

# Midland Breastfeeding Framework

A guide to support future service development to increase breastfeeding rates in the Midland region of New Zealand.

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## Forward

Breastfeeding has been recognised as a core foundation for health and wellbeing of both the mother and infant. Although it is well established that breastfeeding is a key to good public health, breastfeeding rates have not been increasing in general over the past decade and inequity can be seen within our population, with lower rates of breastfeeding in Maori mothers.

The *Midland Breastfeeding Framework* offers a clear direction on how different sectors can work together to provide a suite of services and initiatives that could turn the tide and increase breastfeeding rates across our Midland region. By adapting current services to meet the needs of the 'millennial mother' and planning for a wrap-around of well equipped services and initiatives, it is hoped that we can positively change the breastfeeding statistics for our future generations. The framework offers targeted approaches that have been shown to support the needs of Maori, it is hoped that equity is achieved through prioritisation and sustainable funding of integrated services that work well.

The Midland Maternity Action Group recommends that this framework is used by DHBs to advocate for change and sustainable and adequate funding. Breastfeeding needs to be a priority for the future health of our region. The framework offers tools, with practical checklists and outlines the evidence behind the recommendations to support service improvement and development. It can be used as a guideline for planners, funders and service leaders to look across the whole system to provide a fully integrated service that will improve breastfeeding rates in the Midland region.

Many great minds and passionate advocates from across the region were pulled together through the consultation process to develop the *Midland Breastfeeding Framework*, and the final product reflects their valuable input. We hope that you, as a reader, are encouraged that increasing breastfeeding rates is possible - it has happened before and it will happen again.

**Corli Roodt**

**Chair, Midland Maternity Action Group**



## Acknowledgements

Thank you to all the participants of the focus groups held across the five DHBs that make up the Midland region, especially to the mothers and babies that gave up their own time to share their experiences and provide valuable insight that contributed to this Framework. Thank you to the experts in their fields that have provided ongoing advice and expertise. It is hoped that this framework is not a report to go on a shelf, but a practical tool that is well used to facilitate and enable system level changes that facilitate the best quality care we can for our mothers and babies for generations to come.

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# Executive Summary

The protection, promotion and support of breastfeeding are vitally important public health issues. Breastfeeding promotes health, prevents disease and helps contribute to reducing health inequalities. For some women, breastfeeding can be challenging, especially if they do not have good support systems in place. Breastfeeding rates in New Zealand have fluctuated over the years, with great inequity seen in Māori breastfeeding rates.

Through consultation with the people of the Midland region, expert input from the sector and stakeholder focus groups, and the insight provided from previous reports and current evidence has influenced the following key overarching vision for breastfeeding in the Midland region.

## **Midland will be a region that:**

- **Supports, protects and celebrates breastfeeding in the community**
- **Provides quality support services for all women to overcome breastfeeding challenges**
- **Has maternity and community services that are sustainably resourced and well integrated**
- **Achieves equity for Māori breastfeeding rates**

The Midland Breastfeeding Framework has been developed to be suitable in the New Zealand context, with a targeted approach to reduce disparities in breastfeeding outcomes of Māori.

Core elements of an effective breastfeeding support service and a checklist for each are included in the body of this framework. It is envisaged that each DHB utilises the best practice recommendations provided in this framework to influence future planning and funding of services and service improvement. In order to facilitate this whole of system change, an integrative process needs to be engaged.

Figure 1 provides a visual overview of the integration of services and initiatives. The diagram displays the layers of services and initiatives required to positively influence population breastfeeding outcomes—namely breastfeeding according to the Ministry of Health guidelines.

**The diagram shows an encompassing arrow with key themes that need to be considered in all the components of the framework.**

This diagram shows the macro level components of the framework; the mother/infant dyad should be at the heart of all service design.

Each component is likely to have a more dominant effect on either of the two main components of breastfeeding outcomes; initiation and duration. This further emphasises the need to plan and fund the whole system of services and initiatives to make a difference to breastfeeding rates.

A fully funded service that aims to increase breastfeeding rates would include;

- 1) Settings based public health initiatives; supportive environments, policy and early awareness raising
- 2) Antenatal education, both from primary practitioner (LMC) and quality antenatal classes
- 3) BFHI accredited maternity facilities
- 4) Integrated breastfeeding peer support programme and community lactation service
- 5) Specialist services
- 6) Ongoing workforce development

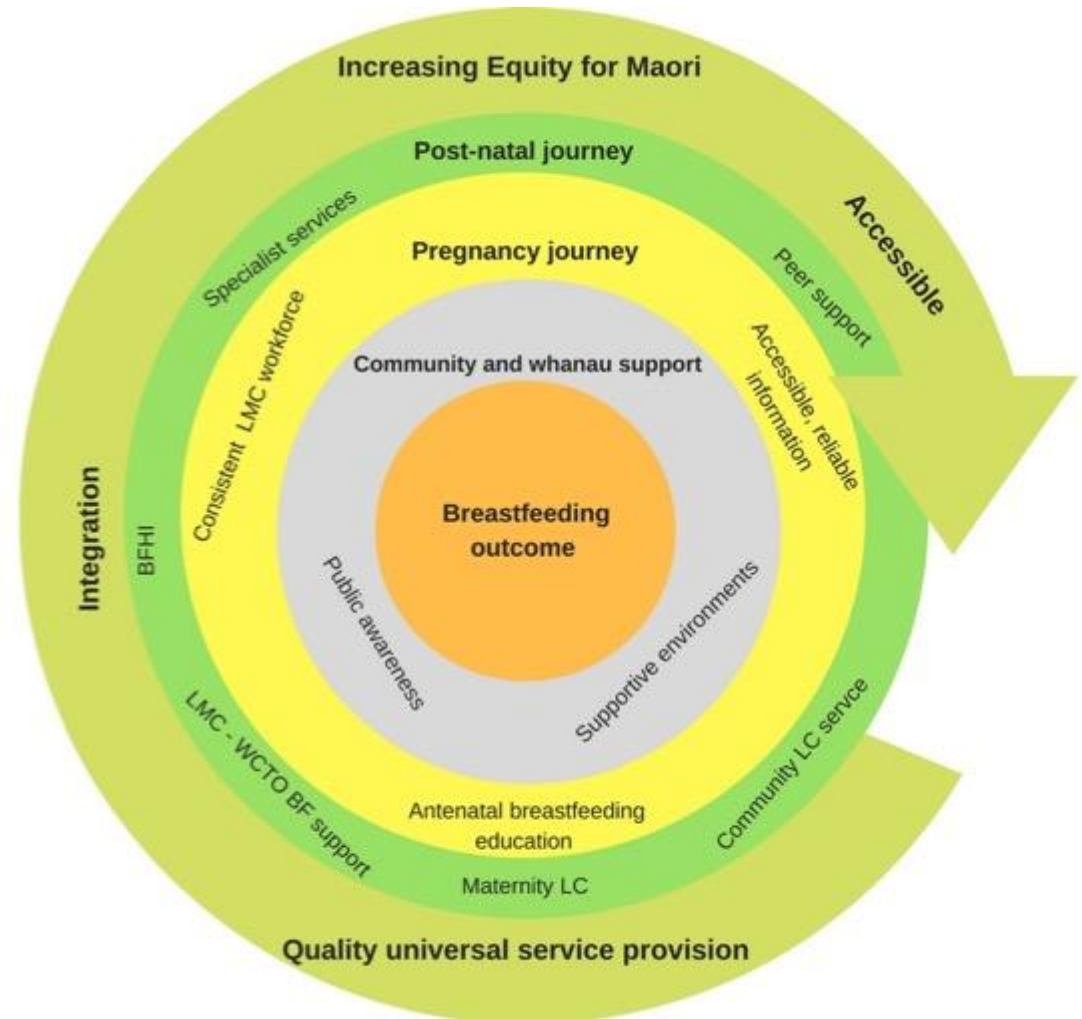


Figure 1: Midland Breastfeeding Framework diagram

# Introduction

The Midland region comprises of five District Health boards. Each DHB services their diverse population. The Ministry of Health encourages integration, information and resource sharing between District Health Boards.

The development of this Midland Breastfeeding Framework is a result of direction from the Midland Maternity Action Group (MMAG), a collaborative action group comprising of key stakeholders from the five Midland DHBs and facilitated by HealthShare Ltd.

The purpose of the Midland Breastfeeding Framework is to inform and prioritise breastfeeding initiatives in the Midland region.

The Midland Maternity Action Group have proposed that the framework includes:

- an overview of literature
- New Zealand and Midland research findings
- quantitative breastfeeding data
- qualitative feedback from Midland’s women and maternity and WCTO health care providers (focus groups, semi-formal interviews)
- learning from existing breastfeeding activity within DHBs of the Midland region

Adoption of the full framework will improve breastfeeding rates in the Midland region, creating a region that:

- Supports, protects and celebrates breastfeeding in the community
- Provides quality support services for all women to overcome breastfeeding challenges
- Has maternity and community services that are sustainably resourced and well integrated
- Achieves equity for Māori breastfeeding rates





## Background

Breastfeeding is important for the physical, social, emotional and mental health and wellbeing of infants, mothers, fathers/partners and families.

Children who are exclusively breastfed for around 6 months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of SUDI, asthma and childhood obesity.

The World Health Organisation (WHO) have an implementation plan for maternal, infant and young child nutrition, which specified a set of six global nutrition targets for 2025 (WHO, 2014). One of these targets is for breastfeeding:

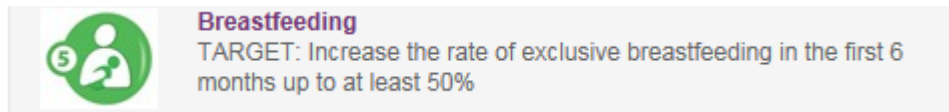


Figure 2: WHO international target for breastfeeding

It is possible to increase levels of exclusive breastfeeding. Between 1985 and 1995, global rates of exclusive breastfeeding increased by 2.4% per year on average (increasing from 14% to 38% over 10 years) but decreased subsequently in most regions. However, 25 countries increased their rates of exclusive breastfeeding by 20 percentage points or more after 1995, a rate that is similar to what is needed to achieve the global target (WHO, 2014).

### What contributes to low exclusive breastfeeding rates globally?

Inadequate rates of exclusive breastfeeding result from social and cultural, health-system and commercial factors, as well as poor knowledge about breastfeeding.

These factors include:

## What are the recommended breastfeeding practices?

The WHO and UNICEF Global Strategy for Infant and Young Child Feeding outlines three recommended breastfeeding practices:

1. Early initiation of breastfeeding – place newborns skin-to-skin with their mother immediately after birth, and support mothers to initiate breastfeeding within the baby's first hour of life.
2. Exclusive breastfeeding – provide only breastmilk to infants from birth until 6 months of age, with no other food or liquids (including water)
3. Continued breastfeeding – breastfeeding until age 2 or longer, in addition to adequate and safe solid, semi-solid or soft foods (also called complementary foods).

- caregiver and societal beliefs favouring mixed feeding (i.e. believing an infant needs additional liquids or solids before 6 months because breast milk alone is not adequate);
- hospital and health-care practices and policies that are not supportive of breastfeeding;
- lack of adequate skilled support (in health facilities and in the community);
- aggressive promotion of infant formula, milk powder and other breast-milk substitutes;
- inadequate maternity and paternity leave legislation and other workplace policies that support a woman's ability to breastfeed when she returns to work;
- lack of knowledge on the dangers of not exclusively breastfeeding and of proper breastfeeding techniques among women, their partners, families, health-care providers and policy-makers. (WHO, 2014)

“Breastmilk is more than just food for babies – it is also a potent medicine for disease prevention that is tailored to the needs of each child. The ‘first milk’ – or colostrum – is rich in antibodies to protect babies from disease and death.”

(UNICEF, 2016)

Although having information about the health advantages of breastfeeding is important, knowing how to breastfeed is crucial. Mothers who do not know how to initiate and continue breastfeeding after a child is born may fear that it will always be painful or that they will be unable to produce enough milk to fully feed the baby (US Department of Health and Human Services, 2011).

#### **What does the WHO recommend to increase breastfeeding rates? (WHO, 2014)**

1. provide hospital- and health facilities-based capacity to support exclusive breastfeeding, including revitalizing, expanding and institutionalizing the baby-friendly hospital initiative in health systems.
2. provide community-based strategies to support exclusive breastfeeding, including the implementation of communication campaigns tailored to the local context.
3. significantly limit the aggressive and inappropriate marketing of breast-milk substitutes by strengthening the monitoring, enforcement and legislation related to the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.
4. empower women to exclusively breastfeed by enacting six-months mandatory paid maternity leave as well as policies that encourage women to breastfeed in the workplace and in public.
5. invest in training and capacity-building in exclusive breastfeeding protection, promotion and support.

## The New Zealand Context

District health boards (DHBs) are required by the Ministry of Health to improve the health of Māori and reduce health disparities compared to other population groups in New Zealand. Breastfeeding rates are identified in the Ministry of Health targets, previously held within the DHB Māori Health Plan, and in 2017/18 planning year have been integrated into the 2017/18 DHB annual plans.

*Nationally, breastfeeding rates for Māori infants start at a similar (although slightly lower) rate as the total population, but drop off more quickly than the total population at the 3 and 6 month time points. Breastfeeding is an important area of focus because there is significant room for improvement, and breastfeeding has wide-reaching benefits and potentially results in reduced cost for families (Ministry of Health , 2016).*

Māori tend to look at health as encompassing whanāu, mental, spiritual and environmental wellbeing. It is therefore important when planning to turn the tide on any indicator that records disparities between Māori and non-Māori, that a Māori view point of health is woven into the planning process.

As with any inequities in health and social outcomes, improving equity in breastfeeding rates for Māori will take both a specific targeted approach alongside high quality, accessible services for all.

The closing of the gap in breastfeeding disparities between Māori and non-Māori should occur through significant improvements in the social determinants of health (see figure 2) for Māori, seeing strides towards removing the underlying causes of poor health outcomes.

One approach to improving health for Māori and for all, is by applying Pae Ora when planning health and social services and initiatives.



Figure 3: The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life.



Figure 4: The three interconnected elements of Pae Ora

The New Zealand Health Strategy (Ministry of Health , 2016) sets the framework for the health system to address the pressures and significant demands on its services and on the health budget. It sets the direction for development during the next 10 years.

The five themes – **people-powered**, **closer to home**, **value and high performance**, **one team** and **smart system** – are cornerstones in establishing a health sector that understands people’s needs and provides services that are integrated across sectors. These themes can be recognised in the recommendations within this framework.

Pae Ora is a model that looks beyond the individual to the place the individual has within whanau and their environment. This framework has been developed with consideration of the three elements of Pae Ora (see figure 3).

Pae Ora can assist in ensuring key elements of a whole system are present to strive towards achieving equity in health and wellbeing through the acknowledgement of three interconnected elements.

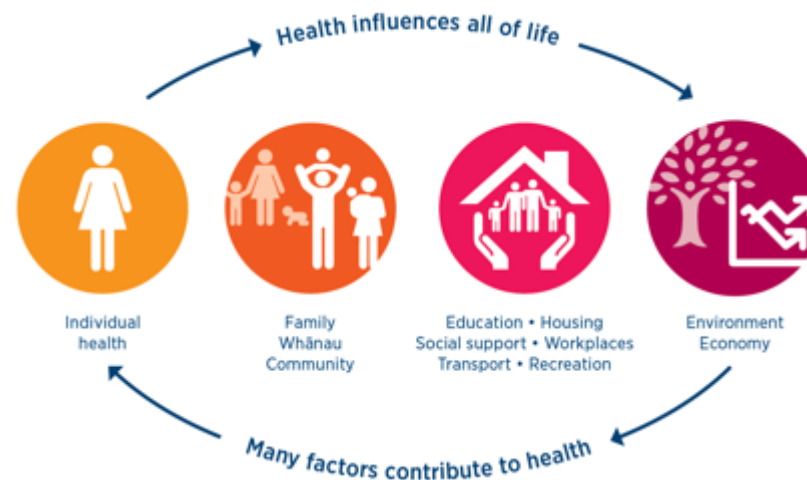


Figure 5: NZ Health Strategy: Future Direction, 2016, Ministry of Health

## History of Breastfeeding Rates in New Zealand

Prior to colonisation, all Māori infants were breastfed (Papakura, 1938). An early colonial ethnographer, Elsdon Best (1929) studied Māori during the late 1800s and early 1900s and noted the varying lengths of time that Māori women breastfeed, for example, until their baby could turn over without assistance, until teeth appeared, or for as long as the child chose to breastfeed (Reinfelds, 2015). Breastfeeding was protected and considered of high importance in pre-colonised Aotearoa. One of the practices of breastfeeding protection was through wet nursing. If the biological mother was unavailable or could not breast feed, the baby would be breastfed by another woman in the whānau or hapū (Glover & Cunningham, Hoki ki te ukaipo: Reinstating Māori infant care practices to increase breastfeeding rates, 2011).

Post colonisation policies and culture saw the unjust loss of many Māori practices and the introduction of, often detrimental, westernised practices into Māori society. The detrimental impact of colonisation on the underlying determinants of health have passed through generations and are realised in today's inequity between Māori and non-Māori. Breastfeeding rates are one of the indicators of Māori health and wellbeing that have unfortunately been pulled into this intergenerational decline.

Worldwide the introduction and marketing artificial feeding methods have been highlighted as a key factor in the initial decline in overall breastfeeding rates in New Zealand. The unrestricted marketing of these feeding products was dominant until the International Code of Marketing of Breast Milk Substitutes was implemented in 1981 (Reinfelds, 2015).

