postnatal care	3%

A large percentage of Counties Manukau DHB women receive their maternity care from CMDHB employed staff compared to other areas in New Zealand where care is delivered predominantly by independent LMCs

The need for continuity of service delivery is vital to realise the positive health outcomes resulting from breastfeeding. For more than half the women in Counties Manukau district there is no continuity of care or seamless service (as embodied in the S88 document) Gaps are apparent particularly between antenatal care and immediately after birth. These are critical times when mothers decide whether or not to breastfeed. The key factor in the currently disjointed maternity system is that there are insufficient numbers of Lead Maternity Carers working in Counties Manukau district and therefore there is a limited number of women able to access the 'seamless' service that independent LMCs provide. Also, a large proportion of Counties Manukau women are accessing a "Shared Care" model of antenatal care between the woman's General Practitioner and a CMDHB community midwife or only utilising Middlemore Hospital employed midwives for birth and postnatal care.

Of the 22% of women who access antenatal shared care, a large percentage of the mothers do not attend midwifery appointments. In addition these mothers are only given 2-3 antenatal midwifery appointments and therefore are not able to build a relationship with the midwife or

[19] Not all of these services are funded by Counties Manukau District Health Board

receive complete information, and possibly the effectiveness of antenatal breastfeeding education may not be evident.

Table 7: Ethnic Breakdown of Deliveries and Discharges in the Counties Manukau District (Middlemore and Community Maternity Units (Botany, Papakura, Pukekohe) 2007 Data[20]

Ethnicity	Middlemore	Community Maternity Units
Maaori	24%	26%
Pacific	50%	20%
Chinese	2%	3%
Indian	7%	5%
Other	17%	47%

Fifty percent of deliveries and discharges from Middlemore Hospital are categorised as being of Pacific ethnicity, followed by Maaori and then 'Other'. In comparison, 47% of deliveries and discharges at the Community Maternity Units are from the 'Other' ethnic group, followed by Maaori and then Pacific.

Middlemore Hospital has a poorer initiation success rate and because a high percentage of Pacific women use Middlemore Hospital for primary births, this could directly impact on the rate of exclusive breastfeeding on discharge for Pacific women.

Table 8. Counties Manukau DHB's Maternity Facilities and Utilisation by Ethnic Group[21]

	Maaori	Pacific	Asian	European	Other	Unknown
Pukekohe	22.6%	5.4%	5.5%	64.3%	1.9%	0.3%
Papakura	39.5%	13.0%	6.1%	37.7%	3.3%	0.3%
Botany Downs	15.9%	23.8%	14.3%	40.6%	4.6%	0.7%
Middlemore	24%	50%	2%	7%	4%	13%

Table 8 shows the percentage of mothers based on ethnicity who utilise the three Community Maternity Units compared to Middlemore Hospital. Maaori utilise Papakura maternity facilities more than other ethnic groups. Pacific utilise Middlemore Hospital and Asian mothers more frequently utilise Botany maternity facilities.

[20] This data is based on facility of final discharge in 2007 and accounts for women who are domiciled in Counties Manukau DHB.
[21] New Zealand Breastfeeding Authority, Stocktake of Breastfeeding Report – Counties Manukau District Health Board, February 2008

Key Points

- A range of services is provided by or contracted for by Counties Manukau DHB and the Ministry of Health - but not well connected
- 57% of Counties Manukau DHB women receive their maternity care from CMDHB employed staff compared to other areas in New Zealand where care is delivered predominantly by independent LMCs.
- If you birth at Middlemore you are less likely to exclusively breastfeed

Gaps/Issues/Barriers

Community Feedback

Counties Manukau DHB has undertaken focus groups and stakeholder discussions to determine the views, concerns, and suggestions of our community. This is in order to identify gaps, issues and barriers specific to our population and to seek their input on how we can better achieve our vision (see Appendix 3 for further detail).

Focus groups have involved:

- x 3 Maaori groups (young mothers)
- x 2 Pacific mothers group (1 focus group was of Pacific mothers who had diabetes)
- x 1 Chinese mothers group

Some 86 mothers, fathers and children have attended the focus groups to discuss breastfeeding[22]. Numerous stakeholders were also involved in the first round of discussions about breastfeeding. See Appendix 4.

The following key issues were identified by our community (both focus groups and stakeholders) as particular barriers to breastfeeding in Counties Manukau DHB:

- socio-economic background and poverty;
- acute workforce shortages;
- fragmentation of current services being delivered and as a consequence mixed messages from health professionals;
- whaanau and community attitudes;
- employers workplaces; and
- data collection and management.

Some areas are beyond the DHB's ability to significantly influence such as socio-economic background and poverty.

Acute Workforce Shortages

Counties Manukau DHB faces acute midwifery workforce shortages. For example only 46% of Counties Manukau population access independent Lead Maternity Carers (due to either choice or because of the shortage of LMCs). The other 54% received care from fragmented maternity services where a community midwife, GP or obstetrician provides antenatal education and care. Labour and birth care is provided by DHB core staff who are responsible for providing postnatal support to maintain breastfeeding once the mother and baby go home.

Anecdotal evidence suggests there is a need for more Lactation Consultants to support those women with breastfeeding complications or who need specific clinical assistance to

breastfeed (whether the consultants are based in Middlemore or the primary maternity units or in community health providers the need for more Lactation specialist advice has been raised as a key issue that needs to be addressed)[23].

Table 9. Counties Manukau DHB Midwifery and Access Holder Summary

Workforce	Number of people in Counties Manukau DHB[24]
GP Lead Maternity Carer (LMC)	2
Obstetrician LMC	5
Self-employed LMC[25]	98
CMDHB Caseloading Midwife[26]	3
CMDHB Community Midwife	24
CMDHB Diabetic Midwife	3
CMDHB Core Midwives	86
CMDHB Lactation Consultants	3

Table 9 shows the number of Counties Manukau midwifery staff and independent midwife access holders. In addition, Counties Manukau DHB Women's Health service also employs another 43 Registered Nurses to support the service as well as a number of Health Care Assistants. Counties Manukau DHB also funds one Community Lactation Consultant via the B4Baby service delivered by Turuki HealthCare.

Fragmentation of services and lack of continuity

There is a wide range of different services involved in breastfeeding. Refer to 'current services' on page 18 for further information, and also Appendix 2 for a detailed list. These services are not always well linked and do not always have the capacity to deliver to all geographic areas - this creates gaps in service delivery. Another example of fragmented services is when the maternity care services (provided by CMDHB community midwives) need to discharge healthy babies prior to the 6 weeks due to resource constraints. Tamariki Ora/Well Child providers may not visit until 6 weeks if referral processes are not consistent and clear (and referrals timely). In addition, the lack of clarity of the role for DHBs in the development of non-DHB midwifery services (e.g. independent midwives) exacerbates fragmentation.

Families are often not clear about who, how or when to access services. Furthermore, families report they are receiving inconsistent and conflicting advice from the range of health personnel involved. Consistency in breastfeeding education is required for all relevant Counties Manukau health personnel. This can be achieved through initiatives such as Baby Friendly Hospital (BFHI) and the Baby Friendly Community (BFCI) - see Appendix 5.

[23] For 1 FTE Lactation Consultant in 2007 an estimated 728 contacts were made with mothers (minimum).
[24] Note this is not FTE but number of people employed in this service
[25] Self-employed or independent midwives can carry a case load of approximately 150 clients
[26] Both CMDHB and Community Midwives can carry a caseload of approximately 50 clients each

Whaanau and community attitudes (including workplace and employers)

Breastfeeding remains a traditional practice for most cultures. However the breastfeeding rates suggest that the prevailing environment within Counties Manukau is such that connection with, and implementation of these traditional values has been compromised. The need to return to work soon after birth and the very limited support made available to working mothers by employers has significant impact for the Counties Manukau population. The focus groups also highlighted that in some cases older and respected family members may not appreciate that formula feeding does not offer the same benefits as breastfeeding and so were not encouraging and nurturing young mothers to breastfeed. Also identified was a lack of support from some health professionals (e.g. GPs) who may not always promote the value of breastfeeding or emphasise a mother's capability to breastfeed. Some cultures were uncomfortable regarding breastfeeding in public view, while others would do so discreetly but were discouraged by attitudes (looks and comments) of the wider community. There is also a lack of appropriate private and comfortable facilities within the community (including workplaces) for those who need this, for expressing and breastfeeding. This reflects a limited understanding of the differing cultural norms amongst or population, and also of the benefits of breastfeeding and the consequent level of unimportance accorded to breastfeeding and child health by the wider community.

Data Collection and Management

Breastfeeding rates are being measured by the Ministry of Health utilising data Plunket only. However, there are a number of reasons why this measure may not accurately translate to all babies and the MoH quoted timeframes. They include:

- The fact that some mothers do not attend any WCP and therefore their breastfeeding status will not be recorded at all (as a result national MoH quoted figures may not be accurate);
- The time at which Tamariki Ora/Well Child providers record breastfeeding varies. As a result of this data cannot be consistently interpreted. The way the timeframe information is presented by MoH is unreliable.
- Some WCP have different interpretations of the meaning of 'exclusive' or 'fully' breast fed;
- The standard MoH reporting requirements of Tamariki Ora/Well child providers are not clear i.e. what constitutes the denominator?

Counties Manukau DHB records rates on hospital and LMC discharge, however there are also constraints around this information:

- Discharge rates recorded are available only for women under the care of Counties Manukau DHB employed midwives as self employed LMCs are currently not required to provide this information to the Counties Manukau District Health Board database;

- A large proportion of women who birth at Counties facilities (e.g. Middlemore) live in the adjacent suburb of Otahuhu (which is within Auckland District Health Board's district not Counties). Approximately 600 women who live within Auckland District Health Board region utilised Counties Manukau DHB maternity facilities in 2007.

The need for nationally consistent data and reporting is crucial to be able to measure accurately current coverage and future improvements. This may include reviewing how current data is collected and reported by Tamariki Ora/Well Child providers, utilising maternity facility data (e.g. discharge data) plus ensuring that independent LMCs record breastfeeding rates at discharge and the information is made available to DHB. Essentially the need is for consistent collection and reporting of breastfeeding data regardless of the provider.

Inequalities

In all of the measures outlined and identified issues above, Maaori and Pacific were faring less well than all other groups. Clearly access to and availability of appropriate supports to Maaori and Pacific mothers needs special attention. Asian mothers are also not accessing some of the support services currently available and their breastfeeding initiation rates are lower compared to Maaori and Pacific groups. It is vital that current services and development of any new or expanded services be better aligned to the aspirations and needs of these population groups. Their active input and involvement in the planning and development processes is essential (refer to 'context' and 'current services' for related information regarding Maaori and Pacific). Other new migrant groups and those who are most deprived need careful consideration and innovative solutions may be necessary.

Key Points

- Acute workforce shortage with Maaori and Pacific under-represented
- Fragmentation of services and lack of continuity
- Gap in transfer of maternity care to Tamariki Ora/Well Child providers and GPs
- Inconsistent and conflicting advice from the range of involved health workers
- Whaanau and community attitudes often unsupportive (including workplace and employers)
- Poor data
- Disparities/inequalities for Maaori and Pacific and between geographic areas – Asian also feature.

I

Addressing the issues

Information gathered from literature, strategies, plans, feedback from focus groups and stakeholder discussions Counties Manukau highlighted the need for ensuring any actions recommended were those that would address the needs of our priority populations. As part of the development of this breastfeeding action plan the Health Equity Assessment Tool (HEAT) (Ministry of Health, 2002) was utilised. Counties Manukau DHB will focus efforts on intervening at Level 3 where the DHB can have the most effective impact e.g. Health and Disability Services

- Improve access – distribution, availability, acceptability, affordability
- Improve pathways through care for all groups
- Take a population health approach by:
    - Identifying population health needs;
    - Matching services to identified population health needs; and
    - Health education.

Counties Manukau DHB intends to develop an integrated and co-ordinated continuum of care. The continuum of care framework (see page 26) will include a specific focus on engaging with Maaori, Pacific peoples, and Asian groups where needed; and improving their breastfeeding rates by employing a number of different interventions such as social marketing and utilising the education sector to promote positive breastfeeding messages.

A number of key recommendations utilising He Korowai Oranga framework and The Whaanau Ora Plan to improve breastfeeding rates for Maaori are:

- Focussing on, and including Maaori in, social marketing efforts (development of whaanau and communities, changing attitudes, behaviours) as opposed to translations at the end of the process;
- Further developing tailored peer support programmes (participation and self determination, self determination and autonomy);
- Upskilling and training more Maaori, as Breastfeeding Advocates and Lactation Consultants (effective health services, support in improving outcomes, empowerment) and;
- Working with Early Childhood Education centres, Kohanga Reo and the Ministry of Education in promoting and supporting breastfeeding. (development of whaanau and communities, working across sectors, working together and ensuring Maaori are informed);

All of the above also apply for other priority groups, and ensuring Pacific are actively involved in the decision making around the development and delivery of solutions will align with The (national) Pacific Health and Disability Action Plan (2002) which focuses on the need for Pacific people to be involved in the development, management and implementation

of health services within New Zealand. Locally, the Tupu Ola Moui framework encourages community capacity building and participation as the key for success with Pacific peoples. In particular The Counties Manukau DHB Tupu Ola Moui (2008) goal of

"Improved access to an integrated continuum of care spanning maternity services, antenatal, postnatal, primary care and Well Child handover"

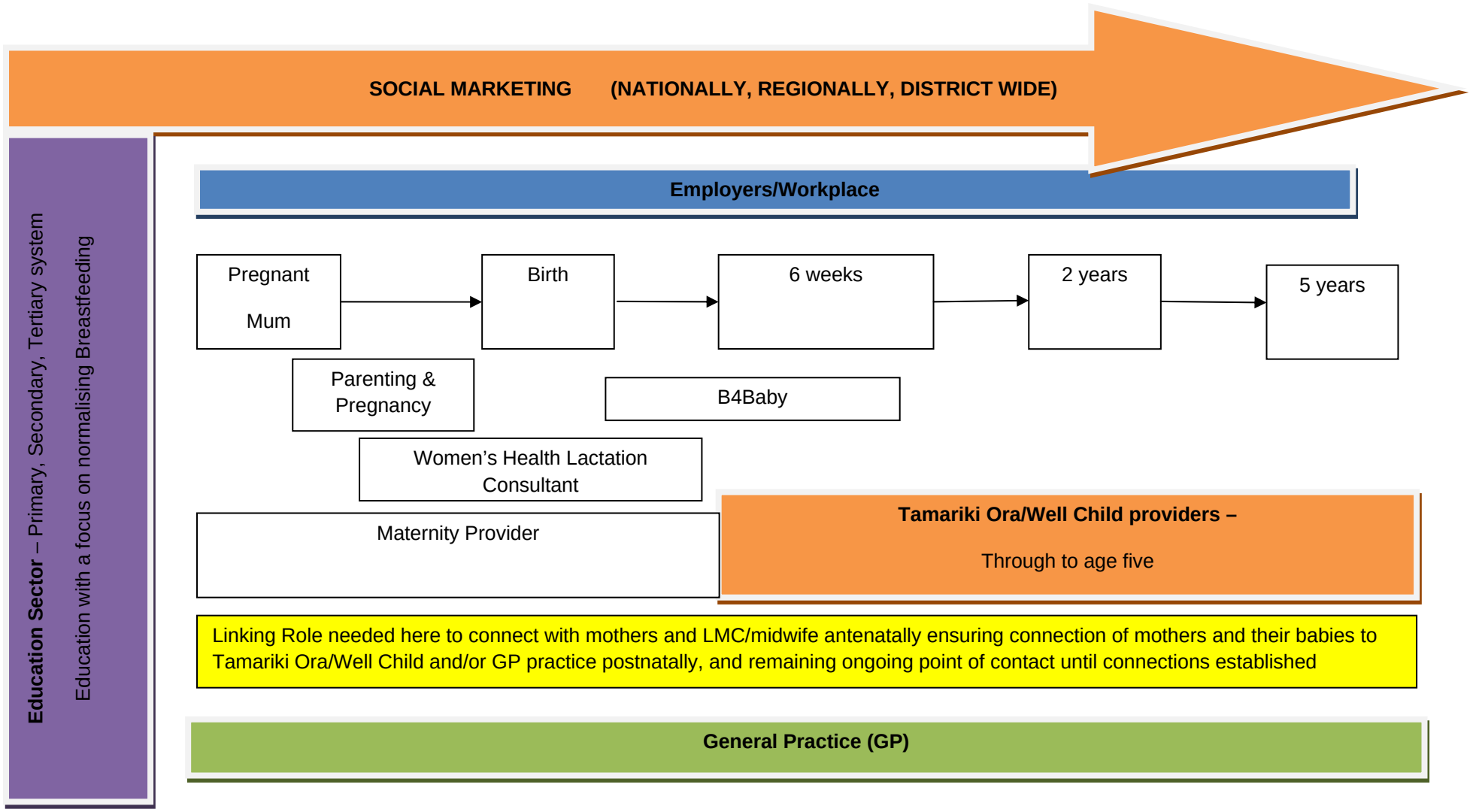
will be partly addressed within this plan through utilising ethnic specific initiatives being currently developed.

The needs of other population groups (e.g. Asian groupings and the most deprived populations) will be considered and included in the enhancement of services and/or the development of initiatives.

Key Points

- Ensure any service enhancements or new initiatives address the specific needs of the Counties Manukau Population –and reduce disparities
- Ensure Maaori are actively involved at all levels and initiatives which deliver services to Maaori should align with the He Korowai Oranga and The Whaanau Ora Plan
- Ensure Pacific are actively involved at all levels and initiatives which deliver services to Pacific align with Pacific Health and Disability Action Plan and the Tupu Ola Moui framework

Diagram 4: Proposed Integrated Continuum of Care Model for Breastfeeding



Goals and Objectives

The following plan has goals and objectives that have been developed utilising the following three settings:

4) Within the DHB;

5) Community health providers; and

6) Wider community (e.g. local councils, marae, churches, employers, schools, community leaders and champions).