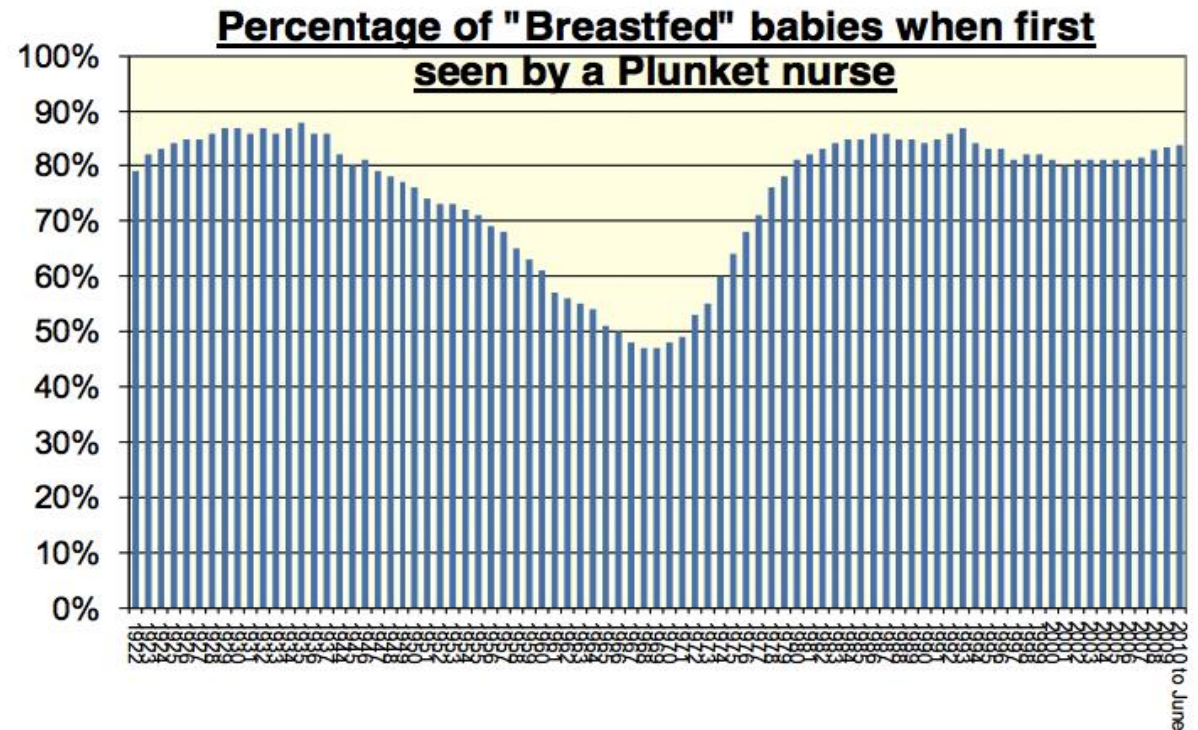


Figure 6: Breastfeeding rates recorded by Plunket 1922-2010



Breastfeeding rates were increasing since the 1970's, with vast improvements in breastfeeding initiation over time. However, breastfeeding according to the WHO guidelines have stagnated or fluctuated over time for both Māori and non-Māori, despite government targets being set.

Plunket have been recording breastfeeding data since 1922. Figure 3 shows the impact that the introduction of formula had on breastfeeding rates in the 1960s.

**“Women in most countries encounter promotion of formula feeding in various forms, a factor which has been implicated in women choosing to feed their babies on formula. “ (WHO Data Bank 1996).**



Figure 8: A Māori mother (centre) breastfeeds her child in an 1849 image. Before the arrival of Europeans breast milk was the only suitable food available for young babies. (Alexander Turnbull Library) Artwork by Richard Aldworth Oliver

## Stages of Breastfeeding

From a mother's perspective breastfeeding can be seen as progressing through several stages, with each stage offering unique opportunities for tailored support.



Figure 7: Stages of breastfeeding

## Midland Breastfeeding Rates

Across the midland region there are differences in breastfeeding rates. Differences in breastfeeding rates may be due to both actual variations in local rates and data recording variances.

[Trendly.co.nz](http://Trendly.co.nz) provides a centralised data set, displaying performance against some New Zealand priority health indicators. Trendly.co.nz can be used for DHB performance monitoring, and includes three breastfeeding related indicators; exclusive breastfeeding at 6 weeks, 3 months and any breastfeeding at 6 months.

When considering breastfeeding data, it is important to consider the differences in rates between Māori and non-Māori. This offers an indication of equity for breastfeeding rates in each district.

Table 1 is a breakdown of the Jan-June 2016 recorded breastfeeding rates across the Midland region, broken down into Māori and non-Māori categories.

Breastfeeding rates are gathered through Well Child Tamariki Ora providers recording processes (includes Plunket and kaupapa Māori providers). The indicators are measured against the national targets, **with red indicating that the target has not been met, and green indicating that the national target has been met.**

Table 1: Jan-June 2016; 6 weeks, 3 months, 6 months Breastfeeding rates comparing Māori and non-Māori, Midland region

Jan/June 2016	Tairāwhiti	Taranaki	BOP	Waikato	Lakes
6 Weeks (full or exclusive) MAORI	59.7%	49.6%	64%	56.3%	51.7%
6 weeks (full or exclusive) NZ EU/ OTHER	77.8%	66.7%	77.1%	69.3%	66.2%
3 Months (full or exclusive) MAORI	38.2%	41.3%	44.5%	41.4%	41.4%
3 Months (full or exclusive) NZ EU/ OTHER	57.4%	59.2%	67.4%	61.5%	57.9%
6 Months (Full/exclusive/partial) MAORI	55.4%	46.8%	53.6%	49.1%	57.7%
6 Months (Full/exclusive/partial) NZ EU/ OTHER	69.5%	68%	72.4%	67.3%	62.5%

National Targets
6 weeks target: 75%
3 month target: 60%
6 month target: 65%

## Breastfeeding initiation rates

The New Zealand Breastfeeding Association (NZBA) collates the Baby Friendly Hospital Initiative (BFHI) maternity services breastfeeding data from their completed annual surveys. The most recent published data is from 2015. To maintain BFHI accreditation status, it is required that breastfeeding rates at discharge are maintained above 75%.

The New Zealand exclusive breastfeeding rates at discharge in BFHI accredited units in the last year averaged 82.8%. Tertiary services averaged 78.8%, Secondary 83.6% and primaries 92.4%. There have been slight fluctuations around these rates over the past few years (see table 2)

Table 2: NZBA collated Breastfeeding rates at discharge from BFHI maternity units

	National Average	Primary	Secondary	Tertiary
2012	84.4%	92.3%	84.3%	82.0%
2013	83.3%	92.1%	82.1%	81.7%
2014	82.3%	93.1%	82.9%	79.6%
2015	82.8%	92.4%	83.6%	78.8%

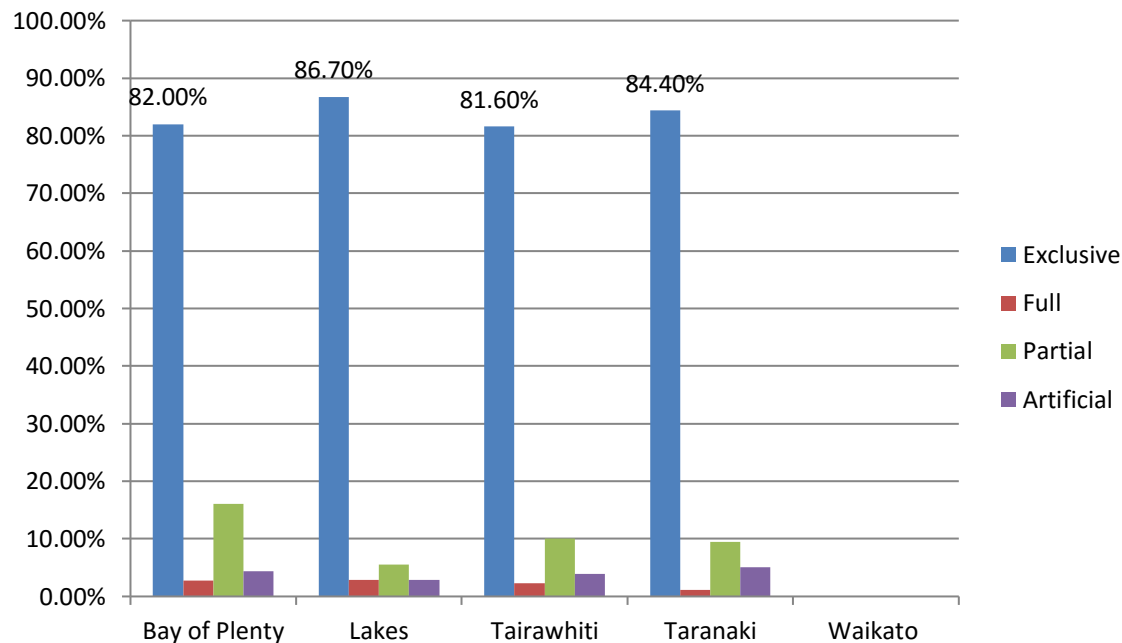


Figure 9: 2015 Midland breastfeeding at discharge rates (data unavailable for Waikato in NZBA report)

### Artificial feeding rates and Māori

In 2015, the NZ breastfeeding rates showed that Māori infants have the highest and earliest rates of formula feeding only compared with the population average.

For Māori over 5.2% of infants receive no breastmilk and this has implications for health outcomes. By 6 weeks 21.8% are having no breastmilk and this climbs to 36.2% by 3 months and then nearly half (47.2%) by 6 months.



## Trends over time

It is difficult to accurately comment on trends over recent times, due to data fluctuation - possibly being attributed to data recording variances. More specifically, around 90% of babies are enrolled with a Well Child Tamariki Ora service. Of the enrolled WCTO population, 90% of infants are enrolled with Plunket, the other 10% with another WCTO provider. This 10% of other WCTO have not been included in data until recent years. The unenrolled 10% are not recorded at all.

Plunket have collected data nationally for some time and have used the current definitions of breastfeeding indicators since 2002. While Plunket sees over 90 percent of babies, it does not see every baby in New Zealand. As a result, these data should not be generalised, and should not be used as a replacement for collecting and using specific local or regional data, including data for particular ethnic groups (National Breastfeeding Advisory Committee of New Zealand, 2009).

Plunket produced a report that examines breastfeeding data between 2004-2009 (Plunket , 2010). The key findings of the report were;

- Over time there has been an increase in Exclusive breastfeeding, but when this is combined with Full breastfeeding there has been no significant change.
- Māori and Pacific people have lower breastfeeding rates than other ethnicities. These disparities between Māori and Pacific and other ethnic groups are not improving over time.
- The higher the deprivation level, the less likely it is that the infant is exclusively breastfed.
- Only Northland achieved the Ministry of Health's 2005 breastfeeding targets across all ages.
- Counties Manukau has the lowest rates of breastfeeding across all ages.

*Whanau, partners, peers and health professionals each have a role to play in providing support to for breastfeeding.*

*Whanau support can be crucial to the success of breastfeeding because of their availability, knowledge sharing and positive role modelling. Where a history of breastfeeding is strong mothers are more likely to breastfeed.*

(McLeod, 2008).



## Midland breastfeeding trends

The graphs below offer an indication of trends by DHB in 3 months full/exclusive breastfeeding rates for Māori and non-Māori across the Midland region. The graphs use data available on [trendly.co.nz](http://trendly.co.nz).

## Bay of Plenty

New Zealand European/other population groups in the Bay of Plenty (BOP) have seen an increase in 3 months full/exclusive breastfeeding rates since July 2014. These rates have been consistently above the 60% target. However, Bay of Plenty Māori has been consistently below the 60% target and no trend can be seen since July 2014.

In the Jan-Jun 2016 quarter, 44.5% of BOP Māori infants were breastfed. If 62 more Māori infants were breastfed (242 breastfed in total) BOP would have reached the national target of 60%.

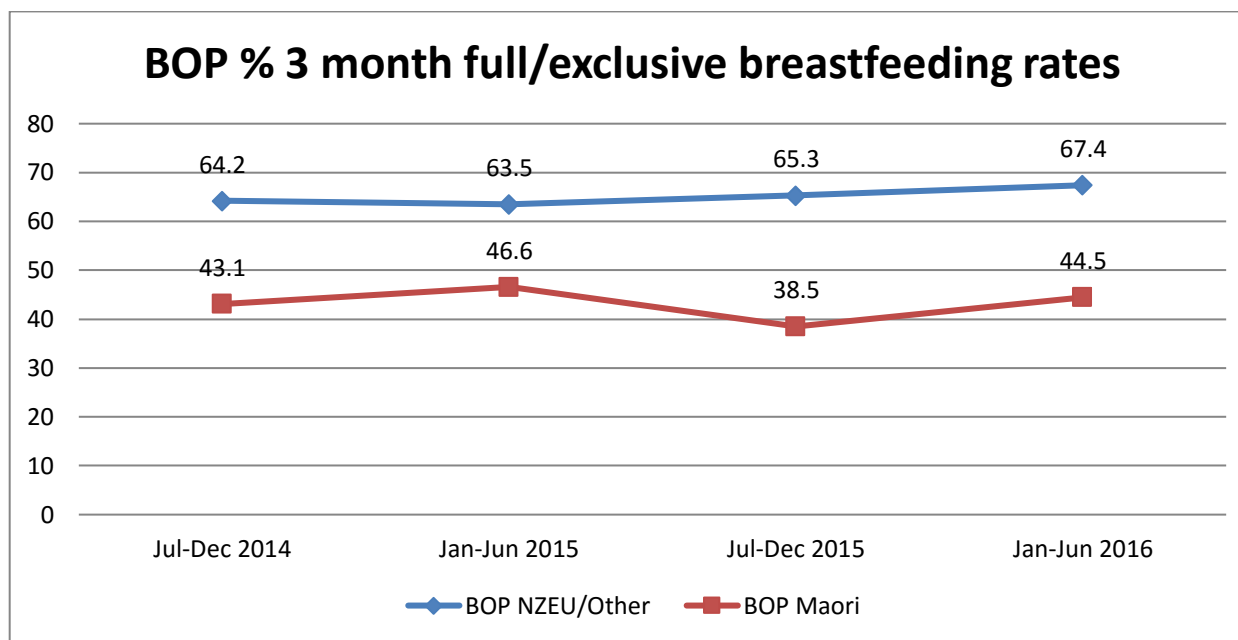


Figure 10: BOP 3 month BF data by quarter

## Taranaki

New Zealand European/other population groups in Taranaki have seen an increase in 3 months full/exclusive breastfeeding rates since July 2014. These rates have been consistently below the 60% target. Taranaki Māori breastfeeding rates have also been consistently below the 60% target and a decline in rates can be seen since July 2014.

In the Jan-Jun 2016 quarter, 41.3% of Taranaki Māori infants were breastfed. If 31 more Māori infants were breastfed (100 breastfed in total), Taranaki would have reached the national target of 60%.

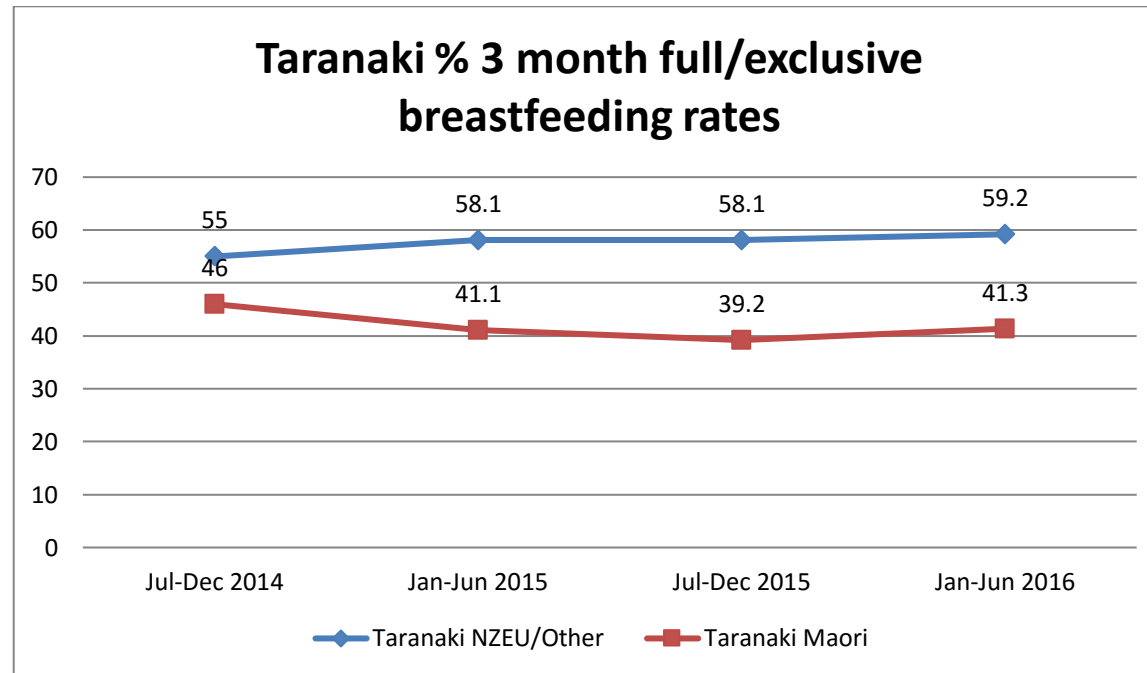


Figure 11: Taranaki 3 months BF rates by quarter

## Waikato

New Zealand European/other population groups in Waikato have seen an increase in 3 months full/exclusive breastfeeding rates since July 2014. These rates have been inconsistent in achieving the 60% target. Waikato Māori breastfeeding rates have also been consistently below the 60% target and a slight overall increase in rates can be seen since July 2014.

In the Jan-Jun 2016 quarter, 41.4% of Waikato Māori infants were breastfed. If 128 more Māori infants were breastfed (411 breastfed in total) , Waikato would have reached the national target of 60%.

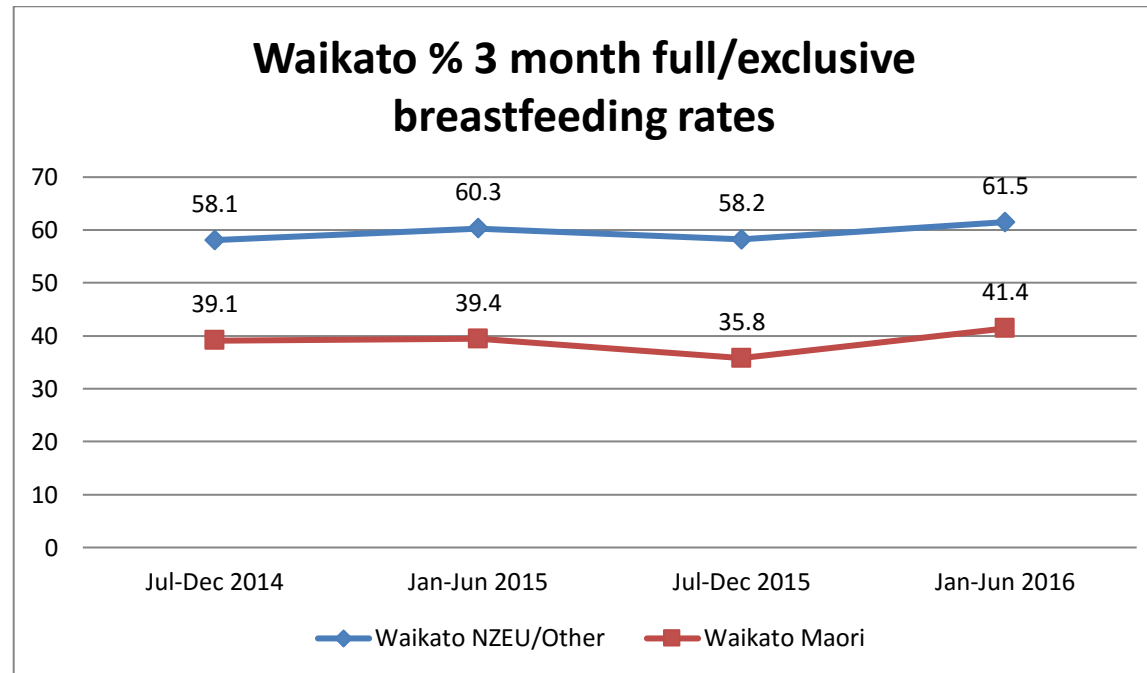


Figure 12: Waikato 3 months BF rates by quarter

## Lakes

New Zealand European/other population groups in Lakes have seen an increase in 3 months full/exclusive breastfeeding rates until Dec 2015, followed by a decline until June 2016. These rates have been inconsistent with meeting the 60% target, with the final data recording not achieving the target. Waikato Māori breastfeeding rates have also been consistently below the 60% target and a decline in rates can be seen overall since July 2014.

In the Jan-Jun 2016 quarter, 41.4% of Lakes Māori infants were breastfed. If 61 more Māori infants were breastfed (196 breastfed in total), Lakes would have reached the national target of 60%.

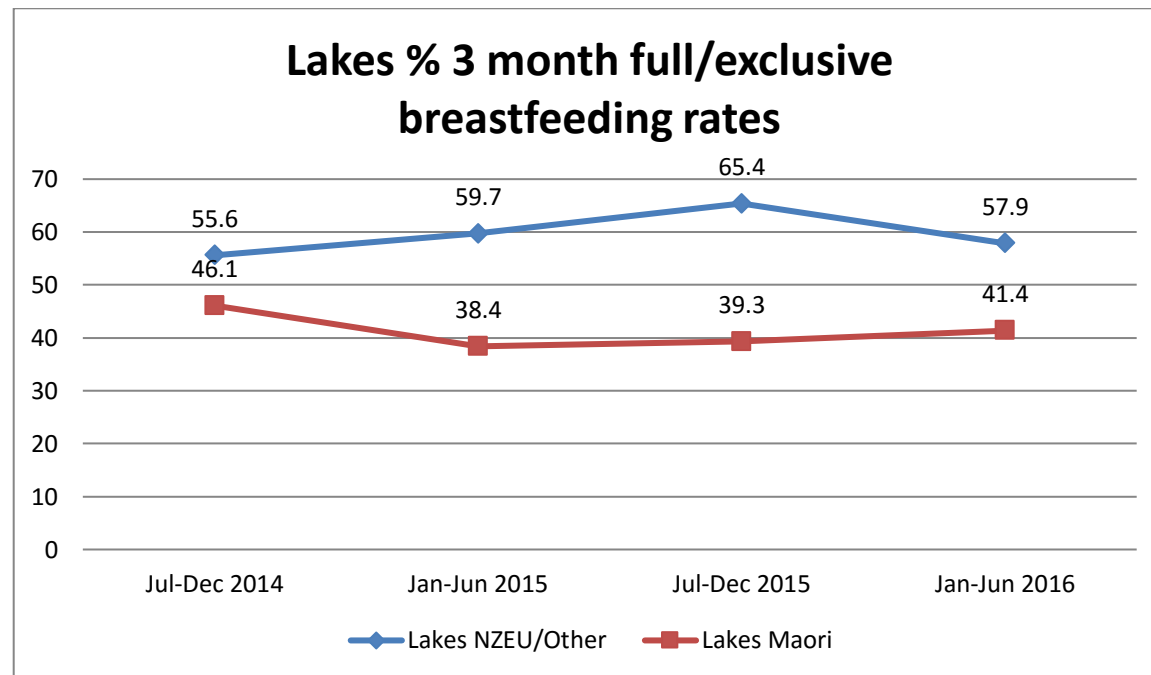


Figure 13: Lakes 3 months BF rates by quarter

## Tairawhiti

New Zealand European/other population groups in Tairawhiti have seen a decline in 3 months full/exclusive breastfeeding rates until June 2016. These rates have been inconsistent with meeting the 60% target, with the final data recording not achieving the target. Tairawhiti Māori breastfeeding rates have also been consistently below the 60% target and a decline in rates can be seen overall since July 2014.

In the Jan-Jun 2016 quarter, 38.2% of Tairawhiti Māori infants were breastfed. If 44 more Māori infants were breastfed (122 breastfed in total), Tairawhiti would have reached the national target of 60%.

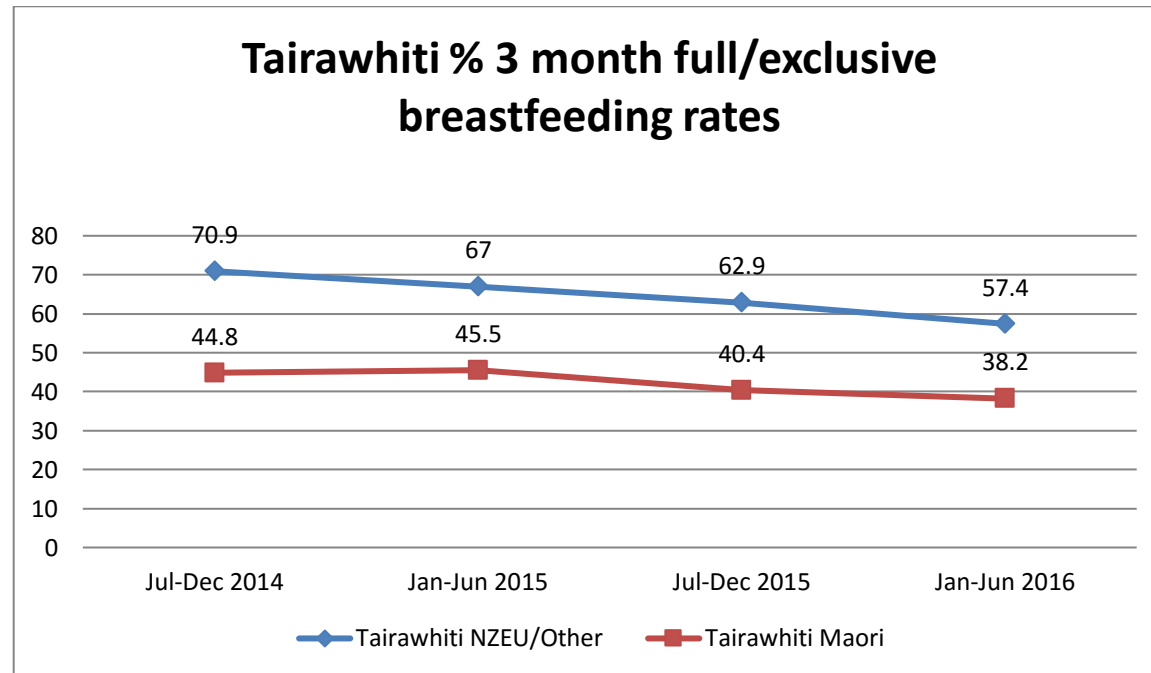


Figure 14: Tairawhiti 3 months BF rates by quarter

## Evidence for breastfeeding support services

A [Cochrane review](#)<sup>1</sup> was published on the 28 February 2017 and provides an analysis of 100 randomised trials that investigated the effectiveness of breastfeeding support initiatives on breastfeeding outcomes. There are many trials in this field and this number continues to grow. This is possibly due to stagnation in breastfeeding rates despite the strong understanding of the importance of breastfeeding on public health.

The findings of a Cochrane review of this size, with international scope, will offer relevance to the New Zealand setting. *“The effect of supportive interventions is robust across settings and population groups, and results from a wide range of interventions.”* The review showed that support interventions were associated with greater effect on exclusive breastfeeding in countries that had high breastfeeding initiation rates (such as New Zealand) compared to settings with low or intermediate breastfeeding initiation rates.

When breastfeeding support is offered to women, the duration and exclusivity of breastfeeding is increased. Characteristics of effective support include: that it is offered as standard by trained personnel during antenatal or postnatal care, that it includes ongoing scheduled visits so that women can predict when support will be available, and that it is tailored to the setting and the needs of the population group. Strategies that rely mainly on face-to-face support are more likely to succeed with women practicing exclusive breastfeeding.

Support is effective when offered either by professional or lay/peer supporters, or a combination of both. Lay support and more contact in the form of scheduled visits (4 to 8 visits) were also associated with greater treatment effects.

*“There is evidence that effective breastfeeding support interventions are cost-effective and likely to realise a return on investment within a few years”*

*- Cochrane Review 2017.*

*“While there are still questions to address about how best to provide support, the key messages are clear – we have ample evidence to know that women need support to be available and to be provided using the characteristics we have identified to increase the duration and exclusivity of breastfeeding.”*

*- Cochrane Review 2017.*

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<sup>1</sup> Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognised as the highest standard in evidence-based health care resources.

In 2016, [the Lancet](#) released a global health series on breastfeeding. Within this series a systematic review of available studies was conducted to identify the determinants of breastfeeding and reviewed and revised previous conceptual frameworks.

The conceptual model (figure 12) includes the determinants that operate at multiple levels and affect breastfeeding decisions and behaviours over time. Nearly all women are biologically capable of breastfeeding, bar very few with severely limiting medical disorders. However, breastfeeding practices are affected by a wide range of historical, socioeconomic, cultural, and individual factors.

Research conducted to create this Lancet series on breastfeeding generated the following settings based recommendations.

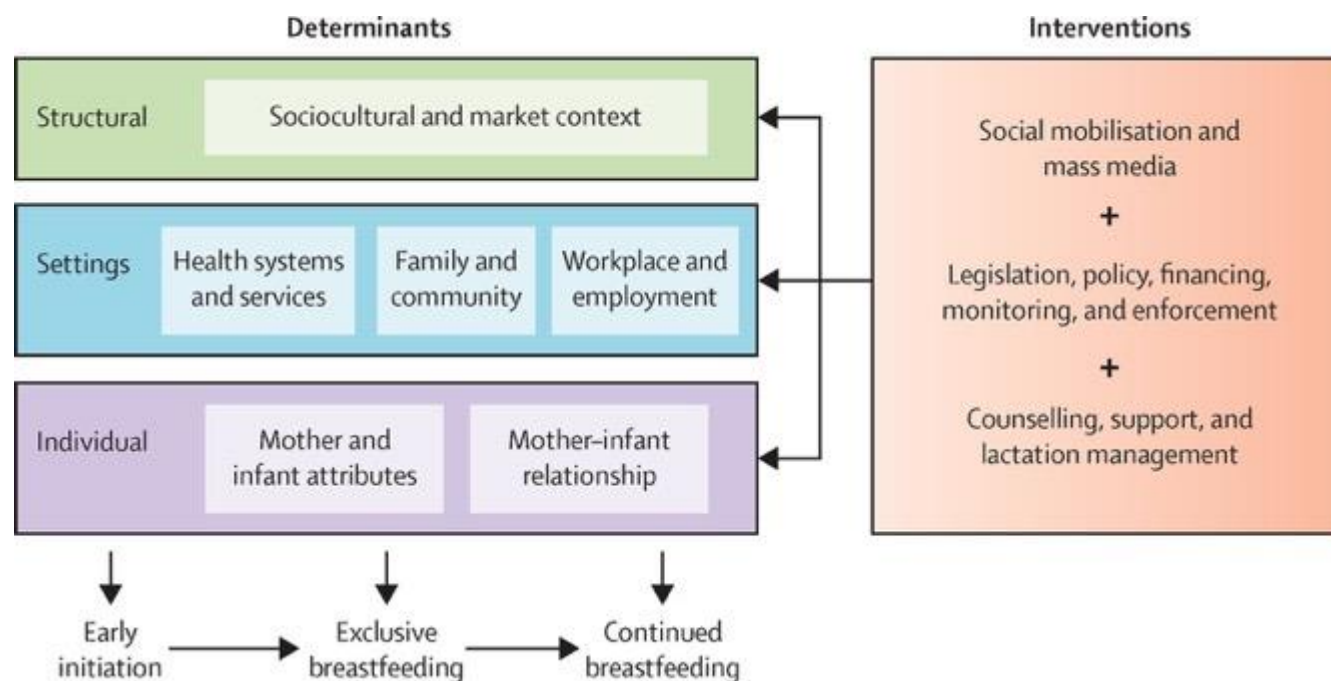


Figure 15: Determinants of breastfeeding and interventions associated with longer breastfeeding duration (Lancet 2016)

### Health system

The Lancet meta-analyses considered several interventions included in the Baby Friendly Hospital Initiative (BFHI): individual counselling or group education, immediate breastfeeding support at delivery, and lactation management. These interventions increased exclusive breastfeeding by 49% (95% CI 33–68) and any breastfeeding by 66%.

### Home and Family

Home and family-based interventions were effective at improving exclusive (RR 1.48 [95% CI 1.32–1.66]), continued (1.26 [1.05–1.50]), and any (1.16 [1.07–1.25]) breastfeeding, and tended to improve early initiation (1.74 [0.97–3.12]). Interventions that provided antenatal and postnatal counselling were more effective than were those targeting one period only, whereas interventions targeting fathers gave mixed results.



## Community

Community-based interventions, including group counselling or education and social mobilisation, with or without mass media, were similarly effective, increasing timely breastfeeding initiation by 86% (95% CI 33–159) and exclusive breastfeeding by 20% (3–39). Findings from the one study that researchers identified on the effect of mass or social media on breastfeeding suggested that it has a major effect on early initiation of breastfeeding (RR 5.33 [2.33–12.19]). The authors recommend that social media needs additional study in view of its wide and effective use to market breastmilk substitutes and other products.

## The workplace

The reduction of barriers for working mothers to breastfeed by providing lactation rooms and breastfeeding breaks are low-cost interventions that can reduce absenteeism and improve workforce performance, commitment, and retention. An analysis of national policies in 182 countries showed that breastfeeding breaks with pay were guaranteed in 130 countries (71%), unpaid breaks were offered in seven countries (4%) (including New Zealand), and 45 countries (25%) had no policy. In multivariate models, paid-break guarantees for at least 6 months were associated with an 8.9% point increase in exclusive breastfeeding. Findings from a study in the USA showed that lactation rooms and breaks to express breastmilk increased breastfeeding at 6 months by 25% (95% CI 9–43).

*“The largest effects of interventions on breastfeeding outcomes are achieved when interventions are delivered in combination. For example, combined health systems and community interventions increase exclusive breastfeeding by 2.5 times”*

*- Lancet series on Breastfeeding*

*Breastmilk makes the world healthier, smarter, and more equal: these are the conclusions of a new Lancet Series on breastfeeding. The deaths of 823 000 children and 20 000 mothers each year could be averted through universal breastfeeding, along with economic savings of US\$300 billion. The Series confirms the benefits of breastfeeding in fewer infections, increased intelligence, probable protection against overweight and diabetes, and cancer prevention for mothers. The Lancet Series represents the most in-depth analysis done so far into the health and economic benefits that breastfeeding can produce.*

**There is support, from New Zealand based studies for provision of services that support Māori breastfeeding supported that services would be more effective if they were provided ‘by Māori for Māori’ and included traditional Māori birthing and breastfeeding concepts (Glover, Manaena-Biddle, Waldon, & Cunningham, 2008)**

# Framework Development

A mixed method was used ensure collaboration from the five Midland DHBs, their services and their communities in the development of the framework. Particular attention was given to attain the views of population groups most at risk of not breastfeeding, for example; Māori, young mothers and people of low socioeconomic status. Furthermore, insight was gained from the five midland DHB maternity services, lactation services, Plunket, Well Child Tamariki Ora, antenatal and other relevant services.

## Methodology Outline

### 1. Scoping stage

- a. At the initiation of this project a brief scoping report was produced
- b. A project implementation plan (PIP) was completed during the scoping phase
- c. The scope and PIP was presented to MMAG at the meeting in November

### 2. Quantitative data analysis

- a. Desktop analysis of regional breastfeeding data
- b. Brief literature scan including New Zealand and Midland research findings
- c. Regional service and workforce mapping

### 3. Qualitative stakeholder and service provider insight

- a. Semi-formal interviews were held with experts (e.g. lactation specialists, Māori health experts, planning and funding)
- b. Regional cluster discussion forums (focus groups) were held in Waikato, Taranaki, Bay of Plenty (East and West), Lakes and Tairāwhiti. Representatives from maternity, LMCs, children's services (paediatricians), lactation services (private and public), Plunket, Māori organization WCTO providers, antenatal and relevant community initiatives were among the participants.

### 4. Qualitative service user insight

- a. Findings from existing surveys and reports investigating the views of mothers (especially Māori mothers) and breastfeeding were used.
- b. Three focus groups of mothers (pregnant or new mothers of less than 2 year olds) were held. One at a teen parent unit in Tauranga, one in Hawera and one in Gisborne. Additional interviews were held with mothers who were prepared to share their breastfeeding experiences. The focus groups and interviews gained specific insight from; Māori, mothers living rurally, teenage mothers and mothers living in urban settings.

## Midland Workforce Snapshot

There is variability of maternity and breastfeeding support workforce capacity across the Midland region. This workforce stocktake (table 3), paired with the breastfeeding indicators (initiation, 6 weeks, 3 months and 6 months) could be used as the baseline for an annual 'Midland breastfeeding report card' such as what the Centre for Disease Control and Prevention (CDC) published every two years in the US (CDC, 2017).

The ratio of the number of International Board Certified Lactation Consultants (IBCLC) per 1000 live births (nLC:1000) is used as a relative measure for workforce capacity. **In the US, the average IBCLC:1000 live births in 2016 was 3.79:1000.** All the DHBs in the Midland region were well below the US average at the time of this stocktake. There is no recommended ratio of LC:1000 live births and the US average may not be an appropriate comparator as they do not have a LMC system. It should be noted that the number of trained IBCLCs may be greater in each region than what is recorded here, as they may be trained as an IBCLC but not employed by the DHB or a community lactation service. They may be practicing as a nurse, midwife, or as a self-employed IBCLC.