Diagram 5: Key Settings

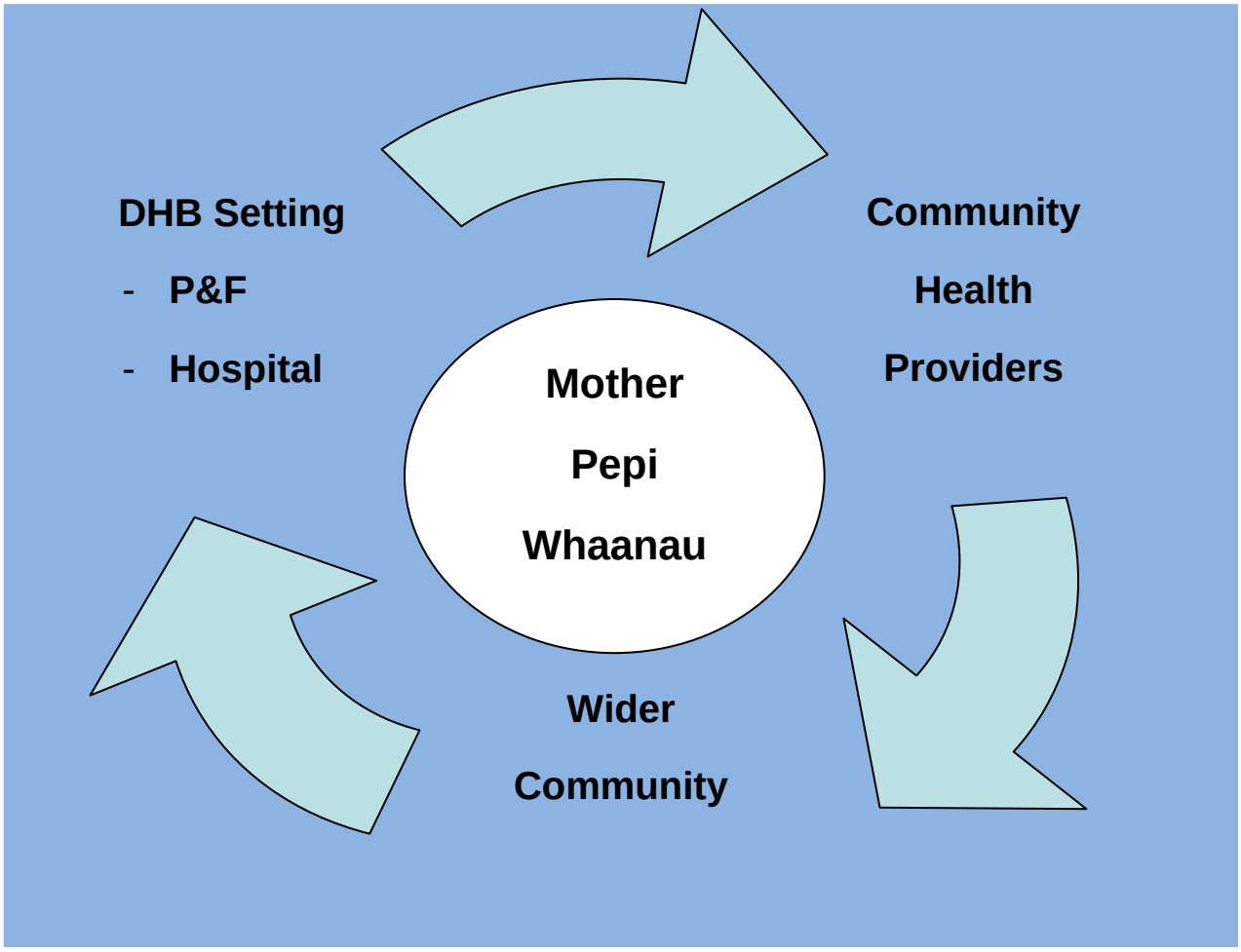


Table 10: Proposed Goals and Objectives

Goal 1: Increase capacity and capability of workforce to improve breastfeeding rates

Workforce Development

Objectives:

1. DHB setting - Educate all health workers involved in child health related services about the benefits of breastfeeding. Implement Baby Friendly Hospital Initiative (BFHI) in Middlemore Hospital (refer to Appendix 1)
2. Community health provider setting (including PHOs) - Increase knowledge and skills of Maaori, Pacific and Asian community health workers to become Breastfeeding Advocates and Lactation Consultants. Ensure consistency of messages by supporting providers to access common education and training for Baby Friendly Community Initiative (BFCI - refer to Appendix 2)
3. Wider community setting - develop more appropriate methods of providing antenatal and postnatal education to at risk groups e.g. supporting peer support initiatives with a focus on Maaori, Pacific, and Asian communities and increase knowledge and skills of community champions around the importance and the benefits of breastfeeding

Action	Deliverable	Timeframe	Responsible	Resource
Develop a workforce development plan for maternity, Tamariki Ora/Well Child, and community setting to protect, promote and support breastfeeding. The plan will focus in particular on the need of Maaori, Pacific and where needed Asian communities	Work with Maaori, Pacific and Asian groups, – both internal and external, and PHOs. Workforce Development Action Plan developed Plan will focus on increasing the knowledge and skills of the current Maaori, Pacific and Asian workforce and developing future career pathways	31 December 2008	Breastfeeding Steering Group – Pacific Programme Manager	Within existing workforce development staff/teams (Maaori, Pacific, maternity and primary care) Note *
Prepare the Middlemore Facility for BFHI accreditation	Contract a Project Manager to scope and develop an implementation plan including the 10 steps to successful breastfeeding and WHO code compliance ▪ Implementation plan developed ▪ Consultation plan completed	Total timeframe = 26 months from 5 May 2008 to 30 June 2010	General Manager, Women's Health and Kidz First Services	1x FTE Project Manager 2x additional FTE Lactation Consultants to assist with staff training and development of lactation consultant service

	▪ Staff education plan completed ▪ BFHI Pre and post implementation assessment completed			Subject to additional funding for training of staff and bureau replacement See Appendix 8 for provisional breakdown of costs.
Work to develop Counties Manukau DHB as a Breastfeeding Friendly employer Review current HR and facilities/accommodation current policies and procedures.	Overall CMDHB policy on BF developed Relevant policies and procedures across the DHB are reviewed Gap analysis and action plan with recommendations to DHB	31 December 2009	Acting Chief Planning & Funding Officer	Internal staff time and resources (including Human Resources) Note *
Encourage community health providers to be ready for BFCI accreditation	Three providers (e.g. .Tamariki Ora/Well Child providers or independent maternity providers) ready for BFCI accreditation assessments	31 December 2010	Breastfeeding Steering Group – Pacific Programme Manager	Additional resource required for providers to undergo accreditation (e.g. utilisation of PPDF and MPDS under workforce development)

*Additional resource for 1 FTE Project Management for Breastfeeding Action Plan development/implementation

Goal 2: Support mothers to breastfeed through more accessible antenatal education and postnatal support

Objectives:

1. DHB setting – Implement BFHI (refer to Goal 1 and Appendix 1). Explore ways to ensure increased access to antenatal care within Counties Manukau DHB. Ensure relevant DHB agreements and contracted services support breastfeeding. Explore ways to improve access to pregnancy and parenting information.
2. Community Health Provider setting (e.g. PHOs) – Implement BFCI (refer to Goal 1 and Appendix 2). Improve access to and engagement with antenatal care and education
3. Wider Community setting – Support the national social marketing campaign on breastfeeding and implement with a local flavour

Action	Deliverable	Timeframe	Responsible	Resource
Explore new ways for improving delivery and access to parenting and pregnancy information for Maaori, Pacific and Asian communities	Work with Maaori, Pacific and Asian groups – both internal and external, and PHOs. Scoping paper	April 2009	Breastfeeding Steering Group - P&F Programme Manager	Internal staff time and resources Note *
Create a standard paragraph to be utilised in all relevant agreement service specifications to encourage and support breastfeeding	Develop standard paragraph for all service specifications	May 2009	Acting Chief Planning & Funding Officer in conjunction with legal advice	Internal staff time and resources Note *
Review process of handover from LMCs to Tamariki Ora/Well Child / B4 Baby and other breastfeeding support service providers to ensure timely handover	Consultation with internal and external providers and Maaori, Pacific teams. Clearly defined process, responsibilities, and timeframe for handover agreed and documented	March 2009	Breastfeeding Steering Group - Well Child Programme Manager	Internal staff time and resources Note *
Scope the future roles and responsibilities of maternity support services, Tamariki Ora/Well Child providers and PHOs in the co-ordination of timely and seamless services	Work with Maaori, Pacific and Asian groups – both internal and external, and PHOs. Scoping paper	March 09	Acting Chief Planning & Funding Officer	Internal staff time and resources Note *

*Additional resource for 1 FTE Project Management for Breastfeeding Action Plan development/implementation

Support the national breastfeeding social marketing campaign implemented by the Ministry of Health and add a local flavour.	Work with Maaori, Pacific and Asian groups – both internal and external, and PHOs. Local implementation plan	Ongoing December 2008 (subject to timely receipt of MoH campaign details)	LBD Communications and Social Marketing Staff – in conjunction with Maori Health Team	Internal staff time and resources (e.g. Pacific Health team, Public Health Physician & PHO Health Promotion Group))
Work with TLAs to improve community facilities to become more breastfeeding friendly	Established ongoing link with TLAs to support breastfeeding Advertise World Breastfeeding Week	August – December 2008 1-7 August 2008	Planning & Funding Public Health Physician,	Internal staff time and resources (e.g. LBD for contacts in TLAs)).