Table 3: Midland workforce stocktake

	No. births (2015)	No. LMCs	Number of secondary/primary birthing units	DHB employed IBCLCs nLC:1000 live births	Community LC service	Māori antenatal programme	Breastfeeding Peer support	Public health BF initiative
Waikato	5361	160-180	1 secondary / tertiary: Waikato Hospital Primary/secondary/complex care birthing (Hamilton)  10 Primary: <ul style="list-style-type: none"> <li>Thames Birthing Unit</li> <li>Tokoroa Hospital</li> <li>Te Kuiti Hospital</li> <li>Taumarunui Hospital</li> <li>River Ridge East Birth Centre (Hamilton)</li> <li>Waterford Birth Centre (Hamilton)</li> <li>Pohlen Maternity (Matamata)</li> <li>Birthcare Huntly</li> </ul>	Total 1.9 plus 0.6 for NICU =2.5 FTE (4 LC's)  <b>0.18:1000</b>	WDBH LC's cover inpatients and community for whole DHB region. But no designated community LC service.  River Ridge East Birth Centre has 0.2FTE and Thames Birthing Unit has 2 LCs.	Yes: Hapu Wananga	No current peer support programme.  La Leche League groups are offered. Hamilton (3 groups) a group in Waihi, Thames, Morrinsville, Cambridge, Matamata, Tokoroa, Taumarunui, Te Awamutu.	No current population health led initiative

			<ul style="list-style-type: none"> <li>Waihi Hospital Maternity Annex</li> <li>Te Awamutu Birthing Ltd</li> </ul>					
<b>BOPDHB</b>	2783	88 access holders	2 Secondary- (Whakatane and Tauranga) 3 Primary- Murupara, Opotiki and Bethlehem.	2.5 FTE (0.8 currently vacant as of March 2017) 2 people in post (usually 3)  <b>0.90:1000</b>	Yes: (partial region coverage) Western BOP- Plunket (since 2017). 1 LC, 0.8FTE.	Yes: Eastern BOP delivered by local midwife  Yes: Te Huria Marae (Te Puke)	No current programme  (historical trained peer supporters)  Plans to link up with Community Lactation services and Kaiawhina/Karitane workforce	Yes. Toi Te Ora - Public Health Service. Breastfeeding Friendly spaces (Early childcare, public spaces, workplaces)
<b>Taranaki</b>	1527	84	1 secondary: Taranaki Base Hospital (New Plymouth)  1 Primary: Hawera Hospital	0.8 FTE (1 LC)  <b>0.58:1000</b>	Yes: Tui Ora Hauora community lactation service	Tui Ora offer antenatal classes	Yes: Training and volunteers managed by Tui Ora Hauora	Yes: Taranaki Public Health  Breastfeeding Welcome Here.
<b>Lakes</b>	1519	67 Access Holders  (25 with active caseloads with 2 leaving practice this year)	1 Secondary: Rotorua Hospital  1 Primary: Taupo maternity unit	2.4 FTE (4 LCs- includes DHB funded community LCs and maternity LC)  <b>1.58:1000</b>	Yes: Lakes DHB (since June 2016)	Yes, available in Rotorua and Taupo	No current programme  Plans for implementing peer support programme later in 2017	Yes. Toi Te Ora - Public Health Service. Breastfeeding Friendly spaces (Early childcare, public spaces, workplaces)
<b>Tairāwhiti</b>	769	16 (some are part time)	1 secondary: Gisborne Hospital  1 Primary: Te Puia Springs	0  <b>0:1000</b>	Yes: Managed by MamaPukeko. 2 LCs with Service cap of 20 referrals/ month	Yes, managed by Turanga Health – 2 day Wananga	No current programme	No

# Midland Regional Consultation Findings

## Stakeholder consultation

Five focus groups were conducted with key representatives from antenatal, maternity, NICU, community midwives, Well Child Tamariki Ora (WCTO), public health, Māori health, other related programmes, planning and funding and specialist lactation services between December 2016 and April 2017 across the Midland region. A standard set of questions was asked to guide the five focus groups (see appendix 1). Key themes were identified using thematic analysis of the qualitative information gathered. The top themes for each DHB region are highlighted in the table 4.

Table 4: Top four themes for each DHB region (derived from stakeholder focus groups)

	Top theme (1)	Top theme (2)	Top theme (3)	Top theme (4)
<b>Waikato</b>	Workforce capacity and Funding and resourcing	Equity: for Māori, rural, young and ethnic diverse mothers	Service model change; integration, community LC, drop in clinics, peer support, tongue tie service.	Quality and attitude concerns
<b>Tairāwhiti</b>	Require adequate funding and resources	Workforce development and FTE capacity	Equity and access (including role of whānau and environment)	Return of 'Kia Mama' programme (community LC/peer support/antenatal package)
<b>Bay of Plenty</b>	Improved service integration	Workforce development and FTE capacity	Timely, accessible and relevant support at critical times (including LC and peer support)	Use of relevant communication channels and technology
<b>Taranaki</b>	Service model change; triage and referral pathway, integration, hubs	Inconsistency of workforce and workforce development	Equity; access for Māori and rural	Workforce capacity and resourcing
<b>Lakes</b>	Improved integration between services and sectors	Workforce development and FTE capacity ( <i>funding and resources</i> )	Equity for Māori, access (including rural), environment, partnership and communication with mothers	Importance of antenatal awareness and early support for breastfeeding

The sector provided a great depth of insight into key issues that are happening in each region. **Securing the strategic planning and funding of sustainable, equitable breastfeeding support services was the most common barrier raised overall.** The sector provided some specific insight into key issues that the sector is facing, namely around what works and doesn't work for Māori, workforce capacity and quality of care, tongue tie assessment and treatment and the handover process between the Lead Maternity Carer (LMC) and the Well Child Tamariki Ora (WCTO) provider.

These issues had variances around the region in terms of service provision, but there were limitations around the scope of what each DHB can do to address these individually. Some of the limitations would be better suited to be addressed at a Midland or National level (such as a robust clinical pathway and guideline for tongue tie).

The inconsistency in the quality of breastfeeding messages and support offered by the key staff interacting with pregnant and post-partum mothers was raised in each of the five regional stakeholder focus groups. Most notably the sector recognised an inconsistency in messages or the delivery of messages from health professionals to mothers and their whanau. The sector discussed that this variability is likely caused by practitioner bias, poor conversational technique or relapsing or lack of training.

Some lactation consultants have concerns about the variability in advice given by health professionals such as General Practitioners, pharmacy workers, naturopaths, chiropractors and even from IBCLCs who may not have a foundational clinical qualification (such as midwifery or nursing).

In the first 6 weeks postnatally, a crucial window of time for breastfeeding establishment, some LMCs may be able to support mothers through simple breastfeeding challenges, but refer to their lack of time that is required to support more complex breastfeeding challenges.

A strong triage and referral pathway was called for from the sector. The success of referral pathways depends on several factors, including communication and awareness of the pathway, but also the level of trust from professionals to use the pathway. There was commonality across the region that historical

“The continuum of care relies on links and collaboration between providers The LMC leads maternity and postnatal care through to around 4–6 weeks. Then, following the transitional period, responsibility for WCTO care is transferred to a WCTO Provider. The general practice team remains the essential health contact throughout this period and beyond, once the child starts school.”

“The quality of care in the first year of life is dependent on this three-part care continuum functioning well. Gaps in this system can break the chain of care, causing crucial assessments and interventions to be missed. This can have serious consequences for the most vulnerable infants (CYMRC 2009).

Excerpt From: MOH. “Well Child Practitioner Handbook.”

circumstances have reduced the level of trust between workforces resulting in a lack of future referrals, it was noted this lack of trust can extend for many years, even through multiple service changes.

Limited workforce capacity was a common theme throughout the consultative process, LMCs and WCTO staff have had to increase their case load to meet increased population demand or financial needs (in the case of LMCs). The increased portfolio of work by providers can impact the quality of care given to women due to time restraints. As a result women may not be receiving the level of breastfeeding support from their LMC/ WCTO provider that is required to protect and promote breastfeeding. It was also noted by the sector that the number of LMC access holders are generally declining across Midlands, this could be due to increased work demands, the lack of financial increases over the past decade for the sector and the ageing workforce.

Breastfeeding challenges are often rapid and need to be addressed in a timely manner to support the continuation of breastfeeding. The sector (and mothers who attended the focus groups) noted that Plunketline and Healthline were available 24/7. Overall the feedback around breastfeeding advice from Plunketline was good, but varied from a mothers perspective. Plunket confirmed that Plunketline staff do receive breastfeeding support training. Mothers that have spent time with the neo-natal unit often call the unit which is available 24/7 for support, however this is not a formal support pathway.

Adequate lactation consultant support for the neo-natal unit and pre-term babies (including late pre-term infants) was identified as a need from the sector. There are more complexities required to be managed in the NICU around breastfeeding initiation and duration, and adequate LC FTE is required to cover this. Many DHBs attempt to spread out an already stretched maternity LC service to extend to the NICU and all other areas of the hospital.

Workforce development was another strong theme that arose during the consultation. Generally, it was noted that there is a good level of breastfeeding workforce development opportunities available, except for more isolated DHBs and health professionals limited by rurality. However, the uptake and application of trainings concerned the sector.

The sector viewpoint was strong in reference to the need for integration between services and 'non-health' sectors such as iwi, councils and schools. This level of collaboration was seen as an essential part of a highly functioning system that influences breastfeeding and other positive maternal and child health and wellbeing outcomes. There were some sector examples where good integration on a systems level (such as accessing the same database) had reduced the number of women who 'fell through the cracks' and were able to receive the care designed to support them.

The early development of health literacy and normalising health language in the community was seen as another foundational aspect in achieving health and wellbeing goals.

Achieving equity for Māori, considering the relatively lower Māori breastfeeding rates was a strong theme in all five DHBs. Many examples were given that Māori do not attend or engage in the universal services provided at the same rate as non-Māori. A very common example was with mainstream antenatal and parenting classes, often funded by the DHB, but have low attendance by Māori and younger mothers.

Kaupapa Māori antenatal classes record a greater attendance by Māori, with each region being aware of the success of the Hapu Wananga programme that is funded by Waikato DHB. A predominant issue with these types of targeted services is often to do with inadequate resourcing and sustainability of funding.

Another key issue around protecting breastfeeding duration for Māori is the lack of a culturally responsive community lactation service and peer support programme in some regions. Mothers who have attended a kaupapa Māori antenatal programme and have decided to breastfeed but encounter breastfeeding challenges often discontinue breastfeeding if there is not an adequate community support system in place. There have been several examples where due to service delivery being reduced or discontinued from a region and therefore the culturally acceptable referral continuum is no longer present, Māori breastfeeding rates declined. Anecdotally, when Māori mothers have been offered an alternative universal service, such as attending a hospital based lactation service they have said they do not want to go to that “paru” place or pay for parking and transport.

### **Expert interviews**

There is a wide range of expertise across the Midland region in this field. From the interviews, phone calls, meetings and correspondence throughout the development of this framework, some key insights were gained and supported some of the service recommendations.

In particular, the insight around Māori experience was gained, regarding the critical loss of traditional breastfeeding knowledge throughout previous generations. The loss of generational breastfeeding knowledge impacts the passing down of practical knowledge and guidance from kuia through to mokopuna, which is a typical knowledge source in Māori culture. Involvement of the three generations is therefore important in protecting and promoting breastfeeding.

A core issue around workforce development of Lead Maternity Carers was raised in regards to the recent changes that the Midwifery Council NZ have made to their mandatory training. Breastfeeding support training has been removed as a mandatory training and is now optional. The rationale for removal of the mandatory status of the training was an attempt to reduce the demand and time pressures that are currently placed on the LMC workload. It was noted that newly trained midwives will continue to have a breastfeeding component within their bachelor degree level training, however this is early in the degree- before to clinical placement.



The experts raised a key issue around the inconsistency of practice around **tongue tie** assessment, diagnosis and treatment around the region. There is greater clinical ambiguity about other tethered oral tissues, such as lip and cheek (buccal) ties, as well as the practice of re-opening wounds post a surgical procedure. This has been a growing concern from the workforce as there has been examples of malpractice by non-regulated health professionals causing harm to the infants involved. There have also been many accounts of a lack of timely and accessible treatment for genuine tongue tie cases. The treatment of tongue tie can vary in degrees of intervention, and clinical best practice guidelines are not currently established in New Zealand. For an example of an established tongue tie pathway, see [Waitemata DHB service](#) pathway (Waitemata DHB , 2017).

A recent Cochrane review around frenotomy for tongue-tie in newborn infants defines tongue-tie, or ankyloglossia, is a condition whereby the lingual frenulum attaches near the tip of the tongue and may be short, tight and thick. The review states that **tongue-tie is present in 4% to 11% of newborns**. Tongue-tie has been cited as a cause of poor breastfeeding and maternal nipple pain. The review investigated whether frenotomy is safe and effective in improving ability to feed orally among infants younger than three months of age with tongue-tie (and problems feeding). Five randomized control trials met the inclusion criteria (n=302). The key findings were; **In an infant with tongue-tie and feeding difficulties, surgical release of the tongue-tie does not consistently improve infant feeding but is likely to improve maternal nipple pain**. The overall quality of evidence was low and further research is needed to clarify and confirm this effect (O'Shea , et al., 2017).

Recently the [International Board of Lactation Consultant Examiners](#) have released an advisory opinion on assessment, diagnosis and referral.

**“The IBCLC certificant neither practices medicine nor diagnoses a disease or disease process unless the certificant is separately licensed or authorised to perform such procedures. An IBCLC certificant does: carefully assess, document findings, and refer appropriately as needed, to obtain a medical diagnosis and possible treatment.”**

(IBLCE, 2017)

## Community consultation

Three focus groups were held to gain insight into the experience of mothers around breastfeeding. The focus groups were guided by using a series of questions (see focus group questions in appendix 1). A focus group in Hawera was set up to gain insight into mothers living at a distance from a secondary hospital, where access to breastfeeding and other support services may be more limited. A second focus group held in the Tauranga school for teen parents provided insight into a vulnerable group of mothers. The third group was held in Tairāwhiti to gain insight into a Māori and geographically isolated mothers. *Below is a summary of the key findings from each consumer focus group.*



Figure 16: Tairāwhiti workforce and mothers

## Teenage mothers focus group

10 mothers participated in the focus group (7 Māori, 3 NZ/European, age range from 13-19 years old), some were currently pregnant others had infants aged two or younger. The focus group was held on 14<sup>th</sup> March 2017.

Key findings from the focus group were that;

- Teenage mothers confirm their pregnancy late in the first or in their second trimester.
- Teenage mothers want to be informed throughout their pregnancy.
- Teenage mothers prefer visual displays of information and information accessible online and through apps. In general, they do not read the Well Child book, bounty book, pamphlets and booklets that are given. They firstly ask family/whanau for advice, followed by 'uncle google'. They always consult the internet first (including Facebook groups) for topics they may consider 'embarrassing'.
- Teenage mothers are a unique group with relatively low literacy of the health and social system. They would like additional support than the standard antenatal and postnatal pathway of care.
- Most teen mothers involved in the focus group stated they decided during their pregnancy that they wanted to try breastfeeding.
- Teen mothers stated they were unprepared for breastfeeding, and received none or very little antenatal breastfeeding education.
- Many teen mothers did not know what an antenatal class is. Māori teen mothers would prefer to go to a Māori antenatal class. Those who had attended only attended 1-2 sessions and were relatively late in their third trimester when they attended (36-38 weeks). Teen mothers did not return to subsequent classes as they did not understand what they were talking about. They also had limited transport (most over 16 year olds were working towards getting their drivers licenses) and would prefer ante natal classes to be held over 1-2 days and tailored in a way that makes sense to them.
- Teen parents are highly influenced by family in their eventual breastfeeding outcomes, stating that putting their baby on the bottle so that whanau can look after them.
- Most teen mothers stopped breastfeeding 'because it was difficult, sore etc.' or due to personal lifestyle related reasons. The majority stopped breastfeeding before 6 weeks. One teen mother mentioned receiving support from her midwife, no teenage mother participants recalled seeing a lactation consultant or other breastfeeding support service.
- Teenage mothers said that they are comfortable to breastfeed around family, but are not supported by partners or their perception of public attitudes to breastfeed in public.

## Hawera mothers focus group

Six mothers participated in the focus group held at the Hawera hospital 16<sup>th</sup> February 2017.

Key findings were;

- Determination was a key word that was used frequently in this focus group. The mothers felt that it was their personal determination that kept breastfeeding going for them.
- Most mothers decided they were going to try to breastfeed during the antenatal period. Three mothers referenced that they made the decision during antenatal classes.
- The attitudes of others can influence the eventual breastfeeding outcome (duration). In particular, this group sighted the influence of the Mother-in-law as being negative, but not necessarily changing their breastfeeding outcome. This group mentioned husbands and partners as being a key person in supporting breastfeeding outcomes and practices, for example one mother stated that her partner did not support her to breastfeed in public. Partner support was said to be due to several reasons namely as it is cost saving and the breastfeeding mother can be a sober driver. Mothers did not state that partner incentives to support breastfeeding were due to the improvements in health for mother and baby.
- Returning to work was sighted as a key reason that breastfeeding was discontinued
  - One mother continued to express milk during work hours when she returned to work. This mother stated that she had to “educate the day care about expressed milk”.
  - One mother reduced her feeds (to morning and night) when returning to work.
  - One mother planned to cease breastfeeding all together when she returns to work next month.
  - One mother resigned from her job so she could continue breastfeeding.
  - Two mothers could take their infant to work with them. One found this difficult and the other found it made breastfeeding easier.
- 5/6 mothers had downloaded and actively used the BreastFedNZ app. They actively shared the app with other mothers. All mothers search online for information and support (e.g. Facebook groups).
- Hawera mothers would like greater access to breastfeeding support services, there is a delay in access because they live rurally (less provision than in New Plymouth).
- All six mothers were interested in the peer support service and would have used it if they had known about it. They suggested including it in the bounty pack information.
- All mothers thought that general awareness around breastfeeding and support services that are offered needed to be better promoted.
- Access to tongue tie release services was raised as a local issue by two mothers. They both travelled outside of the district to receive release services (Palmerston North and Hamilton). These were provided by a dentist. The mothers sighted ‘a long waiting list’ as to why they travelled outside of the district.

“I really like it when my husband encourages me. He said ‘well done honey, for keeping on breastfeeding’ it made me feel so good.”

-Hawera focus group participant

“Because I am back to work, the whole Breastfeeding thing has changed, I just feed morning and night. I am ok with it. My husband is being laid off and I have to work. I am fortunate cause he will take a bottle. Expressing is another thing, I sit here for an hour and get 50mL.”

- Hawera focus group participant

## Tairawhiti mothers focus group

Mothers participated in the focus group held at Hauora Tairawhiti on the 6<sup>th</sup> April 2017. Mothers were recruited through being past service users of the community lactation service, Hauora Tairawhiti or Hauiti Hauora.

Key findings were;

- This group shared some deeply personal experiences around their recent experiences with breastfeeding, birth and interactions with health professional throughout this time. A common theme between these stories is the depersonalisation of messages and care they received.
- Each of the eight mothers had an experience with tongue and lip tie assessment and treatment.
  - o Recent experiences have resulted in travelling outside of the district (to Hamilton or Auckland) to have the treatment performed due to lack of grade 3 or 4 frenotomy services.
  - o Timeliness of assessment was considered an issue; the waiting is painful and distressing. For one mother this delay resulted in introducing formula and is now mixed feeding.
- Mothers in this group were in agreeance that while pregnant they had perceived breastfeeding as an easy thing that just happens naturally, they were disappointed and aggrieved when in the early days it hurt and was not 'easy', rather a skill that needed to be learnt and required support from whanau, LMC and in some cases a LC.
- The mothers discussed their experiences as inpatients at the maternity ward, they noted that each midwife had different ways of 'doing it' and received mixed messages which they had to decipher as they went along.
- Mothers felt they had pressure to leave the maternity units (from staff), even though they were not confident with breastfeeding
- Mothers were grateful to be shown how to express colostrum
- The way messages are delivered by health professionals were often perceived as judgemental and condescending by mothers
  - o In particular, when approaching conversations around formula
  - o Comments that 'it shouldn't hurt' from health professional's vs whanau said 'it does hurt but it will subside'
  - o Mothers do not like it when the LMC 'shoves the baby on your breast' this may be quicker for the LMC, but does not support the mother around learning how to breastfeed
  - o Messages around co-sleeping were conveyed in a way that made mothers feel guilty
  - o Everyone is tired an exhausted with a new pepi and 'you are told to persevere but not given support'
  - o Some mothers always felt like they 'were being told what you should do' 'felt blamed' and 'feel like a bad young mum'
- Mothers felt that in general when information is provided by an LMC it is helpful,
- Timeliness of onward referral to LC services from a LMC was considered crucially important to maintaining breastfeeding
- Breastfeeding in public was considered fine with this group 'Gisborne is a good place to feed, the community is ok with it'
- Mothers were not sure how to look after themselves when breastfeeding; stress, eating, hydration
- Mothers find it hard and awkward to complain about health professionals and their negative experiences
- Mothers want to have a voice in developing services 'ask us', 'talk to us' and work on the strengths that the workforce does have

# Midland Breastfeeding Framework

This section provides the key components of a breastfeeding service that is required to be provided simultaneously to increase breastfeeding rates. The views of the sector and mothers alongside best practice evidence has been used to build the key components of the full framework. The framework has been designed to be suitable in the New Zealand context, with a targeted approach to reduce disparities in breastfeeding outcomes of Māori.

Figure 13 provides a visual overview of the integration of services and initiatives. The diagram displays the layers of services and initiatives required to positively influence population breastfeeding outcomes- namely breastfeeding according to Ministry of Health guidelines.

The diagram shows an encompassing arrow with key themes that need to be considered in all the components of the framework. This diagram shows the macro level components of the framework; the mother/infant dyad should be at the heart of all service design.

Each component is likely to influence either of the two main components of breastfeeding outcomes; initiation and duration. This further emphasises the need to plan and fund the whole system of services and initiatives.

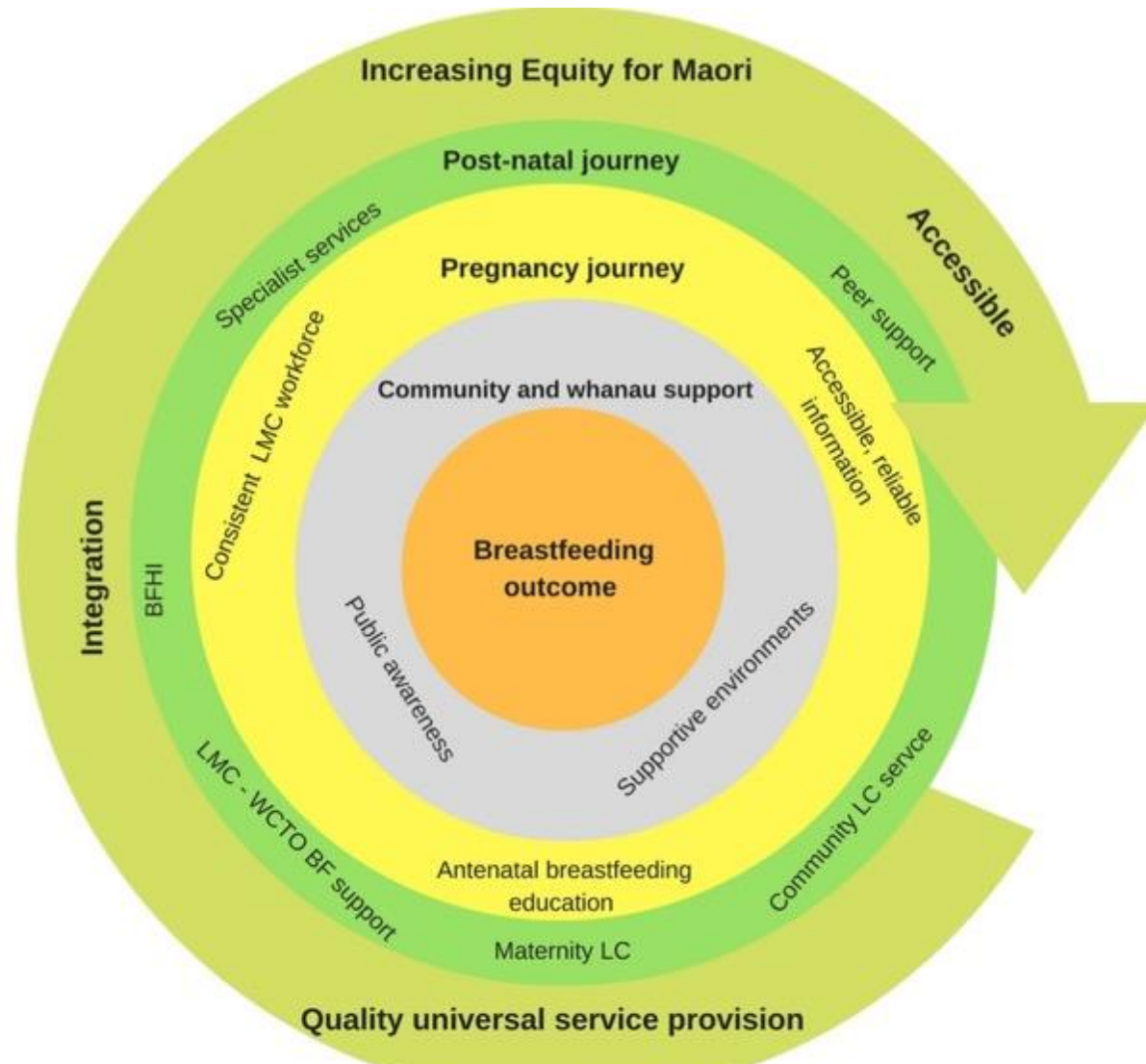


Figure 17: Midland Breastfeeding Framework overview



The following section outlines the evidence behind each of the components in the framework and highlights local examples where relevant. Reference to 'the midland sector' is the consideration of the view point gained through the people involved in the consultation.

## Community and Whanau Support

Analysis of the findings from New Zealand and international research revealed that almost all modifiable influences on breastfeeding could be categorised into these three key types of support: tangible, emotional, informational (Quigley and Watts, 2007). Support needs could be further categorised according to a mother's stage of breastfeeding (see figure 4), and the settings or systems which could potentially provide additional support for example, the health system, family/whānau systems and community/workplace systems (Quigley and Watts, 2007).

This conceptualisation of the three dimensions of support listed above (tangible, emotional, informational) fits with Te Whare Tapa Wha (see Figure 14). An environmental focus is also consistent with the Ottawa Charter's emphasis on creating supportive environments for health (WHO, 1986).

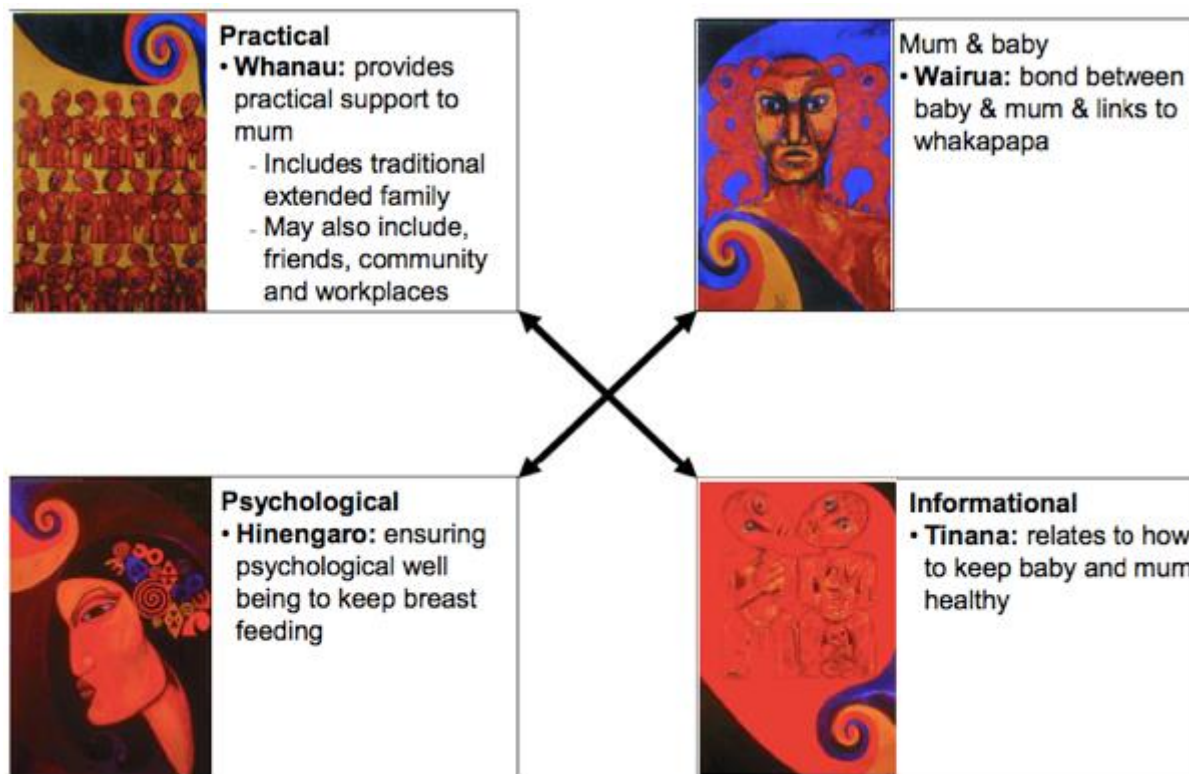


Figure 18: Breastfeeding and Te Whare Tapa Wha as sited in (Quigley and Watts, Ministry of Health, 2007) The pictures depicted were painted by Robyn Kahukiwa

## Public health initiatives

The 2016 Lancet series on breastfeeding recommended social mobilisation and mass media as having an impact on breastfeeding initiation rates. The Oxford dictionary defines social mobilisation as *“the process by which individuals or sections of society mobilise to effect social change.”* Mass media is the plural noun for media and can be defined as *“The main means of mass communication (broadcasting, publishing, and the Internet) regarded collectively.”*

In 2007, the Ministry of Health released a comprehensive plan to inform the design of a national breastfeeding promotion campaign. The plan recommended that the following key messages were used across a wide range of audiences (Quigley and Watts, 2007) .

- breastfeeding is natural and normal
- breastfeeding is important for baby’s (and mother’s) wellbeing
- it is everyone’s responsibility to support a mother to breastfeed, especially partners/family/whānau and peers/other mothers
- a realistic image of breastfeeding as a learned skill with common problems and solutions should be presented.

The public health discipline of health promotion is a useful overarching framework that offers several tools for behavioural and social change, at individual, community, environmental, health system and societal levels. Health promotion is the process of enabling people to increase control over and improve their health (World Health Organization , 1986). Health promotion is underpinned by the acknowledgement that the determinants of health are often not directly within the control of an individual, and therefore it takes efforts at community, organisational and societal levels to enable people to improve their health (Quigley and Watts, 2007).

It can be tempting to focus efforts to promote health on individual behaviour change; however, this often overlooks the determinants of these individual behaviours. Just as social marketing is more than advertising; health promotion is more than health education. A conscious focus on those who are most disadvantaged or marginalised is fundamental to health promotion. It is important to avoid reinforcing inequalities in health by affecting only those who are already advantaged (Quigley and Watts, 2007).





The WHO has noted that social marketing campaigns to improve breastfeeding are more likely to be successful if:

- women perceive the messages as being beneficial, feasible and socially acceptable
- messages are targeted towards the breastfeeding mother, her family, health providers and community in which they interact
- attitudes of the target audience are identified to ensure messages are appropriate
- barriers to the behaviour change are identified and influenced

Television campaigns have led to improved attitudes towards breastfeeding where newspaper advertisements were not effective. Locally developed media campaigns are likely to increase initiation across all groups of mothers, especially if used in conjunction with a local clinical programme. (National Breastfeeding Advisory Committee, 2008)

## Breastfeeding supportive environments

*Likely to have the greatest effect on the improving the duration of breastfeeding.*

### What the evidence says:

Social marketing campaigns for increasing local businesses and services to develop a supportive environment for breastfeeding have been shown to be effective when personal engagement of businesses is used (face to face visits, promotional stickers and inclusion in list of breastfeeding friendly services). There is no published evidence about the effectiveness of a 'national breastfeeding week' Given other evidence, it is expected that the impact would vary depending on how it was promoted and whether it was run in conjunction with other awareness, attitude-influencing and support campaigns (National Breastfeeding Advisory Committee, 2008)

Workplaces and early childcare centres are key settings that can influence breastfeeding outcomes. A woman's return to work can negatively influence the duration of exclusive breastfeeding, particularly if the mother returns to work within six months postpartum. Exclusive breastfeeding can become more complicated, particularly if the mother is separated from her infant and there are constraints on the mother's time while she is at work.

The National Breastfeeding Advisory Committee 2008 report states that there are three dimensions to this relationship:

By law, as far as is reasonable, employers are required to:

- Give women unpaid breaks to breastfeed their baby or express milk at work
- Provide women with facilities to do this.

*Under the Human Rights Act, it is illegal for someone to stop women breastfeeding in public.*

- Timing of return to paid employment: early return to work makes it more difficult for a woman to continue to breastfeed and statistics indicate that significant drop-offs in breastfeeding rates occur at 11-15 weeks<sup>2</sup> (when women return to work following the lapse of paid maternity leave);
- Pattern of work hours: many women find part-time work more conducive to continuing to exclusively breastfeed than full-time employment (especially if there are limited supports within the workplace);
- Nature and status of the work: women who return to employment for a career have more control over breastfeeding continuation whereas women who return to work for economic reasons generally have more limited control over their working environment

### **What the Midland sector says:**

The Midland stakeholders and mothers raised the importance of the broader environment and settings in influencing their eventual breastfeeding outcome. Notably, mothers raised that workplaces and childcare centres can have an impact on continued breastfeeding. Working mothers who attended the focus groups had mixed levels of support for breastfeeding after returning to work. This variation may have been directly from the employment conditions, or from the mother's decision to continue to feed after returning to work. Longer duration of paid parental leave was considered by mothers to have a possible greater effect on breastfeeding duration than supportive workplace settings based changes alone.

Many regions across New Zealand offer variations of a breastfeeding friendly public health initiative (see workforce stocktake section of this report for Midland initiatives- table 3). The existing initiatives in the Midland region have been set up and implemented by the public health units.

There is also a national 'Breastfeeding Welcome' sticker available from the Women's Health Action in Te reo Māori and English available. Information about breastfeeding in the workplace is offered <http://www.bfw.org.nz/>.

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<sup>2</sup> Note that paid parental leave in NZ has increased to 18 weeks since the 2008 report was published

### Spotlight on: Breastfeeding Friendly Spaces- Toi Te Ora Public Health Service, serving the Lakes and BOP DHB

**Short Description:** Breastfeeding Friendly Spaces accreditation is an initiative that creates and sustains breastfeeding friendly environments with the aim of normalising breastfeeding within our communities. Toi Te Ora's breastfeeding friendly team work with a number of settings including cafes, libraries, early childhood education services (ECE's) and health providers to help develop breastfeeding policies, encourage staff training, provide breastfeeding signage and encourage provision of comfortable spaces for mothers to breastfeed. The hope is that both customers and staff of a Breastfeeding Friendly accredited space can be reassured to know they will be supported to breastfeed. Since the project began in July 2011, over 240 spaces throughout the Bay of Plenty and Lakes districts have created breastfeeding friendly environments, and achieved Breastfeeding Friendly accreditation.



**Target audience:** Businesses, cafes, libraries, retailers early childhood education services (ECE's) and health providers in the Bay of Plenty and Lakes District. The secondary audience is the mothers who work or visit these spaces. We prioritise spaces in or frequented by mothers from low socio-economic backgrounds.

**Funding and costs:** The Ministry of Health funds Toi Te Ora. There is approximately 1.0FTE in total supporting this initiative and approximately \$1,800 which includes frames, resources, bottle labels, signage and two breastfeeding friendly updates/newsletters each year. The budget for 2017-18 will be \$1,400; which is lower than the current one due to cheaper newsletter costs via BOPDHB Design & Print.

**Evaluation:** Overall, feedback from the 2014 BFF evaluation shows the project is sustaining supportive breastfeeding environments for mothers and their families. Moreover, at the 2015 Well Child Day on 9th October women who had children under five were approached and asked to complete a survey. Mothers who participated in the survey were able to identify a range of accredited spaces where breastfeeding friendly signage had been sighted. This confirmed that breastfeeding signage is achieving the intended purpose of increasing the visibility of breastfeeding friendly spaces. Mothers also identified the current range of spaces the breastfeeding project is already covering wing that current targeting criteria are in line with the expectations of members of the community.

**Weblink:** [http://www.ttophs.govt.nz/breastfeeding\\_friendly](http://www.ttophs.govt.nz/breastfeeding_friendly)

### Public Health Initiatives checklist:

1. A breastfeeding friendly environments project that covers multiple settings including public places, workplaces and early childhood centers should be designed and implemented locally. Public Health FTE would need to be designated to the recruitment, training and auditing of the spaces achieving accreditation. Existing packages and resources should be shared between DHBs to reduce duplication
2. The project plan is to be guided by fundamental health promotion principles (e.g. Ottawa Charter, Pae Ora, Te whare tapa wha) and be adapted according to a health equity lens, such as the HEAT tool analysis for equity
3. The project should be regularly monitored and evaluated for effectiveness, and improvements made thereafter
4. Campaigns should be co-designed with the target audience (eg. Maori) and use mediums that are relevant to young mothers today (eg. social media)

## Breastfeeding Information

*Likely to have the greatest effect on the initiation of breastfeeding.*

### What the evidence says:

A [Cochrane review](#) on interventions for promoting initiation of breastfeeding looked at 28 trials involving 107,362 women in seven countries (Balogun, et al., 2016). The researchers concluded that health education delivered by doctors and nurses and counselling and peer support by trained volunteers improved the number of women who began breastfeeding their babies.

High quality breastfeeding information should be offered at as many touch points as possible throughout the antenatal period. Information should be non-invasive, highly visual and utilise technology.

### What the Midland sector says:

Both front line service providers and mothers agree that harnessing technology is the preferred way of messaging for this generation of mothers. The teen parents interviewed particularly stressed the importance of having highly visual and technology based sources of information. However, all mothers still valued face-to-face support for breastfeeding challenges.

The midland breastfeeding sector highlighted that information around breastfeeding should start very early in life, normalising breastfeeding in childhood, through teenage years (including within sexuality and health education in schools), into young adulthood and right through to grandparents.

It is important that any breastfeeding messages that are distributed, either from a health care professional, such as an LMC through to promotional material convey a realistic image of breastfeeding. Many of the mothers who shared their experiences in the development of this framework shared that their disappointments when their expectations of breastfeeding versus their actual experience of breastfeeding in the early stages did not match.

*“We need to start early- this generation of mothers require more information today than generations before.”*

- Workforce focus group participant





### **Spotlight on: BreastFedNZ app**

**Short Description:** A free smart-phone app providing breastfeeding help, information and support when it's needed. The app fills the void which exists in electronic access to reassurance and support during vulnerable times, like the middle of the night when the baby is crying and won't settle. The app supplements, and does not seek to replace, other forms of breastfeeding support.

#### **Target audience:**

Midland women who are either pregnant or have become mothers and want to breastfeed. Dads/partners, family/whanau, health care providers, and others who are wanting to support women with breastfeeding.

#### **Funding and costs:**

Regionally held Maternity Quality & Safety Programme national funding administered by the Midland Maternity Action Group. Approximately \$30,000 to develop and implement (excluding project manager support).