*Additional resource for 1 FTE Project Management for Breastfeeding Action Plan development/implementation

Goal 3: Ongoing support in Tamariki Ora/Well Child years and beyond

Objectives:

1. DHB setting – Focus increasing capacity by introducing and/or upskilling key community health workers within the maternity services and community health providers to become both peer support counsellors and breastfeeding advocates. Undertake joint training sessions, develop relationships across the sector and ensure communication is consistent. Monitor breastfeeding data regularly (see Goal 1)
2. Provider setting (e.g. PHOs and WC providers) –Commence a programme of implementing BFCI with all Tamariki Ora/Well Child providers in Counties Manukau DHB region
3. Community setting - Investigate opportunities around supporting peer support programmes and developing Breastfeeding champions in the communities with a focus on Maaori, Pacific and Asian.)

Action	Deliverable	Timeframe	Responsible	Resource
Review how Counties Manukau DHB and providers can improve recording and collecting of breastfeeding data	Improved data collection as part of BFHI. Report to identify gaps and actions to remedy.	September 2008 Ongoing	Breastfeeding Steering Group - Maternity Services Manager	Internal staff time and resources Note*
Work with the Ministry of Health to identify how Counties Manukau DHB and providers can improve recording and collecting of breastfeeding data in Tamariki Ora/Well Child providers	Consult with MoH and providers. Report to identify gaps and actions to remedy	September 2008 Ongoing	Breastfeeding Steering Group - Well Child Programme Manager	Internal staff time and resources Note*
Develop a plan to enhance and expand breastfeeding support services (e.g. B4Baby or others) tailored to better meet the needs of priority populations	Work with Maaori, Pacific and Asian groups – both internal and external, and PHOs Ensure agreed models link with maternity services and Tamariki Ora/Well Child services Implementation of appropriate recommendations from B4baby reviews	March 2009	Breastfeeding Steering Group - Maaori Programme Manager	Maaori Health Pacific Health Note *

*Additional resource for 1 FTE Project Management for Breastfeeding Action Plan development/implementation

Develop a 'programme of action' on planned implementation of BFCI with all Tamariki Ora/Well Child providers	Overview to Tamariki Ora/Well Child providers' forum on progress	Ongoing for next two years	Breastfeeding Steering Group - Pacific Programme Manager	Internal staff time and resources Note*
Monitor progress of Breastfeeding Advocacy training funded by the Ministry of Health for Community Health Workers - and actively seek to establish and support community breastfeeding champions/groups with ideas and influence in Maaori, Pacific and Asian communities	Updates from Tamariki Ora/Well Child providers participating in training and progress/usefulness, to the Tamariki Ora/Well Child provider forum Develop plan for extending training to other CHW in PHOs, and community breastfeeding support services/groups	Ongoing for next two years	Breastfeeding Steering Group - Well Child Programme Manager	Internal staff time and resources Note*

*Additional resource for 1 FTE Project Management for Breastfeeding Action Plan development/implementation

APPENDIX ONE

POLICIES AND PLANS

Table 11. Policies and Plans Relating to Breastfeeding

National Plans	Counties Manukau District Plans
The National Strategic Plan of Action for Breastfeeding 2008-2012 (draft)	CMDHB District Strategic Plan (2006 – 2011)
Breastfeeding: A Guide to Action (2002)	CMDHB Annual Plan (2007/08)
Ministry of Health Targets 2007/08	Let's Beat Diabetes Strategy (2005)
The New Zealand Health Strategy (2000)	Child Health Action Plan 2007
The Primary Health Care Strategy (2001)	Primary Health Care Plan 2007 - 2010
He Korowai Oranga (2002)	Whaanau Ora 2006-2011
The Pacific Health and Disability Action Plan (2002)	Tupu Ola Moui – Pacific Health & Disability Action Plan 2006 - 2010
Reducing Inequalities – Intervention Framework and the HEAT tool (2002)	
National Strategic Plan for Action for Breastfeeding 2008 - 2012	
Background Report – Protecting, Promoting and Supporting Breastfeeding in New Zealand (Literature Review) 2008	
Healthy Eating - Healthy Action – Oranga Kai – Oranga Pumau, Implementation Plan 2004-2010	
Food & Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0-2). A Background Paper (2008)	
Tamariki Ora/ Well Child Framework	
Baby Friendly Hospital Initiative (BFHI) Baby Friendly Community Initiative (BFCI)	

APPENDIX TWO

CURRENT SERVICES

Table 12: Complementary Services that Support Breastfeeding in the Counties Manukau DHB District

Service	Provider/s	Target Groups
Tamariki Ora/Well Child	Papakura Marae	Maaori
	Raukura Hauora O Tainui Healthcare	Maaori
	South Seas Healthcare	Pacific
	Royal New Zealand Plunket Society	All
Breast for Baby (B4Baby) - encourages breastfeeding in babies up to 6 months of age, provides breastfeeding promotion, advocacy, lactation consultancy service in the community and an 0800B4Baby phone line	Te Kupenga O Hoturoa – Turuki Health Care	Maaori (however currently Pacific population utilise B4Baby service more than Maaori)[27]
CMDHB Women's Health Lactation Consultant Services (providing antenatal breastfeeding education and postnatal support services)	Counties Manukau District Health Board maternity services.	All (assisting those with some complications or difficulty with initiation and maintenance)
Private Lactation Consultants. These lactation consultancy services also include classes, clinics and phone lines	Available in the community as private practitioners	All
Pregnancy and Parenting Classes[28]	Turuki Healthcare	Maaori
	South Auckland Maternity Care (SAMCL)	All
	Plunket	Niche classes for young mothers
Community Maternity Care	Independent Lead Maternity Carers (LMCs)Ministry of Health (Section 88)	All
CMDHB Community Midwifery Service	Middlemore Hospital, Botany Downs, Papakura and Pukekohe Maternity Units	All

[27] This service is funded by the Maori team in Planning & Funding at Counties Manukau District Health Board. From 1/01/07 to 31/03/08 approximately 45% of referrals to the B4Baby service were for Pacific mothers, 27% for Maori and 28% for Other (Turuki Healthcare Data provided to Maori Health Team in 2008).

[28] Breastfeeding is a component of the majority of Pregnancy and Parenting Classes as part of the requirements for Breastfeeding advice and education. The 'Pregnancy and Parenting Education' service specification states that 'In particular, the course content must comply with the Baby Friendly Hospital Initiative and include: Benefits of breastfeeding, including nutritional, protective, bonding and health benefits to the mother; importance of exclusive breastfeeding for the first four hours to six months; basic breastfeeding management, including the importance of rooming-in, the importance of feeding on demand, how to ensure there is enough milk, positioning and attachment".

Service	Provider/s	Target Groups
Community General Practice	General Practitioners (Shared Antenatal Care)	All
Childbirth Education and Parenting Support	Parents Centre (Auckland East, Manukau, Franklin & Papakura)	All
	BirthWise (Pukekohe)	All
Family Start	Turuki Healthcare	All
	Papakura Marae	All
Mother & Pepi	Turuki Healthcare	Maaori
	Papakura Marae	Maaori
Breastfeeding Support Groups	La Leche League New Zealand[29] (Two groups in Counties Manukau district)	All
	Other provider support groups	
Multiple Birth Support Groups	Multiple Birth Parent Support(2 clubs operating in Counties Manukau	Parents with multiple births
Pacific public health promotion	Health Star Pacific	Pacific
Auckland Regional Breastfeeding Network	Women's Health Action	All stakeholders
Young mothers support service and niche classes	Te Kaha O Te Rangatahi	Maaori young mothers

[29] Unfunded by Counties Manukau District Health Board

APPENDIX 3

FOCUS GROUP & STAKEHOLDER FEEDBACK KEY ISSUES

- An acute shortage of midwives to meet the growing demands and fertility rate;
- Middlemore Hospital not being accredited as Baby Friendly
- DHB have limited ability to effect changes within Section 88 primary maternity services (Ministry of Health is primary funder of Lead Maternity Carers);
- Ministry of Health have has provided minimal national leadership in maternity services and management of LMC S88 agreement;
- Breastfeeding has not been the highest priority within Middlemore Hospital maternity services due to competing priorities of midwife shortage and facilities upgrades;
- Specific ethnic and cultural groups requiring specific and various approaches;
- Counties Manukau DHB community midwives due to workforce shortage, discharge well mothers and babies between 2 -4 weeks post birth[30];
- Time lag between mothers being discharged from LMC to Tamariki Ora/Well Child provider visit and enrolment;
- Some women and families not accessing LMC care early enough if at all antenatally;
- Limited up to date and New Zealand specific health promotion, education, social marketing and resources on breastfeeding[31] ;
- Shortage and limited access to specialists/lactation consultants available to women who are having difficulties with breastfeeding both at maternity facilities and in the community[32];
- Lack of community support services for all mothers wanting to breastfeed (feedback from two focus groups, stakeholder discussions and the evaluations of B4Baby identified the need to expand the B4Baby service);
- Lack of prioritisation by General Practitioners who may perceive breastfeeding support and advocacy as not being their core business;
- The average length of stay for women at all Counties Manukau DHB maternity facilities is just over 2 days[33]. The early discharge (either planned or not) could have an effect on mothers' abilities to establish breastfeeding. The amount of support available for those who are finding it difficult may be limited[34] and;

[30] Anecdotal evidence suggests the majority of well mothers are discharged from LMC care at approximately 2 - 4 weeks
[31] This was identified through stakeholder discussions and in all focus group sessions
[32] This was identified in stakeholder discussions and in focus group sessions. In particular a young mother required assistance with inverted nipples as she wanted to breastfeed but was unsure of how to.
[33] Personal communication with Debra Fenton (Primary Maternity Service Manager, Women's Health, Middlemore Hospital)
[34] For example one young mother in a focus group advised that she had been sent home after 4 hours at Middlemore Hospital but wanted to stay longer to establish breastfeeding

- The misconception by mothers that if they choose to smoke or drink alcohol they should not breastfeed at all. Approximately 20.4% of women in Counties Manukau DHB regularly smoke. Fifty percent of Maaori women regularly smoke compared to 19.3% of NZ/European and 26.7% Pacific.[35] Research has indicated that mothers who smoke are more likely to cease breastfeeding earlier than mothers who do not smoke[36]

- Feedback from focus groups indicated that young mothers in particular wanted the freedom to go out in the weekends with their partners and therefore would introduce formula so that grandparents could adequately care for the baby in their absence;

- Inconsistent messages provided by health professionals to a mother and whaanau.

- Lack of support from whaanau

- Lack of support in the wider community

- Data collection and management

[35] www.moh.govt.nz/moh-nsf/pagesmh/6384/$File/nztus-census-dhb-estimates-vz.doc

[36] (Jakobson et al 1996, Janke 2993, Scott & Binns 1999, all cited in Zareai 2007; Forster et al 2006; Amir and Donath 2002, Hogan 2001, both cites in Callander 2007, all cited in the Ministry of Health Background Paper – Protecting, Promoting and Supporting Breastfeeding in New Zealand (2008);

Focus Group Feedback

Current Issues

WORKFORCE DEVELOPMENT

- Mixed or incorrect messages from health professionals and family (e.g. a midwife advised a mother she should only either breastfeed or formula feed as baby will get confused about different types of milk);

MIDDLEMORE HOSPITAL

- Middlemore Hospital facilities not welcoming, unclean, old, overcrowded, no beds available (described by one participant as;

  'software good, but hardware bad)[37]*'*

- Middlemore Hospital staff (some nurses and midwives supportive, others confused mothers by advising different techniques to ensure baby latches, some did not understand about personal space). Lack of consistent messages from health professionals in maternity services;

- Bounty bags provided as you leave Middlemore old, sachets had ants in them, some mothers did not receive bounty bags;

- Middlemore too noisy, bad, overcrowded. Unable to sleep because babies crying

PREGNANCY & PARENTING CLASSES

- Very few Asian attendees had ever attended a Pregnancy and Parenting Class (many were unaware of the classes and how to access classes) ;
  - In one Pacific focus group the majority had attended at least one Parenting and Pregnancy class
- Attending class at a similar stage of pregnancy instead of having mothers who are only 6 weeks pregnant attending class with women who were 8 months;
- Mother too tired to attend parenting and pregnancy classes

LEAD MATERNITY CARERS (LMCs)

- Majority of the Asian focus group did have access to or utilise LMCs;

KNOWLEDGE AND EDUCATION

- First time mothers are unaware of what to expect (both labour and breastfeeding);

[37] This refers to the hospital facilities themselves not being very nice but the people/staff providing a good service

- Mother advised by parents that if she is pregnant she shouldn't breastfeed her older baby;
- Mothers unaware that if you have stopped breastfeeding you can start again (time dependent);
- Benefits include: helps control blood sugar for mothers with gestational diabetes; it's always the right temperature, free, and always available, mobile milk factory, good for baby, mother looses weight, natural, cheap, form a bond with baby

ADVERTISING/MARKETING

- Advertising confusing e.g. Formula tins say 'from birth' and are readily available at the supermarket so cannot be 'unsafe';

CHANGING ATTITUDES

- Discrimination in malls, mothers advised in mall could not feed and had to leave;

COMPLICATIONS – LACTATION SUPPORT

- Issues such as inverted nipples cause problem for mothers who want to breastfeed and need advice or support on how to;
- Multiple births;
- If baby is allergic to formula and soy milk and you have to breastfeed need support to establish and maintain

PERSONAL

- Feeling of weakness, tiredness and pain;
- Concern about stretch marks on breasts if you breastfeed;
- Personal embarrassment;
- Young mothers may not want to breastfeed to "hold onto their perfect bodies;"
- Worried about breastfeeding as mother may fall asleep feeding and the breast may suffocate baby;
- Takes a long time to breastfeed (inconvenience to sit down for so long and just breastfeed when there are many other things that need doing, e.g. cleaning, washing)
- Mothers may smoke, but want to provide a healthier smoke free environment for baby and so do not breastfeed because they are concerned their smoking will affect baby more.

EXPRESSING EQUIPMENT

- Hand pumps not strong enough;

LANGUAGE

- Some mothers have English as a second language and interpreters take a long time to get to hospital;

COMMUNITY SERVICES

- All mothers should have access to B4Baby, excellent, helpful service;
- Men are good with older children and not with young babies, need support to show them how to be a supportive father.

  "When you feel let down by your team mate you feel torn"

- Chinese focus group primarily had midwives advising them during pregnancy

WORKPLACE/EMPLOYERS

- Workplaces do not cater for breastfeeding mothers and babies
- Additional stress on mother (e.g. looking after a sick grandfather)

COMMUNITY FACILITIES

- Do not like breastfeeding in public
- Difficult to stop breastfeeding
- Need privacy

  "Papakura Maternity is good"

  "Botany is awesome"

  "People think it's normal to formula feed"

  "Single mother without a partner is more likely to breastfeed because they have no partner, no money…(and they) had the time to breastfeed (because no partner with demands)"

  "Breastfeeding is good because you get big boobs for free"

  "When I stayed in hospital for a week, a nurse expressed my breastmilk and bottle fed my baby, which was great because I got some rest and sleep"

Suggestions to improve breastfeeding rates included:

- Provision of information antenatally (up to date New Zealand relevant information, DVDs, pamphlets that show you exactly how to breastfeed)
- Provide information in different languages so ethnic specific
- Provide information about how to care for your breast e.g. about engorgement and how to relieve cracked nipples, lack of milk, mastitis, inverted nipples etc…

- Provision of safe, clean and appropriate community facilities
- Nurses at hospital supporting mothers on wards when exhausted by supporting mothers to express and nurse can then take baby away while mother sleeps and give bottle with expressed breastmilk
- Immediate support after birth to breastfeed in hospital[38]
- Healthy Eating Guide for mothers
- Training of hospital staff to ensure aware of cultural appropriateness and need for privacy when breastfeeding
- Training of hospital staff around communication with mothers e.g. one mother advised she asked the midwife to explain to family and friends outside room that she was breastfeeding and could they please wait until she had finished but midwife said mother was too busy to see them and visitors left
- Increased knowledge and awareness by families - as families are often unsure of how to support mothers to breastfeed
- Consistent messages from all health professionals (LMCs, GPs) particularly within Hospital e.g., between day and night staff
- Advertising benefits of breastfeeding (make it fun and sexy)
- More positive support, coaching for mothers
- Extend and roll out B4Baby service to all ethnic groups across Counties Manukau DHB so better access, greater capacity, key workforce role in leadership and mentoring Lactation Consultants and Breastfeeding Advocates
- Utilise role models other mothers (e.g. young mothers coming into teen parent units to discuss breastfeeding most effective)
- Health promotion or social marketing should focus on fact that breastfeeding is free, convenient (e.g. no sterilisation or bottles required) and efficient
- Utilise text messaging and websites (mothers, parents, caregivers computer savvy)
- Targeted ethnic specific antenatal classes (utilise incentive e.g. free massage voucher to encourage attendance)
- Extend length of stay in Middlemore to ensure all mothers that want to are provided advice and support to establish breastfeeding[39]
- DVDs helpful at antenatal classes and at Community Maternity Units

[38] One young mother advised she waited 13 hours for support in the hospital to breastfeed
[39] One mother advised that she was forced to leave Middlemore only 4 hours after giving birth when she wanted to stay in hospital to get assistance with Breastfeeding before she left. Mother and family were very upset.