#### **Available:**

GooglePlay and iTunes stores [www.breastfednz.co.nz](http://www.breastfednz.co.nz) Facebook: BreastFed NZ

## Antenatal breastfeeding education

*Likely to have the greatest effect on the initiation of breastfeeding.*

### What the evidence says:

Antenatal Breastfeeding education is teaching women about Breastfeeding during pregnancy, before the baby arrives. One reason women are unable to breastfeed has to do with lack of education and knowledge about how to breastfeed (Lumbiganon, et al., 2016). A [Cochrane review](#) was published in December 2016 to collate the evidence around antenatal breastfeeding education and breastfeeding duration and included 24 randomised controlled studies (with 10,056 women) and a further 20 studies (9789 women) contributed to data for the analyses.

The authors concluded that there was no conclusive evidence supporting any antenatal Breastfeeding education for improving initiation of breastfeeding, proportion of women giving any breastfeeding or exclusively breastfeeding at three or six months or the duration of breastfeeding.

However the results of studies for antenatal breastfeeding education when combined with other forms of breastfeeding support offered more positive results. This further enforces the need to offer high quality antenatal breastfeeding education alongside a suite of breastfeeding support initiatives and services. The funding and service delivery of antenatal breastfeeding education in isolation is likely to have little effect on breastfeeding rates.

**There is support, from NZ based studies for provision of services that support Māori breastfeeding supported that services would be more effective if they were provided 'by Māori for Māori' and included traditional Māori birthing and breastfeeding concepts (Glover, Manaena-Biddle, Waldon, & Cunningham, 2008).**

### Spotlight on: HAPU WANANGA- Waikato

Hapu Wananga is a two-day antenatal and parenting programme developed by Waikato DHB's Te Puna Oranga (Māori Health) team which uses a kaupapa Māori approach. The principles of the Treaty of Waitangi are pivotal to the delivery of Hapu Wananga. Wāhine are empowered and protected through knowledge and guidance, partnership is encouraged with other organisations and with the wāhine and whanau, and most important the classes promote participation through activities and group work as opposed to just information.

All participants receive a baby starter pack which includes a pēpi-pod safe sleep bassinet and other products related to pregnancy and birth. Hapu Wananga provides all meals for participants and can offer support for transport if needed.

**Target audience:** Young Māori pregnant women and their partners or support whanau.

**FTE and Funding:** WDHB fund the service at \$200 per woman. All Wananga are at full capacity (20 woman) and booked up in advance. The service is run at full capacity by a child birth educator and a facilitator.

**Referrals:** are received from midwives. There is an active Facebook page that advertises the service and provides ongoing support. Approximately 70% of woman are Māori.

**Impact on Breastfeeding:** At the completion of the course 100% of woman in attendance state they intend to breastfeed. However, in the absence of a designated community lactation service, onward appropriate service referral (face to face, home visits or drop in clinics in a kaupapa Māori based location) breastfeeding rates are not maintained at 6 weeks.

### What the Midland Sector says:

The midland sector called for protection of antenatal breastfeeding education, as a part of broader antenatal education. Greater protection includes adequate and ongoing funding. Existing antenatal classes should increase the amount of breastfeeding education currently offered. Classes should be offered at different frequencies, locations, durations and offer targeted kaupapa Māori programs. A specific antenatal education program, designed for teenage mothers could be considered in highly populated regions. An option for mothers in subsequent pregnancies such as a 'breastfeeding booster session' could support breastfeeding for these infants.

#### Antenatal education program checklist

1. Universal breastfeeding education within antenatal classes
  - a. Web and technology based information
  - b. Face to face as a part of accessible antenatal education classes (delivered by trained child birth educator)
  - c. A variety of evening and weekend classes available
  - d. Integrated with ongoing support services (LMC, WCTO, maternity and community LC's)
  - e. Evaluation and follow up around breastfeeding outcomes
2. Kaupapa Māori antenatal program
  - a. Delivered face to face by Māori qualified child birth educator (IBCLC or breastfeeding advocate to provide breastfeeding elements)
  - b. Needs to be visual
  - c. Adaptable
  - d. Practical
  - e. Accessible (run over 1-2 days)
  - f. Free (and food/ transport options provided)
  - g. Whanau friendly
  - h. Integrated with ongoing support services (LMC, WCTO, maternity and community LC's)
  - i. The programme is evaluated and offers ongoing follow up with participants
  - j. Has designated administration support
  - k. Utilises social media to interact with potential and past participants
  - l. Is sustainably and well resourced



## Breastfeeding Peer Support

*Likely to have the greatest effect on improving the duration of breastfeeding.*

### What the evidence says:

Breastfeeding peer supporters can provide the psychological and emotional support required to continue breastfeeding. Peer support can be defined as ‘a specific type of social support that incorporates informational, appraisal (feedback) and emotional assistance’ (Curtis, Woodhill, & Stapleton, 2007). This assistance is provided by volunteers who are not part of the participant’s family or immediate social network; instead they possess experiential knowledge of the targeted behaviour (i.e. successful breastfeeding skills) and similar characteristics (e.g., age, socio-economic status, cultural back-ground, location of residence).

There are many different models of peer counselling or peer support. Some begin pre-natally with others being initiated during the postpartum period. Some programmes require the mother to initiate contact, whereas other programmes provide visits to all mothers to determine the level of support required (National Breastfeeding Advisory Committee, 2008). Peer supporters can be a paid and voluntary workforce, ideally mothers should be paid for their work. However, voluntary peer support programmes have been successful worldwide in the past. The scope of the role will need to match the paid/unpaid nature of the position held.

***Strategies that rely mainly on face-to-face support are more likely to succeed with women practicing exclusive breastfeeding.***

The UK based National Institute of Clinical Excellence (NICE) reviewed evidence to create a guideline There is strong evidence to support peer counselling as a mechanism to promote breastfeeding duration, especially when skilled peer counsellors are used (NICE 2005).

Peer support programmes are recognised by the United Kingdom’s Department of Health (DH) and NICE (National Institute of Clinical Excellence) as being one part of a multi-component programmed aimed at increasing breastfeeding rates.

An evaluation of 26 Department of Health (UK) funded breastfeeding peer support projects emphasised the importance of peer support in giving positive role models and in enabling the shifting of local cultural norms around breastfeeding (Dykes, 2005). This work also identified a series of steps, necessary to implement successful peer support schemes. These included:

*“Peer support is recognised as an important and effective method of supporting breastfeeding women, as part of a wider breastfeeding strategy within a co-ordinated programme of interventions (NICE, 2008b). This necessitates partnership working between a range of statutory, voluntary and community services. Peer support is particularly recognised as important in socially deprived communities and in places where breastfeeding is not culturally accepted (Dykes, 2005).”*



- Having an in-depth understanding of the local culture before setting up groups (including exploring local beliefs about infant feeding, identifier key influencers on infant feeding practices and understanding constraints on women initiating and continuing with breastfeeding).
- Building on existing infrastructure (to learn from previous experiences and avoid reproducing either successes or failures).
- A comprehensive planning period involving all key stakeholders including, if appropriate, community and religious leaders. The avoidance of reliance on one key coordinator was emphasised.
- Engaging peer supporters, with clear processes for recruitment, selection, training and support.
- Managing the interface between peer supporters and professionals, important to have good relationships between the two groups and to ensure that women are referred to peer support. Concurrent training of health professionals is recognised as important.
- Marketing of the peer support programme for it to be acceptable in the community and to maximise uptake. The use of a brand name was considered effective and the marketing important at all levels including key stakeholders and health professionals.
- Having a supportive infrastructure, including having multiple access points to peer support such as a range of places in which drop-in peer support is available, including postnatal wards and antenatal clinics. Peer support was most successful when linked to other activities such as baby clinics. Other aspects of infrastructure include having a telephone and home visit system, paying peer supporters expenses and offering support with childcare.

In New Zealand, the La Leche League provides access to a Breastfeeding Peer Counsellor Programme. The programme provides women with training and resources to offer skilled and knowledgeable help to other mothers (their peers). <http://www.pcp.org.nz/>

### **What the Midland Sector says:**

The focus groups held with mothers emphasised that there is a communication disconnect between breastfeeding being 'natural' and breastfeeding coming 'naturally' to a mother. Breastfeeding is a learnt process that often requires guidance from experienced peers or in some cases a relevant health care professional.

There has been a history of peer support training that has been offered across the Midland region in the past. The key issues have been around insufficient support for administration of a peer support programme (managing the volunteers, setting up training and ongoing support). La Leche League training has been seen as expensive and the Midland sector would favour a Midland developed training to be offered locally, at frequent intervals throughout the year. Peer supporters are often a mix of paid and an unpaid volunteer workforce. Due to the nature of a volunteer workforce, turnover should be expected. This should be supported by regularly training new volunteers.

A peer support programme needs to be embedded in a wider community lactation service, with sufficient referral pathways. Alternatively broadening the scope of a paid support workforce such as kaiawhina/karitane by providing peer support training and scheduled visits to protect breastfeeding by anticipating and preventing challenges is an avenue that one DHB in Midlands is investigating. Scheduled visits should occur in critical breastfeeding stages where extra support or encouragement may be well received by the mother, such as day 3, day 10, 6 weeks etc. Paid peer supporter roles may need to be considered to support scheduled visits.

Peer supporters need to reflect the demographics of the birthing population they live within. This requires the recruitment and training of a diverse population of peer supporters, including age and ethnicity. A particular focus should be placed on recruiting Maori peer supporters in consideration of low Maori breastfeeding rates.

### **Spotlight on: Tiaki Ūkaipō - Breastfeeding Peer Support service: Tui Ora (Taranaki)**

**Short Description:** Tiaki Ūkaipō Community Breastfeeding Support Service provides both Lactation Consultant (IBCLC) and trained volunteer peer support to mothers, babies and whanau throughout Taranaki. Peer Supporters are trained using the LLLNZ Peer Counsellor Programme (PCP) curriculum, and resourced with Mama Aroha Talk Cards and relevant LLLNZ information sheets. There is also on-going education provided for the peer supporters. This service provides clinics in several geographical locations, home visits, telephone, text and/or email support as needed. Referrals are received from LMC midwives, Plunket or Tamariki Ora Nurses, other Lactation Consultants (e.g. hospital based), or any other health professional working with the mother and baby. Women or family members can also self-refer. There is no age limit for the baby, therefore they work with families with babies from newborn right through to toddlers. This service also provides breastfeeding education in the community through antenatal education and for a variety of health care professionals in training. This service also coordinates the Taranaki Baby Friendly Community Initiative (BFCI) grouping, which includes Tui Ora, Taranaki Plunket and Taranaki La Leche League group.



**Target audience:** Maori women, young women under 20 years, rurally and socially isolated mothers or those with difficulty accessing services (e.g. transport challenges).

**Funding and costs:** Taranaki District Health Board fund this service. BFCI funding is via Ministry of Health contract. Currently we have 1.2 FTE Lactation Consultants and 0.1 FTE Leadership role.

**Evaluation:** Breastfeeding outcomes from this programme are statistically higher than for the overall population that access Well Child services, although still often below the Ministry of Health targets, particularly for the under 6 week parameter. This programme had initial evaluation undertaken from 2012-2015, with a report supplied by Whakauae. Some changes were made based on this report, including additional resources and formal Lactation Consultant clinics and visits. Internal evaluation is ongoing.

**Website:** <http://www.tuiora.co.nz/Services/Taitamariki/Breastfeeding-Community-Support-Service,-Tiaki-Ukaipo>

## Peer Support Service Checklist

1. The peer support service is a partner service alongside a community lactation service
2. Peer support is offered in multiple access points, in a range of places for drop-in peer support, including antenatal and postnatal clinics
3. Paid peer support service administrator role
  - a. Arranges trainings (an IBLC would deliver any technical content)
  - b. Manages peer support database
  - c. Organises drop in clinics
  - d. Manages Facebook page and other communication mediums (text/phone/direct messages)
  - e. Manages scheduled visits for (paid peer supporters)
  - f. Supports recruitment of peer supporters
  - g. Builds and maintains relationships with key partners (LMC's, LC's, GPs, antenatal programmes, iwi health services, WCTO providers, maternity)
  - h. Supports the advertising and marketing of the peer support service
  - i. Manages programme evaluation
  - j. Manages qualification recognition of the training
4. Peer support training
  - a. Ideally the training is recognised by a recognised NZ qualification standard (NZQA credits) or use LLLNZ PCP training
  - b. Trainings can be run over 2 full days or as preferred by the group (approximately 20 hours total of face-to-face and self-directed learning minimum)
  - c. Group based trainings are more cost effective than one-to-one trainings
  - d. Training to be provided at a low cost per peer supporter trained (no charge to a volunteer to be trained)
  - e. Childcare should be considered for voluntary mothers to attend
  - f. Clinical training content should be developed with input from a Nurse or Midwife with an IBCLC qualification
  - g. Training should offer the use of a visual communication tool (such as the Mama Aroha Talk Cards and the BreastFedNZ app) and be led by a good quality educator
5. Peer supporters
  - a. The peer support workforce should represent the diversity of the population they live in; age, ethnicity etc.
  - b. Peer supporters should attend an annual refresher
  - c. Each trained peer supporter should have access to resources, (such as Mama Aroha talk cards and BreastFedNZ app) and other visual resources
  - d. Should contribute towards evaluation and reporting processes
  - e. Should confidently understand where their role fits within a wider breastfeeding support service
  - f. Should be reimbursed for expenses related to the provision of appropriate services (e.g. travel costs if home visits are required)
  - g. Paid peer supporters can provide scheduled visits, drop in clinics, maternity units and complete referrals with the community and secondary lactation consultant services
  - h. Be supervised and mentored up to one year following completion of the train

## Community Lactation Service

*Likely to have the greatest effect on the improving the duration of breastfeeding.*

### What the evidence says:

A [Cochrane review](#) showed that when breastfeeding support is offered to women, the duration and exclusivity of breastfeeding is increased. Characteristics of effective breastfeeding support include support that;

- is offered as standard by trained personnel during antenatal or postnatal care,
- includes ongoing scheduled visits so that women can predict when support will be available,
- is tailored to the setting and the needs of the population group.
- is offered either by professional or lay/peer supporters, or a combination of both.

The review noted that lay support and more contact in the form of scheduled visits (4 to 8 visits) were also associated with greater treatment effects (McFadden, et al., 2017)

### What the Midland Sector says:

In New Zealand, the first point of call for breastfeeding support is initially from a mothers Lead Maternity Carer and then their Well Child Tamariki Ora provider. However in more complex cases, or due to a lack of confidence or time available from the LMC or WCTO, additional support may be required to protect breastfeeding outcomes. A community lactation service can provide an optimal fit for mothers in these situations.

The Midland sector and consumers both note that access to timely support is important to protect the continuation and duration of breastfeeding. The sector and mothers both raised the importance of face to face support to actively assess and manage breastfeeding challenges.

Infants who have been discharges from Neo-natal specialist care, and late pre term infants (who may have not been in the NICU) may require additional support for breastfeeding after discharge. The community LC service should be integrated to support these mothers and their infants to continue or adequately establish breastfeeding.

“LMCs should refer first time Māori mums to a Māori community LC antenatally. This will provide an opportunity to talk about breastfeeding culture in their whanau and establish whakawhanaungatanga early – establishing relationships. Even though there are challenges, they have more desire to breastfeed.”

- *Workforce focus group participant*

The existing community lactation services (see workforce stocktake) in the Midland region have noted that the demand is greater than supply for their service. International Board Certified Lactation Consultants can provide support for mothers with complex breastfeeding challenges as well as mothers who need lower levels of support and encouragement. The latter case load can be supported by a high quality peer support programme or a second tier of breastfeeding support.

A community lactation consultant is also in a good position to upskill primary healthcare workers when they encounter patients with breastfeeding challenges. By incorporating with the primary practitioner, the IBCLC can provide a reasonable resolution of the breastfeeding issue then hand back the mother to the primary health care professional. This both upsills the primary health care professional and maintains the primary relationship.

The biggest barriers that these services face have been raised around the themes of sustainability (of funding, staff and resources), integration with other services and trust from potential referrers. One DHB region attributes a measurable drop in breastfeeding rates when a well functioning community and peer support lactation service was retracted due to funding changes. This is a local example of a negative outcome if breastfeeding services are not adequately prioritised in funding and resourcing.

A community lactation service from the Midland DHB region shared their recorded success rate, with 80% of mothers seen by the community lactation service recorded 'any breastfeeding' after seeing the lactation consultant. Mothers using this service require support from a LC over 8 weeks, including an average of 2-5 visits plus phone conversations.



**Kia Wana**  
BREASTFEEDING SERVICES





Kia Wana offers specialist breastfeeding services from qualified lactation consultants (IBCLC). We can provide one to one breastfeeding support for all women and babies in the Lakes region.

**WHAT DO WE PROVIDE?**

- Weekly Walk-in Drop-in Clinics
- Phone and text support
- Home visits if required
- Weekly Breastfeeding Clinics
- Resources - We aim to provide all necessary equipment needed to continue breastfeeding
- We provide an integrated approach with other services including support to stop smoking.

*ANYONE at ANY age can use our service  
Talk to your Midwife or Well Child nurse for a referral or  
CALL 0800 LAKES BABY (0800 525 372)*

**WHAT HAPPENS AT A VISIT?**

- We listen and take a detailed history
- We observe baby feeding and do a full breastfeeding assessment
- Together we work out solutions and develop a plan for you and baby.
- We can contact your midwife, well child nurse or doctor.

*Children, partners, whanau are all welcome too.*

**WEEKLY DROP IN CLINICS:**

**ROTORUA**  
TUES: 10-12PM @ Kia Pulawai Whare, 1 Brooklyn St, Western Heights  
THURS: 10-12PM @ Ngati Pikiiao, 1274 Fenton St, Rotorua

**TAUPO/TURANGI**  
MON: 10-12PM @ Awahi House, 17 Paekiri St, Turangi  
FRI: 10-12PM @ Wairoa House, 129 Spa Rd, Taupo

**FREE BREASTFEEDING SUPPORT CALL NOW 0800 LAKES BABY 0800 525 372**

**ROTORUA**  
Amy Wray  
BM, IBCLC

**TAUPO/TURANGI**  
Chelsie Robertson  
RM, IBCLC



There are quality and performance standard related advantages of a community lactation service to be delivered by an International Board Certified Lactation Consultant (IBCLC) who also belongs to a New Zealand Health professional regulatory body (such as a qualified midwife or nurse). Due to the underlying qualifications, the scope of practice of the community lactation consultant can be wider than an isolated IBCLC qualification. The paired qualification (e.g. Midwife and IBCLC) would be considered the optimal qualification background for the Lactation Consultants working in a DHB funded community lactation service, the minimum would be an IBCLC who has continued professional development and robust performance management.