- Provision of culturally appropriate breastfeeding facilities (e.g. at malls the rooms are right next to toilets and there are often not enough of them)

  "anywhere and everywhere"

- Mothers also need help trying to quit smoking and drinking alcohol
- Parenting class for fathers only (possibly ethnic specific)
- Breastfeeding other family member's babies as well as your own
- Teach first time mothers the theory and practice behind breastfeeding
- Parenting and pregnancy classes in own languages (e.g. Chinese focus group)
- Easier to ask health professional for help with breastfeeding rather than own family (Chinese focus group)
- Information provided about caring for your breasts. What to eat and drink during breastfeeding, what are the best creams, lotions and ointments to use. General information to safeguard against cracked nipples, lack of milk and mastitis etc.
- Health professional like a nurse on site at teen parent units is a good idea
- Free Bio Oil in packs to take home so mothers don't worry about stretch marks caused by breastfeeding
- Advertise the benefits of breastfeeding to make it fun and sexy
- Friendly nurses and midwives at Middlemore (felt uncomfortable with some nurses' forward and abrupt manner - unemotional, very clinical)
- Privacy in hospital when trying to Breastfeed
- Ensure all mothers receive a Bounty pack before they leave hospital with all information and freebies
- Education for families and community
- Promote the 'how' to wider communities e.g. that mothers can express their milk
- Health professionals need to listen more to mothers

Other Stakeholders' Feedback

The key themes identified from a number of stakeholder discussions undertaken as part of the development of this Breastfeeding Action Plan are:

WORKFORCE DEVELOPMENT

- Workforce is the number one issue
- Need funding to support training and upskilling
- Need more Lactation Consultants at Plunket Family Centres so mothers do not have to make an appointment
- Sufficient Lactation Consultant capacity within hospital and in the community (not enough support currently)
- Lactation consultants not just in maternity and birthing wards but throughout the hospital supporting mothers that come in for other medical related reasons but also need additional support with breastfeeding
- Need to be able to offer a holistic service with the breastfeeding advice
- Need to be culturally sensitive and aware of mother's wishes
- Need more Maaori and Pacific Lactation Consultants
- Utilise community health workers who already have the trust and relationship with mothers and whaanau (upskill community health workers)
- Some health professionals offer their own personal opinion which may not support breastfeeding
- Practice Nurses in General Practice need breastfeeding training
- Need more leaders and champions at all levels
- Health professionals need to be providing consistent information on breastfeeding to mothers and their families
- Health professionals all need consistent and regular training
- General Practitioners and Practice Nurses need training/upskilling
- Nurses, midwives, paediatricians, surgeons and anaesthetists at Middlemore Hospital need upskilling on breastfeeding (particularly if nurses are utilised from other non maternity related wards)
- Consistent training or support for bureau nurses who come into Middlemore Hospital
- Need breastfeeding advocates that do nothing else except focus on breastfeeding

- Peer Counselling Programme is only 1 week for mothers, very empowering, gives the mother the tools to influence in her own way other mothers. The train the trainer course is only $2,000 for each trainer
- Should link performance reviews of maternity staff within Middlemore Hospital to number of babies breastfeeding on discharge
- Utilising Health Care Assistants and Hospital Aids within Middlemore Hospital is unlikely to improve breastfeeding rates
- Retention and loyalty allowance is a good idea in Middlemore Hospital
- Need a school of midwifery situated at MIT
- New midwives tend to specialise in one area and not the continuum of care
- Need to remove pressure on service carers e.g. LMCs

  "Hard to provide good care if you are worried about paying the mortgage"

GOVERNMENT

- Provide a 'breastfeeding tax credit' as an incentive to breastfeed for young mothers
- Link breastfeeding to benefits that families receive e.g. sickness benefit, working for families
- Inequities in the system e.g. the funding formula and how it calculates 'rurality' fundamentally flawed and does not account for the distances with the Counties Manukau DHB region LMCs and Lactation Consultants have to travel
- Need additional funding and resources as 'no one quick fix'. Need investment up front

EMPLOYERS/WORKPLACE

- Extend the paid parental leave in New Zealand to one year
- Key driver for not breastfeeding is because mothers need to return to work
- Should provide a mother when she goes on maternity leave with a package saying what she is entitled to when she returns, services she can access e.g. crèche, where she can breastfeed etc…
- Need to change workplace culture
- Health & Safety Issues for employers (e.g. in a factory processing chicken may not be able to support mother's to breastfeed because of cross contamination issues)
- Counties Manukau DHB needs to lead the way as a major employer

SERVICES

- PHOs need to make breastfeeding a priority

- Include in PHO agreements the need to focus on breastfeeding so all PHOs district wide are focussing on breastfeeding

  "Each PHO should have a breastfeeding clinic"

- Repackage current model of service delivery e.g. fund coffee groups, leaders
- Require additional funding to invest in breastfeeding
- One to one home based services are the best and most effective (albeit probably the most expensive)
- Community health services need to be better co-ordinated
- Mothers and hospitals and primary maternity units are unaware of the community services available

  'We encourage mothers to go home early but then is there enough support in the community to help them establish and initiate breastfeeding?'

- All breastfeeding related services need increase in funding to be able to address this need
- Concern regarding the national breastfeeding campaign due to roll out soon by the Ministry of Health, because it will increase demand for breastfeeding support services but there has been no or limited activity to ensure demand is met by increasing breastfeeding capacity in the community
- Referral between services is a key issue in Counties Manukau DHB e.g. referral from LMC to Tamariki Ora/Well Child provider (referrals often late). Funding formula does not incentivise timely referral
- Once a woman has a confirmed pregnancy she should be referred immediately to a service or clinic that can provide information on smoking, nutrition, alcohol and drug and breastfeeding (provide a range of public health services)

ANTENATALLY

- Best predictor of whether a mother will breastfeed is to ask her antenatally or at the time of birth if she is going to breastfeed
- Racism possibly experienced in some pregnancy and parenting classes so parents of minority groups may feel uncomfortable attending
- Pregnancy and parenting classes that Turuki provided were useful
- Antenatal classes often are not facilitated in an appropriate manner for Maaori, Pacific and Asian. Need to focus on how classes are delivered, how messages are given.
- Need education prior to mothers becoming pregnant, 'in schools before parents become parents'

- If parents do not attend pregnancy and parenting classes they will receive their antenatal education from other sources such as family members (which may not be accurate)
- Maaori and Pacific parents less likely to attend pregnancy and parenting classes
- Need to focus antenatally on Asian mothers (they are brought up to believe colustrum is not good for the baby so they should wait until their milk comes in)
- Focus on Indian mothers who tend to formula feed antenatally
- Antenatal classes have shown to have a positive experience in second pregnancies and should be provided to all women who need and want them
- No funding for early antenatal service at this crucial time, LMCs not keen to allow access by other health professionals to clients
- Need increased resources

POSTNATALLY

- Middlemore Hospital needs a 'donor milk bank'
- Lack of maternity support in the community
- Pacific families see the hospital as an authority so will want to please the staff and will say they will breastfeed but will go home and stop
- Some Pacific and Maaori women do not know they are entitled to free Lead Maternity Carer (LMC)
- Services that could once refer a mother to an Lactation Consultant can no longer provide that additional support because of the changes to the S88 and funding

KNOWLEDGE & EDUCATION

- Mothers do not realise breastfeeding is learned and does not necessarily come 'naturally' and that it can take time for milk to 'come in'
- Need support on how to 'care for your breasts'
- Mothers need to make informed choices (often not given a choice if midwife or another health professional suggests formula)

EXPRESSING

- Expressing equipment is expensive
- Some mothers do not want to breastfeed or express because it takes too long, some have other children to look after and would rather be doing something else

COMPETING PRIORITIES

- Counties Manukau DHB needs to make breastfeeding a priority and become leaders
- Some Maaori mothers are dealing with multiple social issues such as smoking, drinking, drugs and family violence therefore breastfeeding is not a priority
- Pacific mothers often have grandmothers or support come over from the islands and their perception is that formula is better and will often go home and give formula
- Counties Manukau DHB needs to be aware of the changing demographic and that because the NZ Refugee centre is based in Counties services should be available for this population (e.g. services for Burmese)
- Breastfeeding is a 'piece of art'
- Some mothers are unaware that even if you have adopted there is specific hormone medication you can take to enable you to breastfeed
- Critical intervention areas are prior to becoming parents, antenatally and just after giving birth
- Service mentality needs to change should be 'anywhere – anytime' someone will be there to help you with breastfeeding
- Need greater focus on workforce development (e.g. for health assistants in Middlemore to become breastfeeding advocates; for community health workers in the community to become breastfeeding advocates and/or peer support counsellors and possibly becoming either Registered Nurses or Lactation Consultants.
- Middlemore needs to become BFHI
- Need to implement BFCI if implementing BFHI (need support in the community as well as hospital)
- Breastfeeding is not a priority for young mothers
- Employers are unsupportive of mothers when they return to work (even Counties Manukau DHB is not supportive in terms of facilities available)
- Peer support counselling or the one to one between mothers is very effective (can utilise By Maaori For Maaori, or By Pacific For Pacific model)
- Plunket Family centres are helpful for mothers struggling with breastfeeding
- Concern over migrants who are not New Zealand citizens but yet still need the help

- If mothers are not eating well because they cannot afford healthy food this affects the likelihood of whether or not a mother will breastfeed
- Young Pacific mothers struggling no specific service to support them
- New Zealand has the highest rates of breastfeeding infections in the world and South Auckland is the worst in NZ (referenced to John Collins)

SOCIAL MARKETING/NORMALISING

- Need social marketing campaign targeting at risk groups Maaori, Pacific and Asian. Use the television, bill boards, bus stops etc… to promote positive images of breastfeeding and need to explain what the benefits are because mothers already know it's good for their baby but do not know why
- Need to be clear and consistent marketing that breastfeeding is normal and formula feeding is abnormal
- Resources need to be made available in different languages
- Need to change attitude of community (e.g. mother was advised she had to leave a court room if she wanted to breastfeed, mothers also previously advise they could not breastfeed in church)
- Need popular role models to promote breastfeeding e.g. New Zealand Silver Ferns

  "We eat in public places so why shouldn't babies?"
- Counties Manukau DHB needs to work with the Ministry to influence advertisements on TV (need to show the benefits of breastfeeding and not inadvertently support formula feeding by showing bottles)

FATHERS/SIGNIFICANT OTHERS

- Fathers/partners very important need to participate early on
- Young mothers are often influenced by their partners so partners need to understand clearly the long term benefits of breastfeeding
- Fathers need their own support
- Organise father support groups/pregnancy and parenting classes in comfortable non threatening environment

WHAANAU

- Grandparents often left looking after babies in the weekend and will give formula
- Need wrap around services for the whole family with the mother and baby in the centre

- Pacific families may often move homes – mobile families so will not be easily reached
- Perception by some Maaori mothers that 'Independent Midwives' cost money and therefore they are not approached
- For some families formula feeding is a sign of affluence
- Mothers are stressed, they may experience a multitude of social issues, e.g. poverty, domestic violence etc.. no food for mother, 'it's a cycle of poverty'
- There could be link between breastfeeding and reduced likelihood of family violence
- Need a sustainable long term view of the benefits of breastfeeding
- Need support and basic information in specific languages
- Provide services that are culturally specific and aware

MIDDLEMORE HOSPITAL

- Need Lactation Consultants available in Middlemore not only on maternity wards but also available for other wards where mothers may attend hospital for something else but may also have breastfeeding problems
- Neonatal babies, babies whose mothers had diabetes and who have low blood glucose and babies whose mothers have had Pethidine in hospital are more likely to be given formula at Middlemore Hospital for a number of reasons
- Babies whose mother had diabetes are more likely to receive formula immediately post birth
- Mothers need to stay in hospital at least 48 hours to try and establish breastfeeding, need some flexibility if mother is having trouble with breastfeeding to stay longer than 48 hours
- Midwives discharging at 2 weeks and gap between 2 weeks and when Tamariki Ora/Well Child provider visits – this is a crucial time and all support falls away
- Midwives started encouraging mothers to express colostrum prior to giving to birth
- Mothers need to be discharged with a breastfeeding plan
- Suggest keeping formula locked away to prevent ready access
- Should have a policy that baby never leaves mother e.g. support rooming in, skin to skin
- Donor milk bank at Middlemore Hospital
- On discharge mothers should be given a breast pump

YOUNG MOTHERS

- Young mothers and fathers still think of breasts as sexual objects and therefore do not want to breastfeed
- Advised of safe practices with regards to drinking and smoking because many are still doing both
- Think their breasts will sag and breastfeeding will affect their body image so don't want to breastfeed
- Some young Maaori mothers do not see breastfeeding as cool, however older Maaori mothers are more likely to breastfeed
- Expressing can be sore if you do not know how to do it properly

B4BABY SERVICE

- Good service but needed in Manurewa, Clendon, Takanini, Papakura and Franklin
- Kuia/Kaumatua support group being developed
- Additional resources and funding to expand
- B4Baby has limited resources but is providing an excellent service
- Pacific B4Baby service was going well, unclear as to why the Pacific team at CMDHB removed the funding to South Seas

  "Need to fund South Seas again to provide Pacific B4Baby service as it was doing well for Pacific"
- 0800 phone line that B4Baby runs is invaluable women can ring and get advice immediately
- B4Baby service invaluable but needs to be expanded and rolled out across Counties district
- Do not reinvent the wheel utilise current models such as Lotu Moui'i and B4Baby
- Gap for Pacific services because South Seas no longer provides B4Baby services
- Need to fund a Pacific B4Baby service (could expand to be a Pacific drop in Family Centre)

APPENDIX FOUR

LIST OF STAKEHOLDERS

The following list of people and organisations were identified as stakeholders and in the first round of discussions have provided information and advice on breastfeeding issues, and on ways to improve breastfeeding rates in Counties Manukau DHB.

Name	Organisation
Lynn Austerberry Marian Hunter	Charge Midwife Manager – Pukekohe Community Maternity Unit Lead Maternity Carer (LMC)
Tracey Barron	Let's Beat Diabetes/ Healthy Eating Healthy Action (HEHA) – Project Manager, CMDHB
Michael Chan	Chief Executive - South Seas Healthcare
Siniva Cruickshank	Pacific Service Manager –Health Star Pacific
Marguerite Dalton	Community Paediatrician, Kidz First Community Paediatrics
Amanda Dunlop	Consultant - Researcher
Hilda Fa'asalele	National Breastfeeding Advisory Committee member
Patricia Flanagan	Project Manager Diabetes and Dietician, Middlemore Hospital
Rawinia Herewini	Programme Manager – Maaori Health, Planning & Funding, CMDHB
Robynne Hubbard Shelley Bloxham Margie Ireland	Charge Midwife Manager - Papakura Community Maternity Unit CMDHB Community Midwife Lead Maternity Carer
Pisila Ikahihifo Donna Uo Ranjit Bhatia Elisapeta Letele Trecia Peauvale Tupuna Davis	Otara Health Incorporated – Community Health Worker Community Health Worker Community Health Worker Community Health Worker Community Health Worker

Name	Organisation
Kilimoka Faleafa	Community Health Worker
Tepaeru Teao	Community Health Worker
Ben Iakimo	Community Health Worker
Lailoa Atoaga	Community Health Worker
Salin Reji	Community Health Worker
Louise James	Breastfeeding Advocate - Women's Health Action
Tony Kake	Programme Manager– Maaori Health, Planning & Funding, CMDHB
Te Pare Meihana (CEO)	Turuki CEO
Ngaranoa Kimura(Community Lactation Consultant)	B4Baby Lactation Consultant
Susan Reihana	B4Baby Breastfeeding Advocate
Louise McCarthy	General Manager – Otara Health
Tony Mansfield	Chief Executive – South Auckland Maternity Care Limited
Cecile O'Driscoll	Midwife and Deputy Chair – South Auckland Maternity Care Limited
Wendy van Cingle	Director of SAMCL
Linda Burke	Midwife
Lucy Naidoo	Clinical Nurse Leader, Raukura Hauora o Tainui
Gail McVey	Team Leader, Mokopuna Ora Team
Trish Potter- Jackson	General Manager Counties Manukau, Plunket
Marlene Stratton	Women's Health and Kidz First Inpatient Manager
Niccy Brougham	Charge Nurse Manager Neonatal Unit
Julie Tegg	Community Midwives Manager, Middlemore Hospital
Kathi Ogilvy	Clinical Midwife Educator
Bev Pownall	BFHI Project Manager
Tracey Senior	Women's Health Lactation Consultant
Angela Carpenter	Women's Health Lactation Consultant

Name	Organisation
Jenny Woodley Marie Purcell Thelma Thompson	Midwife Manager, Assessment Labour and Birthing Unit Charge Midwife Manager, Maternity Ward Director of Midwifery Practice
Barbara Sturmfels	National La Leche League – CEO Breastfeeding Advisory Committee member
Hine Tahere Chauntelle Gillette Maisele Thompson Matere Toia	Contracts Manager - Papakura Marae Community Health Worker – Tamariki Ora Community Health Worker – Tamariki Ora Tamariki Ora Nurse
Jennie Valgre	Independent Breastfeeding Education Advocate & Consumer Representative Parents Centre Board Member NZBA Board Member
Alison Vogel	Paediatrician – Kidz First, CMDHB
Liz Weatherley	La Leche League
Sue Dashfield	Programme Manager Personal Health CMDHB
Debra Fenton	Primary Maternity Service Manager - Women's Health, Middlemore Hospital
Louisa Ryan	Programme Manager – Pacific Health, CMDHB
Paula Sole	Programme Manager - Well Child, CMDHB
Mihi Tibble-Williams	Programme Manager – Maaori Health, CMDHB

Other groups attended and feedback provided include: Counties Manukau DHB Tamariki Ora/Well Child Provider Forum, Auckland Breastfeeding Network.

APPENDIX 5

BABY FRIENDLY HOSPITAL INITIATIVE (BFHI)

The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, WHO and UNICEF in 1990 operational targets are:

"All governments by the year 1995 should have:

- Appointed a national breastfeeding co-ordinator of appropriate authority, and established a multi-sectoral national breastfeeding committee from relevant government departments, non-government organisations and health professional associations;
- Ensured that every facility providing maternity services fully practices all ten of the Ten Steps to Successful Breastfeeding as set out in the joint WHO UNICEF statement "Protecting, promoting and supporting breastfeeding is 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 Breastmilk Substitutes[40] 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"[41]

The two goals of the Baby Friendly Hospital Initiative are:

- To transform maternal and childcare practices at the health care facility level by fully implementing "The Ten Steps to Successful Breastfeeding; and
- To eliminate the most detrimental practice inducing mothers away from breastfeeding: the free and/or low cost distribution of breastmilk substitutes through hospitals and maternity facilities.[42]

The Ten Steps to developing a successful Breastfeeding Action Plan identified in a joint WHO/UNICEF statement in 1989 include:

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

[40] The international Code of Marketing of Breastmilk Substitutes states that there should be no advertising of breastmilk substitutes in the health care system or to the public; no samples to be given to mothers or pregnant women; and no free or subsidised supplies to hospitals. Furthermore it states there should be no contact between company marketing personnel and mothers; materials for mothers should be non-promotional and should carry clear and full information and warnings; companies should not give gifts to health workers; no free samples to health workers, except for professional evaluation or research at the institute

[41] Baby Friendly Hospital Initiative – Key Breastfeeding Policies for Aotearoa New Zealand (Part 8); New Zealand Breastfeeding Authority January 2008

[42] Ibid

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 breastmilk, 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

The Baby Friendly Hospital Initiative is lead by the New Zealand Breastfeeding Authority and the majority of maternity facilities within New Zealand are now BFHI accredited[43].