*As breastfeeding is never in isolation, smoke free, safe sleeping, risk assessment and other health assessments need to go into each contact, dual qualifications (IBCLC + nurse/midwife) equips the community lactation consultant to perform holistic assessments.*

### **Spotlight on: Kia Wana Community Breastfeeding Service: Lakes DHB**

The Kia Wana Breastfeeding Service started in April 2016. There have been approximately 650 referrals to the service, an average of 50 referrals per month. These referrals range from complex breastfeeding problems, consultations with health professionals developing breastfeeding plans for women in their care, and women seeking advice and reassurance. In 2015 there were 1519 births in the Lakes DHB region, based on this approximately 40% of Lakes mothers have been referred to the service.



*Kia Wana's vision is to empower all women to breastfeed their babies by reconnecting whanau across the generations to breastfeeding knowledge and support.*

The breastfeeding service came about as part of a project to reduce the rates of Sudden Unexpected Death in Infancy (SUDI). Breastfeeding is one of the protective factors for reducing SUDI, as are Smokefree Pregnancy and Safe Sleep services. The service is designed so it can wrap around the needs of the women rather than they wrap around us. We provide all forms of breastfeeding support within the community setting as well as integrating closely with the hospital setting and do our best to provide individualised care that is flexible and adaptable.

**Target audience:** The main focus of the community breastfeeding service is to increase breastfeeding rates in the following target populations; Maori, Pacific and women living in low socioeconomic areas. Statistics show that breastfeeding rates for these groups are significantly lower than for non-Maori and women living in higher socioeconomic areas. The highest rate of referrals are from LMC/midwives, followed by Plunket/WCTO, and thirdly, by self referral via the 0800 Lakes Baby number and drop-in clinics.

**Funding and costs:** The breastfeeding service is funded by Lakes District Health Board. There are approximately 2FTE Lactation Consultants (three people) in the service across the district (Rotorua, Taupo and Turangi).

**Evaluation:** There has not been any national breastfeeding data available for the last two quarters, so it is not been possible to establish the impact on breastfeeding outcomes, however a significant percentage of all babies born in Lakes are referred to the breastfeeding service, so many women are receiving breastfeeding support. Prior to the Kia Wana breastfeeding service starting, the only specialist lactation support available was part time in the Rotorua Maternity unit.

### Community Lactation Service checklist:

1. Has a well publicised and integrated referral pathway.
2. Utilises social media to advertise and connect with potential and past service users
3. Is delivered by IBCLC's who maintain their accreditation and belongs to a health professional regulatory body (where relevant)
4. Provides clinical expertise and support to health professionals to support mothers to overcome breastfeeding challenges
5. Is integrated with antenatal classes, LMCs, WCTO and peer support services
6. Is located within the community in an accessible location (for scheduled clinic visits and drop in clinics)
7. Has sufficient access to breast pumps and other relevant resources for mothers to use at home
8. Provides additional support to priority population groups (Māori, Pacific and younger mothers), this may include home visiting, additional scheduled visits and partnership with a kaiawhina or relevant iwi health and social service.
9. Provides adequate support for infants discharged from Neo-natal secondary care and late pre-term infants
10. Provides routine follow up for past service users
11. Contribution towards ongoing monitoring and evaluation of the service
12. Is adequately resourced, including provisions for administrative support
13. Has succession plans to effectively sustain the service

## Maternity/ Birthing Facilities

*Likely to have the greatest effect on the initiation of breastfeeding.*

### What the evidence says:

The Baby Friendly Hospital Initiative (BFHI) is an international programme launched in 1991 by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) to ensure all maternity services become centres of breastfeeding support worldwide (NZBA).

The BFHI aims to improve exclusive breastfeeding rates and ensure evidenced-based best practice standards of care are offered by maternity services. Baby friendly facilities work to see that all women, regardless of their feeding method, receive unbiased information, support and professional advice in their decision to feed their babies (NZBA).

In New Zealand, all maternity services are required to achieve and maintain BFHI accreditation. The standards of care and services provided are audited by the New Zealand Breastfeeding Alliance (NZBA) every three to four years. Currently 99.85% of infants born in national maternity services are delivered in BFHI accredited facilities (NZBA).

The BFHI has had a positive impact on New Zealand's maternity services, with annual breastfeeding rates showing more than 80 percent of babies are exclusively breastfed on discharge from Baby Friendly hospitals (NZBA).

All maternity hospitals are encouraged to become baby friendly by adopting the *Ten Steps to Successful Breastfeeding*, and providing good care to mothers and their babies before, during and after birth. A baby-friendly hospital also agrees not to accept free or low cost breastmilk substitutes (baby formula), feeding bottles or teats (NZBA).

Breast pumps should be available in hospital, particularly for women who have been separated from their babies, to establish lactation. All women who use a breast pump should be offered instructions on how to use it (NICE, 2015).

According to *The Ten Steps*, every facility providing maternity services and care for new born infants should:

1. have a written breastfeeding policy that is routinely communicated to all health care staff
2. train all health care staff in skills necessary to implement this policy
3. inform all pregnant women about the benefits and management of breastfeeding
4. help mothers initiate breastfeeding within a half-hour of birth (this step is now interpreted as: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed)
5. show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants
6. give new born infants of breastfeeding mothers 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



### **What the Midland Sector says:**

Initiation of breastfeeding remains fairly high in comparison to international standards; all BFHI accredited facilities must maintain exclusive breastfeeding rates above at discharge from maternity 75%. The quality measures that BFHI instructs, supports best practice within the Midland accredited facilities.

The workforce involved with BFHI accreditation noted that cost for the 3 yearly audit (approximately \$10,000 - \$13,000) and the appointment of a designated BFHI coordinator was necessary to complete the process smoothly. However in most DHB regions there was no designated capacity for a BFHI coordinator. Service allocation of FTE (relative to the number of facilities that are supported by each DHB) for a BFHI coordinator should be planned and funded for.

In the US, the breastfeeding report card shows the number of IBCLC per 1000 live births as an indicator of workforce capacity. The US average is IBCLC:1000 live births in 2016 was 3.79:1000. Even when combining maternity and community based IBCLCs, the Midland regional IBCLC rate per 1000 live births is well below this level (see workforce stocktake section). It should be noted that in the US they do not have an LMC system and so it is possible that they require higher ratios of LC:1000 births than in NZ.

There was concern from the Midland region around capacity versus demand and adequate access to specialist lactation support. This was common in rural and smaller facilities that often have a visiting lactation service, provided by a secondary unit. Another concern was around coverage of leave and the challenge or prioritisation of appropriately recruiting an IBCLC qualified locum.

Being aware of a new mothers vulnerability and the way they may perceive messages as negative or judgmental is an important consideration for staff working in a maternity unit. This is important when conveying the messages put forward through BFHI and the Ministry of Health especially in maintaining compliance with the international code of breastmilk substitutes. All health care professionals working with new mothers in maternity facilities should use a 'motivational interviewing' approach when having conversations around provision of formula in BFHI compliant facilities. Mothers who had asked about formula provision in maternity settings felt stigmatised in the responses that they were given. It is important that conversations are had in a way that the mother feels like her options have been talked through openly and she is given the breastfeeding support that she needs and is comfortable with.

Not all maternity units (primary and secondary) have Lactation Consultants based within unit, or are available every day to new mothers. Midwives and other staff working in the maternity facility should all have at least BFHI relevant training and should be equipped to provide breastfeeding support, including watching a full feed before discharge. Some of the mothers involved in the focus groups recognised that they felt rushed to be discharged even

when they were not confident to feed. The workforce often comment that they 'do not rush mothers to discharge early'; there appears to be a disconnect between the perception of staff and mother's experiences.

A well established and trusted peer support service can assist in supporting mothers to breastfeed in this crucial early stage of initiating breastfeeding in the maternity unit. This level of peer supporter would be a employed breastfeeding advocate with consideration made to security and privacy. Integration with this level of service can free up the FTE of clinical and specialist staff to support mothers with more complex breastfeeding circumstances. A peer supporter can provide a listening ear and time with the mother, alongside good advice, tools and encouragement.

Access to specialist secondary services can be variable across the Midland region, this may be a general lack in a service, or time delays which can have a great impact on the breastfeeding outcome. Adequate lactation consultant support for the neo-natal unit and pre-term babies (including late pre-term infants) was identified as a need from the sector. There are more complexities required to be managed in the NICU around breastfeeding initiation and duration, and adequate LC FTE is required to cover this. Many DHBs attempt to spread out an already stretched maternity LC service to extend to the NICU and all other areas of the hospital. Routine breastfeeding follow up post discharge from the neo-natal unit should also be planned for.

The Midland region has been developing a donor milk bank policy up until the writing of this framework. A donor milk bank can assist infants to be fed breast milk when circumstances are necessary to use a donor. The neonatal service representatives highlighted that this is a key factor to support breast milk in the infants in their care.

### **Maternity/Birthing Unit Checklist:**

1. Is BFHI accredited and maintains accreditation
2. Has a BFHI coordinator and administrative support
3. Offers access to adequate lactation support services according to the size (birth rate) of the maternity unit (neo-natal unit and hospital where appropriate). Primary birthing units should be adequately staffed to provide Lactation Consultant support.
4. All staff are trained in motivational interviewing such as the 'healthy conversations' training
5. All mothers have received a full observed feed before discharge
6. All breastfeeding support services are advertised and promoted during inpatient stays and outpatient visits
7. All mothers receive the length of stay required to support breastfeeding challenges before discharge
8. The maternity facilities referral pathways are integrated with peer support, community lactation and specialist services
9. Maternity units are involved in the wider breastfeeding support sector, including partnerships through coalitions and development of policies and guidelines
10. DHBs should be a breastfeeding friendly employer, with optimal return to work policies that protect their breastfeeding working mothers

## Workforce development

*Likely to influence both the initiation and duration of breastfeeding.*

### What the evidence says:

All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers in all sectors, for example, hospitals, community settings, general practices and peer supporter services (NICE, 2015).

In New Zealand, there is a Ministry of Health code of practice for Health Professionals in implementing the International Code of Marketing of Breastmilk Substitutes in New Zealand (see figure 15).

The national maternity care delivery model is that every pregnant woman is entitled to a LMC who can be a midwife, GP or obstetrician. To receive lead maternity care a woman who is eligible for primary maternity services must register with a LMC of her choice. The key feature of this care is the LMC is responsible for maternity care throughout the pregnancy and until six weeks after the birth, including the birth itself.

New Zealand has more than 2,800 midwives with a current practising certificate. 75% of women have a midwife as their LMC. 70% of women register with a LMC in the first three months of pregnancy (New Zealand College of Midwives, ND). The undergraduate Midwifery degree requires 4,800 hours of theory and practice, which is equivalent to a four year academic degree. The degree requires a minimum of 50% theory and 50% clinical practice hours. The clinical practice occurs in both hospital and the community, urban and rural settings. The theoretical content and educational frameworks are nationally consistent and meet 100% of the international regulatory and education standards (see Appendix 2 for core competencies of LMC and WCTO).

**Code of Practice for Health Workers**  
in Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand

**What is the Code of Practice for Health Workers?**

This is a voluntary and self-regulatory code of practice, which recommends:

- breastfeeding as the best and safest way to feed infants
- how to give advice about infant feeding
- how to be independent of formula companies' marketing and promotions.

Three other codes are also important to know about:

- Code of Practice for the Marketing of Infant formula (Infant Nutrition Council) (formerly the New Zealand Infant Formula Marketers' Association (NZIFMA) (2007)).
  - There should be no marketing/advertising of infant formula for infants less than six months of age.
  - Follow-on formula should be marketed as an alternative to cows' milk not as an alternative to breast milk.
- Code for Advertising of Food (ASA 2006).
- Australia New Zealand Food Standards Code (2002).

These four codes are how New Zealand currently implements the World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.

The WHO code can be accessed at: [http://www.who.int/nutrition/publications/code\\_english.pdf](http://www.who.int/nutrition/publications/code_english.pdf)

**Key resources**

Be familiar with The Code in New Zealand, accessible at: <http://www.moh.govt.nz/moh.nsf/index.nsf/breastmilksubstitutemarketingcode>

and the Ministry of Health's Food and Nutrition Guidelines, particularly in regard to healthy infants and toddlers (aged 0-2 years), accessible at: <http://www.moh.govt.nz/nutrition>

View the supporting health education resources for your clients, including:

- Breastfeeding Your Baby [HE 2098]
- Feeding Your Baby Infant Formula [HE 1306]

both accessible at: <http://www.healthed.govt.nz/>

**Code of Practice for Health Workers – Checklist**

- Protect, promote and support breastfeeding, see: <http://www.moh.govt.nz/breastfeeding>
- Encourage pregnant mothers to breastfeed.
- Give caregivers of formula-fed infants one-on-one, accurate, objective and non-judgmental advice.
- Know where clients can access additional help/information about infant feeding.
- Comply with the policies and procedures of your workplace, including Baby Friendly Hospital and Baby Friendly Community initiatives (accessible at <http://www.babyfriendly.org.nz>) and The Well Child framework (accessible at <http://www.moh.govt.nz/wellchild/>).
- Do not accept formula samples from formula companies or promote their use.
- Do not accept other gifts from formula companies.
- Understand that cows' milk is not recommended until the child is at least 12 months of age.

**Complaints**

Complaints can be made about inappropriate advice you give about infant feeding or if you are promoting formula.

Formula companies can be complained about if they inappropriately market their products, including marketing/promoting infant formula.

Email your complaints to: [code\\_in\\_nz@moh.govt.nz](mailto:code_in_nz@moh.govt.nz)

Or send your complaints to:  
Complaints under NZ BHO Code  
Population Health Directorate  
Ministry of Health  
PO Box 5013  
Wellington

A standard complaints form can be accessed at: <http://www.moh.govt.nz/moh.nsf/pages/mh/1111/5/1e/code-in-nz-complaint-form.doc>

For more information, contact us at: [code\\_in\\_nz@moh.govt.nz](mailto:code_in_nz@moh.govt.nz)

Figure 19: Code of Practice for Health Workers

In New Zealand, there are two broad categories of Well Child service providers:

1. **Plunket** which delivers around an estimated 85% of Well Child services to 91% of enrolled children, and are contracted nationally by the Ministry of Health via Services for Children and Young People – Well Child/ Tamariki Ora Services tier two service specification, June 2011
1. **Tamariki Ora providers usually located in regional or local Māori and Pacific health providers**, and are expected to deliver an estimated 15% of contacts to the remaining 9% of enrolled children. Tamariki Ora provider contracts offer a choice of service providers, and offer services that are culturally competent and meet the needs of Māori and Pacific families/ whānau. The National Health Board holds Tamariki Ora contracts on behalf of DHBs (Litmus, 2013).

The duration of a WCTO core contact is expected to average 45 minutes face-to-face time, with a range of 35 – 55 minutes.

The National Institute for Clinical Excellence (UK) recommends that a woman's experience with breastfeeding should be discussed at each contact to identify any need for additional support. Breastfeeding progress should then be assessed and documented in the postnatal care plan at each contact (NICE, 2015).

### What the Midland Sector says:

The Midland sector and mothers that were involved in the focus groups to inform this framework both highlighted inconsistencies within the workforce as to what level of support is offered. Inconsistencies were notably strong in relation to the LMC and WCTO workforce and also staff roster changes whilst mothers were inpatients at a maternity or another ward. Reasons cited for this may be; due to time constraints, clinical confidence and personal bias.

Another group of health professionals that raised concern over inconsistencies in breastfeeding related advice was staff within the general practice setting. Often incorrect advice was given to discontinue or reduce feeds rather than protect breastfeeding and milk supply. This may be due to lapsed workforce development from the practitioner or time restraints to offer adequate support.

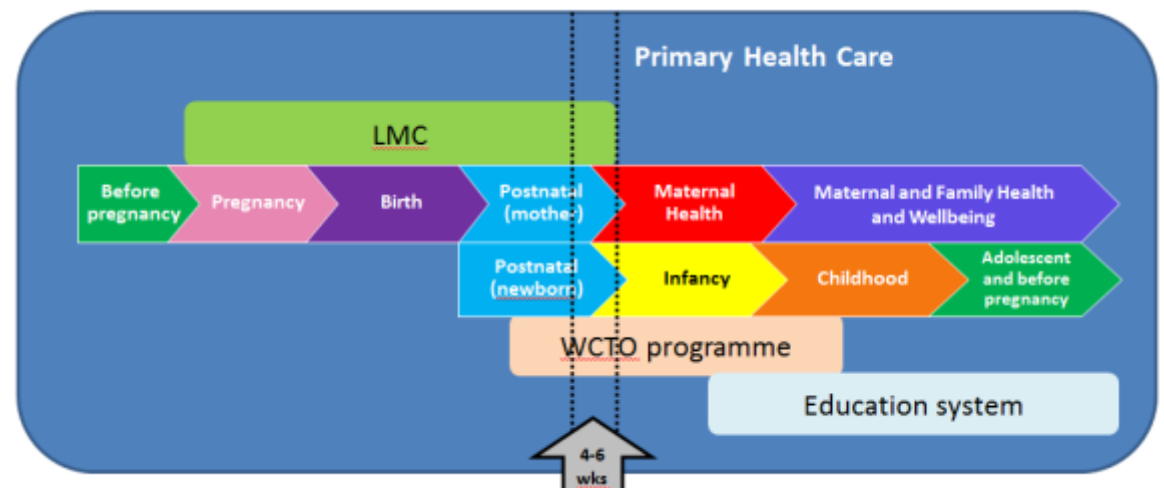


Figure 20: Overview of the service alignment across family/ whānau life pathways (Litmus, 2013)

As a part of the BFHI accreditation process, workforce development is a key step. Some DHBs involved in the consultation for this review said they would be open to extending the workforce development offered by their DHB as part of the BFHI process to non-DHB staff, including the local WCTO and LMC workforce.

The Midland sector noted the crucial timeframe of the handover between LMC and WCTO workforce at 4-6 weeks postnatal (see figure 22). This continuity of care and timing of scheduled visits is important for maintaining breastfeeding at the 6 week mark. The WCTO workforce involved in this framework development noted that they had made attempts with LMCs to provide improvements to this handover, including one provider requesting an introductory shared visit with the WCTO and LMC. However, the WCTO provider has not had any LMCs willing to trial this at this stage. Appropriate handover of support can assist in supporting breastfeeding continuation at 6 weeks, a time when a fall in rates are recorded.

In the Northland DHB region, which has seen an increase in breastfeeding rates over recent years, has included an additional element to the standard orientation process. Each new Plunket staff member spends a day of orientation shadowing a lactation consultant. Observed practice of the lactation consultant supports the professional development of the WCTO staff member, builds awareness of breastfeeding support referral pathways in the region and embeds breastfeeding as a priority in the work they will carry out.

### **Workforce development checklist:**

1. DHBs to provide regular training for differing levels of breastfeeding support competencies and key topics, consider geographical variation in training venues to support the rural workforce
2. DHBs and primary birthing units to extend the invitation of required BFHI training to the community and LMC/WCTO sector
3. Advertise professional development opportunities to a wide range of health professionals, including general practice
4. Communicate professional support opportunities, such as phone based clinical guidance by lactation consultants

## **Data, monitoring and evaluation**

*Likely to influence both the initiation and duration of breastfeeding.*

### **What the evidence says:**

Monitoring and evaluation is a process that helps improve performance and achieve results. Its goal is to improve current and future management of outputs, outcomes and impact. It establishes links between the past, present and future actions (United Nations Development Programme, 2002).