Baby Friendly Community Initiatives (BFCI)

Like the Baby Friendly Hospital Initiative the Baby Friendly Community Initiative is lead by the New Zealand Breastfeeding Authority.

The seven steps to ensure a community health service provider is Baby Friendly include

1. Have a written breastfeeding policy that is routinely communicated to all staff and volunteers

2. Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy

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

4. Support mothers to establish and maintain exclusive breastfeeding to 6 months

5. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods

6. Provide a welcoming atmosphere for breastfeeding families

7. Promote collaboration between health care providers, breastfeeding support groups and the local community[44]

Currently the B4Baby service at Turuki Healthcare is piloting the Baby Friendly Community Initiative (BFCI) in Counties Manukau DHB. It is the intention of the Counties Manukau DHB to work with all of the contracted community health providers directly responsible for child health to promote the implementation of the Baby Friendly Community Initiative and in particular Tamariki Ora/Well Child providers.

[43] New Zealand Breastfeeding Authority – Counties Manukau DHB Stocktake
[44] Ministry of Health - National Strategic Plan of Action for Breastfeeding 2008-2012 (2008)

APPENDIX 6

BARRIERS TO BREASTFEEDING[45]

Maaori

McBride-Henry (2004) identified the following challenges for Maaori women with respect to breastfeeding:

1. Ongoing effects of colonisation;
2. Current socio-demographic trends; and
3. Urbanisation of Maaori that reduces access to traditional support structures.

Glover, Waldon and Manaena-Biddle (2007a) identified further situations in which Maaori mothers introduced solids early and started artificial feeding and these included:

- Returning to work;
- Lack of knowledge about how breastfeeding changes over time leading to a perception of inadequate milk supply at 3 to 4 months;
- Negative or insufficient maternity support for breastfeeding;
- Early interruptions to or difficulties establishing breastfeeding; and
- Breakdown of in the breastfeeding norm within the whaanau.

Pacific

Abel et al (cited in McBride-Henry 2004) identified the following breastfeeding experiences from Pacific women:

- See it as ideal because breastfeeding is cheap, healthy and convenient
- Provides for emotional needs of infant;
- Mothers with good family support rely on mothers and mothers-in-law for support and advice rather than organisations;
- Difficult to establish breastfeeding because of engorgement, cracked nipples and pain;
- Common perception that mothers do not have enough breastmilk and therefore formula and solids are introduced early; and
- Tension between the Western biomedical perspective on breastfeeding and the traditional beliefs and practices.

[45] All references within the Barriers section have been cited from The Ministry of Health (2008). Background Paper – Protecting, Promoting and Supporting Breastfeeding in New Zealand.

McBride-Henry (2004) recommended that breastfeeding needs to be managed in conjunction with support from family and Pacific mothers returning to work.

James (2003) identified that Pacific women prefer to breastfeed discretely and therefore feeding in public places may be uncomfortable as exposure of the breast is unacceptable. Schulter et al (2005) studied Pacific infants in Auckland as part of the Pacific Islands Families First Two Years of Life (PIF) study and found ethnic differences with breastfeeding where Samoan mothers had higher exclusive breastfeeding rates compared to Tongan mothers. Schulter et al (2005) also found that 50% of Pacific mothers participating in the research did not seek advice or support during the first six weeks of life about breastfeeding concerns.

New Migrant

DeSouza (2006) proposed the following recommendations to improve breastfeeding rates for new migrant communities (based on research involving Chinese, Indian, Korean, European and Arab Muslim participants):

- Support services that are father friendly
- Review information needs
- Support and information in own languages
- Consider cultural and linguistic needs
- Workforce development and include cultural competence
- Improve knowledge of staff about resources and services in order to ensure effective support for migrant mothers

General Barriers

In general 'barriers' can be described as being attitudinal, practical, societal, economic or political in nature.[46] General barriers to breastfeeding are outlined below and have been identified in the literature, through focus groups and stakeholder discussions as applying to the Counties Manukau population groups;

- Lack of knowledge and support to mothers and Whaanau antenatally and immediately after birth;
- Cost of equipment to express breastmilk;
- Mothers and Whaanau may not appreciate that breastfeeding is a learned process (Benn, 1998) and can take time and perseverance;
- Mothers are also unaware that initial problems can be prevented or well managed (e.g. cracked nipples, engorgement etc…);
- Some whaanau do not realise that mothers have the ability to feed their baby up until the first 6 months solely on breastmilk and that when a baby goes through a growth

[46] Ministry of Health (2008) , National Strategic Plan of Action for Breastfeeding (Draft)

spurt the mother's milk supply increases to accommodate the increased demand. Given enough rest and nutrition a mother's milk supply is sufficient and adequate to fulfil a baby's needs;

- Pain and exhaustion are also complicating factors and can be a barrier for mothers to initiate and continue with breastfeeding;
- When mothers are having difficulty with initiation or maintenance they are unaware of where and how to access additional support;
- Some mothers also provide supplements at all stages e.g. baby formula and others (particularly Maaori and Pacific) tend to introduce solids early (at approximately 3 months;[47]
- Formula and bottle feeding for some seems to have become a societal norm and breastfeeding unnatural.
- Partner's beliefs;
- Socio-economic status of the parents;
- Returning to work for mothers and depending;
- Whether an employer is supportive;
- Adequate employer and community facilities e.g. an appropriate room to express breastmilk and area to store milk is required;
- Inconsistent information and advice;
- Lack of support from health professionals. Anecdotal evidence suggests that some health professionals do not value breastfeeding or emphasise a mother's capability to breastfeed. Adequate support for a mother is often not provided, possibly due to the lack of knowledge and understanding by the health professional;
- Societal attitudes have been identified as a barrier in focus groups, it is acceptable to bottle-fed babies if mothers are having difficulties and health professionals and whaanau think the mother needs rest and sleep to recover from birth or if the mother is struggling
- Grandmothers are often trying to look after their daughters and suggest giving a baby formula without realising the lost benefits
- Ready access to formula at the supermarket and not restricted to a pharmacy for example, leads mothers to believe "it's normal and ok or else why would sell it"?
- Formula is perceived to be a food staple and a routine nutritional option if a mother is unable to breastfeed rather than a special requirement.

Barriers that have been identified antenatally include:

- Limited antenatal education**;**
- Young mum and no partner**;**

[47] Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand. [47] Http://www.moh.govt.nz/moh.nsf/indexmh/breastmilksubstitutemarketingcode-question...

- Low birth weight & multiple births.

Barriers postnatally include**:**

- Poor initiation;
- Perceived inadequate breastmilk supply (this can be a self-fulfilling prophecy however if mother's believe they have insufficient milk supply and start supplementing then milk supply will be affected);
- Poor sucking/attachment**;**
- Pacifiers;
- Infant formula**;**
- Early weaning and introduction of solids**;** and
- Maternal smoking.[48]

[48] Breastfeeding : A Guide to Action, Ministry of Health, 2002

APPENDIX SEVEN

BENEFITS OF BREASTFEEDING

International evidence shows that breastfeeding contributes positively to infant and maternal well health and has an impact on the likelihood of obesity later on in life.[49] The benefits of breastfeeding include better nutrition, and the improved health and wellbeing of babies, mothers and Whaanau/families. The values and beliefs of "significant others" (such partners and parents) have a large influence on the decision to breastfeed[50]. The establishment and maintenance of breastfeeding is based on the provision of a quality continuum of service, particularly in the post-natal period.

The benefits of breastfeeding include:

- Children receive the most complete and optimal mix of nutrients & antibodies
- The varying composition of breastmilk keeps pace with the infant's individual growth and changing nutritional needs
- Positive impact on the psycho-social development between mother and baby which support infant mental health (attachment and bonding)
- Positive impact on babies health (e.g. increased resistance to illnesses, better cognitive development, reduced risk of a range of conditions such as diabetes and reduces the likelihood of becoming obese)[51]
- Positive impact on maternal health (e.g. protection against postpartum haemorrhaging, and breast and ovarian cancer)
- Meets the full nutritional requirements for a healthy full-term infant for the first 6 months[52]
- Reduces the risk of Sudden Unexpected Infant Death and Sudden Infant Death Syndrome (SUDI/SIDs)
- Decreased incidence of otitis media, acute respiratory infections, diarrhoea and gastroenteritis, urinary tract infection, sepsis and meningitis
- Prevents the occurrence of early childhood caries (caused by frequent and prolonged exposure of the teeth to sugar)53
- Antibody response to vaccines are higher
- Are hospitalized 10 times less than formula fed infants in the first year of life
- Helps the mother's body return to its pre-pregnancy state faster - promotes weight loss
- Helps delay return of fertility and to space subsequent pregnancies
- Breastmilk is free- reducing or eliminating the cost of formula (in the thousands of dollars/per year)
- Breastfed babies are sick less thus reducing healthcare costs to family
- Mums miss less time off from work due to child related illnesses

[49] Ibid
[50] Ibid
[51] Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand. Http://www.moh.govt.nz/moh.nsf/indexmh/breastmilksubstitutemarketingcode-question...
[52] Ibid
[53] The World Oral Health Report 2003

APPENDIX EIGHT

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