BFHI was set up as a way of ensuring quality controlled benchmark to improve breastfeeding in the hospital setting (National Breastfeeding Advisory Committee of New Zealand, 2009). Maintaining accreditation of BFHI provides a good measure of quality in the maternity units across Midlands.

LMCs have quality review cycles that inform midwifery practice at an individual level and sector wide level. There are three main bodies that oversee the quality of New Zealand midwives - the Midwifery Council of New Zealand, the New Zealand College of Midwives (NZCOM) and the Ministry of Health. New Zealand midwifery frameworks meet all international regulatory, education and competency standards (New Zealand College of Midwives, ND).

Currently breastfeeding data is captured at initiation (through LMC reporting), 6 weeks, 3 months and 6 months (through WCTO reporting). There has been work undertaken nationally and locally to have consistent and greater coverage of reporting by all providers (see data section of this report).

The Maternity Quality and Safety Programme provides service development, data analysis and reporting on several relevant indicators for the sector. Breastfeeding rates is one indicator that is included.

The Māori Health Plan performance indicators include three breastfeeding related targets (6 weeks, 3 months and 6 months). By highlighting some key indicators where inequity is seen and improvements are possible, DHBs can provide a strategic response to system level improvements.

### **What the Midland Sector says:**

The maternity and community lactation consultant workforce raised the issue of inconsistent Lactation Consultant referral codes. It was recommended that there is consistency of referral codes used across the Midland region. These should be collaboratively determined and utilised by each DHB to support more consistent data on reasons for referral to lactation consultant services.

The monitoring of the quality of breastfeeding support and initiatives provided in the community and private settings can be more difficult. All programmes funded by the DHB or Ministry of Health require performance monitoring processes. However, outcome evaluation (i.e. impact on breastfeeding rates) is often not evaluated in some programmes.

All DHBs in the Midland region acknowledged the approximate 10% of mothers and their infants who do not go on from their LMC to a WCTO provider. This population group are deemed 'high risk' for ongoing health service engagement. It is unknown whether this 10% breastfed or not as data is reported for the population that engages with a WCTO service only. One WCTO in the region has made strides towards gaining access to this 10% by using the NCHIP database (used by LMCs) and tracking mothers who have been discharged from an LMC but have not been picked up by a WCTO provider. This WCTO provider performs a home visit to initiate a relationship with the mother/whanau to attempt to connect them with their service. They have seen increased service uptake as a response to this process.

Setting of goals is important for a cross sectoral, united approach in increasing breastfeeding rates. In order to ensure steps are being taken to achieve equity between Māori and non-Māori, specific goal setting and monitoring should be prioritised for Māori.

One WCTO provider noted that discussing breastfeeding rates by the WCTO nurse during regular individual performance management meetings can support progression towards increasing breastfeeding rates of an individual's caseload. This can trigger or build a case for further professional development around breastfeeding support.

Local examples of peer review or practice have been deemed effective within the DHB and community lactation consultant workforce in Midlands. This could be formally set up as a routine way of supporting quality of practice through a feedback loop from other LC practitioners. This may be an important step towards quality and consistency, as well as hands on clinical professional development due to the lack of a health professional body for an IBCLC.

Most of the regions within Midlands have at least one breastfeeding coalitions that support integration, action and information sharing between sectors. Coalitions can be a good way of sharing data and gaining diversity of input into local programme development.

#### **Data, monitoring and evaluation checklist:**

1. Support national and regional development of consistent data reporting across sectors
2. Monitor Maori service uptake and breastfeeding rates and set goals to improve rates
3. Have comparative data of breastfeeding rates to smoking and SUDI rates
4. Discuss individual breastfeeding rates per LMC/WCTO staff to improve individual performance during performance management reviews
5. Contribute towards an annual Midland breastfeeding report card



## Conclusion

Each component of the Midland breastfeeding framework needs to be adequately funded and implemented to increase breastfeeding rates. Provision of individual components of the framework are unlikely to increase both initiation and duration of breastfeeding rates across a population.

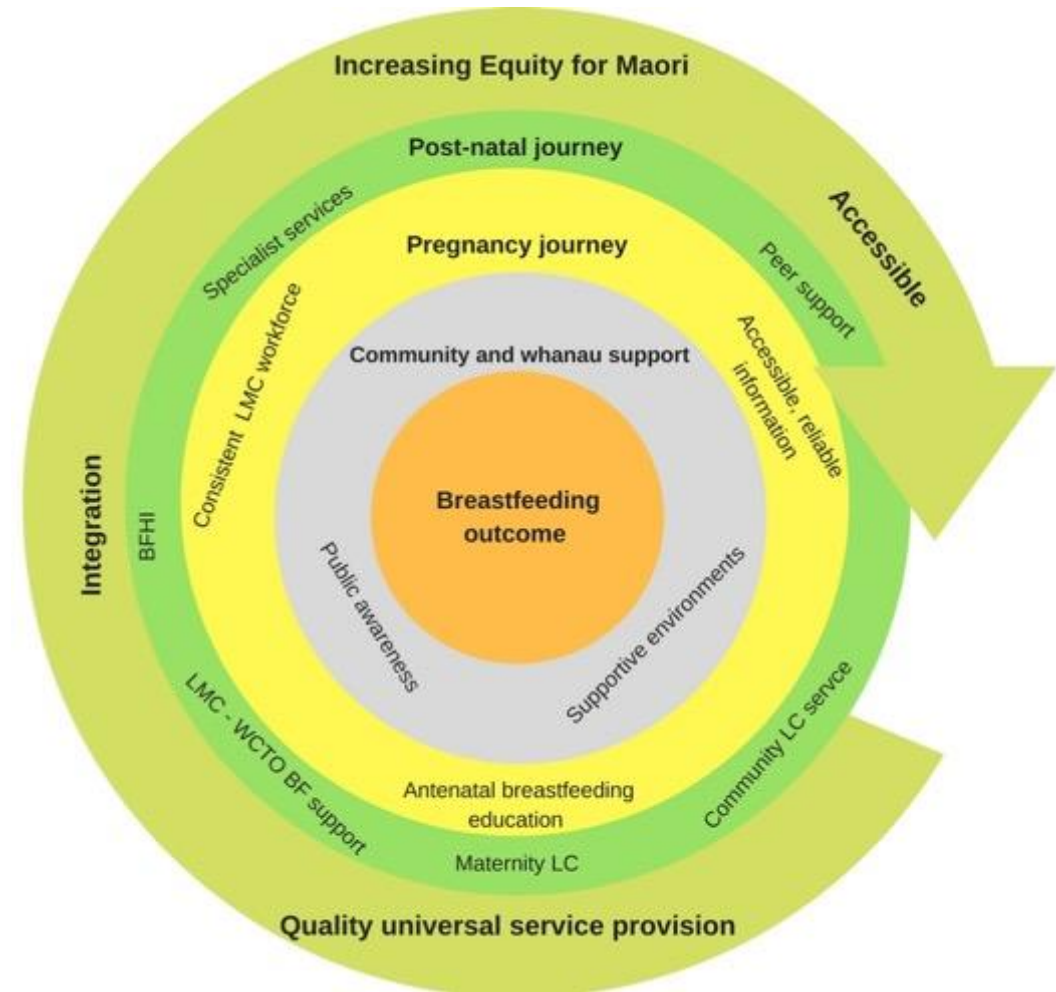
Integration between services is also a key factor that can support continuity and quality of care. Services provided in isolation can result in reduced quality and bias. In contrast, collaborative services open the workforce up to transparency and possibly shared use of expertise and resources.

To achieve equity in breastfeeding rates for Māori, there needs to be both a high quality universal and targeted range of initiatives and services. In particular, services that have a kaupapa Māori foundation and are provided 'by Māori for Māori' are considered best practice. These targeted services are suggested in the body of this framework.

It is important that the whole workforce and services agree to work towards a common vision.

The Midland will be a region that;

- **Supports, protects and celebrates breastfeeding in the community**
- **Provides quality support services for all women to overcome breastfeeding challenges**
- **Has maternity and community services that are sustainably resourced and well integrated**
- **Achieves equity for Māori breastfeeding rates**





## Appendix 1:

### Stakeholder focus group Questions

Question/statement	Score	Comments
<p>1. All midwives and Well Child Tamariki Ora providers are skilled and confident to support women to breastfeed in xxx.</p> <p><i>Consider:</i></p> <ul style="list-style-type: none"> <li>• <i>Establishing breastfeeding initiation</i></li> <li>• <i>Managing challenges</i></li> <li>• <i>Supporting continuation</i></li> <li>• <i>Are they all aware of infant feeding recommendations?</i></li> </ul> <p>2. All primary/secondary birthing units in xxx are consistently set up to protect, promote and support breastfeeding</p> <p><i>Consider:</i></p> <ul style="list-style-type: none"> <li>• <i>BFHI status</i></li> <li>• <i>24 hour access to breastfeeding support</i></li> </ul> <p>3. Health professionals in xxx know where and how to refer mothers to access breastfeeding support and information.</p> <p>4. Antenatal classes in xxx prepare mothers and their partners for breastfeeding.</p> <p>5. Thinking about the existing services that are offered in xxx, how could these services integrate better?</p> <p>6. The Midland Breastfeeding Framework will offer a best practice pathway in order to protect and promote breastfeeding.</p> <ul style="list-style-type: none"> <li>• <i>What would be your two main broad strategic recommendations for this pathway?</i></li> <li>• <i>What would you say is essential to be included?</i></li> </ul>		

## Mothers / Consumer Focus Group; guiding questions

**Welcome-** flow of the day (Help yourself to food, be respectful of each other, anonymous, no pressure, photo/dictaphone)

**INTRODUCTIONS:** Name, age of child and/or stage of pregnancy; “If you had a limitless budget, where would you go on holiday?”

### Engagement Questions:

- 1) What do you notice about your community, whanau and friend’s attitudes to breastfeeding?
- 2) When did you make your decision about breastfeeding?

### Exploration Questions

- 3) Thinking about your breastfeeding experiences, what were the key moments that helped you to breastfeed or continue breastfeeding? [enablers]
- 4) Were there any things that influenced you to stop earlier than you planned, or make it harder? [barriers]
  - a. How about going back to work?
  - b. Breastfeeding in public places? (Taranaki have a breastfeeding welcome here programme- have you ever seen that? If more public spaces signed up for that, would it support you? What kind of places?)
  - c. Lack of support or information?
- 5) Did anyone have any experiences with breastfeeding support services, like a lactation consultant (breastfeeding experts) or breastfeeding peer supporters (other mums that have a bit of training around supporting each other)?

### Exit Questions:

- 6) An outcome of these conversations that I am having with mothers and the maternity workforce across five DHB regions is that we hope to influence better breastfeeding support services in the future; thinking about your experiences or people you know, do you have any final thoughts around what would make a really good breastfeeding support service?

**Prompts:** “Can you talk about that more?” “Help me understand what you mean” “Can you give an example?” “Thanks for that, what do others think?”

## Appendix 2:

### Core competencies of LMC and WCTO providers (Litmus, 2013)

LMCs under Section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88) have a statutory requirement to undertake the discharge check of mother and baby. In summary, LMCs are responsible for providing the following postnatal services to both the mother and baby:

- Reviewing and updating the care plan and document progress, care given and outcomes.
- Delivering between five and ten home postnatal visits (and more if clinically needed) to assess and care for the mother and baby at home until six weeks after the birth.
- Undertaking examinations of the woman and baby including—
  - a detailed clinical examination of the baby as defined by the WCTO National Schedule (Ministry of Health 2002b) before transfer to a WCTO provider
  - a postnatal examination of the woman at a clinically appropriate time and before transfer to the woman’s primary care provider.
- Providing care and advice to the woman, including—
  - **breastfeeding** and the nutritional needs of the woman and baby
  - assessment for risk of postnatal depression and/or family violence, with appropriate advice and referral
  - appropriate information and education about screening
  - provide or refer the baby for the appropriate screening tests specified by the Ministry of Health, and receive and follow up the results of these tests as necessary
  - information on immunisation and the NIR
  - provision of or access to services, as outlined in the WCTO National Schedule
  - advice regarding contraception
  - parenting advice and education.

**At core contact one, WCTO providers are contracted to deliver services across three parallel streams which are delivered as an integrated package** (Ministry of Health 2011, 2010d. As detailed in the Ministry of Health (2010d), WCTO providers are required to undertake the following:

**Clinical assessment** which are the universal health and development assessments that are undertaken at every core WCTO contact (i.e. to monitor health and development) -

- family health and wellbeing
- child growth and development
- vision and hearing.

**Interventions** which are the health interventions and referrals to services that will be offered and documented in response to the specific clinical assessments and care plan agreed with the family/ whānau -

- postnatal depression (PND) screen and respond
- ABC smoking cessation
- family violence screen and respond
- respond to assessments
- additional contacts.

**Health education** which is the range of activities delivered according to the core contact age bands. Health education is undertaken in response to professional judgment and the needs assessment and care plan -

- breastfeeding and infant nutrition
- maternal nutrition
- immunisation
- preventing SUDI
- childhood illness
- parenting for child age and stage
- safety/ injury prevention.

## Appendix 3

### Information to be added to an integrated breastfeeding support service specification

Providers will use the following components as essential contributories to their service. Providers must demonstrate how they will provide integration between services, geographical coverage and offer additional targeted support services for Maori. Each DHB should use an equity tool (such as the HEAT tool) to review the development or adaption of services. Performance management will include both qualitative and quantitative measures.

Each component of this integrated breastfeeding support service either has a greater contribution to the initiation or duration of breastfeeding, it is therefore important that all elements of the service are included when planning and funding services.

#### Public Health Initiatives checklist:

1. A breastfeeding friendly environments project that covers multiple settings including public places, workplaces and early childhood centers should be designed and implemented locally. Public Health FTE would need to be designated to the recruitment, training and auditing of the spaces achieving accreditation. Existing packages and resources should be shared between DHBs to reduce duplication
2. The project plan is to be guided by fundamental health promotion principles (e.g. Ottawa Charter, Pae Ora, Te whare tapa wha) and be adapted according to a health equity lens, such as the HEAT tool analysis for equity
3. The project should be regularly monitored and evaluated for effectiveness, and improvements made thereafter
4. Campaigns should be co-designed with the target audience (eg. Maori) and use mediums that are relevant to young mothers today (eg. social media)

## Antenatal education program checklist

1. Universal breastfeeding education within antenatal classes
  - a. Web and technology based information
  - b. Face to face as a part of accessible antenatal education classes (delivered by trained child birth educator)
  - c. A variety of evening and weekend classes available
  - d. Integrated with ongoing support services (LMC, WCTO, maternity and community LC's)
  - e. Evaluation and follow up around breastfeeding outcomes
2. Kaupapa Māori antenatal program
  - a. Delivered face to face by Māori qualified child birth educator (IBCLC or breastfeeding advocate to provide breastfeeding elements)
  - b. Needs to be visual
  - c. Adaptable
  - d. Practical
  - e. Accessible (run over 1-2 days)
  - f. Free (and food/ transport options provided)
  - g. Whanau friendly
  - h. Integrated with ongoing support services (LMC, WCTO, maternity and community LC's)
  - i. The programme is evaluated and offers ongoing follow up with participants
  - j. Has designated administration support
  - k. Utilises social media to interact with potential and past participants
  - l. Is sustainably and well resourced

## Peer Support Service Checklist

1. The peer support service is a partner service alongside a community lactation service
2. Peer support is offered in multiple access points, in a range of places for drop-in peer support, including antenatal and postnatal clinics
3. Paid peer support service administrator role
  - a. Arranges trainings (an IBCLC would deliver any technical content)
  - b. Manages peer support database
  - c. Organises drop in clinics
  - d. Manages Facebook page and other communication mediums (text/phone/direct messages)
  - e. Manages scheduled visits for (paid peer supporters
  - f. Supports recruitment of peer supporters
  - g. Builds and maintains relationships with key partners (LMC's, LC's, GPs, antenatal programmes, iwi health services, WCTO providers, maternity)
  - h. Supports the advertising and marketing of the peer support service
  - i. Manages programme evaluation
  - j. Manages qualification recognition of the training
4. Peer support training
  - a. Ideally the training is recognised by a recognised NZ qualification standard or use LLLNZ PCP training
  - b. Trainings can be run over 2 full days or as preferred by the group (approximately 20 hours total of face-to-face and self-directed learning minimum)
  - c. Group based trainings are more cost effective than one-to-one trainings
  - d. Training to be provided at a low cost per peer supporter trained (no charge to a volunteer to be trained)
  - e. Childcare should be considered for voluntary mothers to attend
  - f. Clinical training content should be developed with input from a Nurse or Midwife with an IBCLC qualification
  - g. Training should offer the use of a visual communication tool (such as the Mama Aroha Talk Cards and the BreastFedNZ app) and be led by a good quality educator
5. Peer supporters
  - a. The peer support workforce should represent the diversity of the population they live in; age, ethnicity etc.
  - b. Peer supporters should attend an annual refresher
  - c. Each trained peer supporter should have access to resources, (such as Mama Aroha talk cards and BreastFedNZ app) and other visual resources
  - d. Should contribute towards evaluation and reporting processes
  - e. Should confidently understand where their role fits within a wider breastfeeding support service
  - f. Should be reimbursed for expenses related to the provision of appropriate services (e.g. travel costs if home visits are required)
  - g. Paid peer supporters can provide scheduled visits, drop in clinics, maternity units and complete referrals with the community and secondary lactation consultant services
  - h. Be supervised and mentored up to one year following completion of the training



### Community Lactation Service checklist:

1. Has a well publicised and integrated referral pathway.
2. Utilises social media to advertise and connect with potential and past service users
3. Is delivered by IBCLC's who maintain their accreditation and belongs to a health professional regulatory body (where relevant)
4. Provides clinical expertise and support to health professionals to support mothers to overcome breastfeeding challenges
5. Is integrated with antenatal classes, LMCs, WCTO and peer support services
6. Is located within the community in an accessible location (for scheduled clinic visits and drop in clinics)
7. Has sufficient access to breast pumps and other relevant resources for mothers to use at home
8. Provides additional support to priority population groups (Māori, Pacific and younger mothers), this may include home visiting, additional scheduled visits and partnership with a kaiawhina or relevant iwi health and social service.
9. Provides adequate support for infants discharged from neo-natal secondary care and late pre-term infants
10. Provides routine follow up for past service users
11. Contribution towards ongoing monitoring and evaluation of the service
12. Is adequately resourced, including provisions for administrative support
13. Has succession plans to effectively sustain the service

### Maternity/Birthing Unit Checklist:

1. Is BFHI accredited and maintains accreditation
2. Has a BFHI coordinator and administrative support
3. Offers access to adequate lactation support services according to the size (birth rate) of the maternity unit (neo-natal unit and hospital where appropriate). Primary birthing units should be adequately staffed to provide Lactation Consultant support.
4. All staff are trained in motivational interviewing such as the 'healthy conversations' training
5. All mothers have received a full observed feed before discharge
6. All breastfeeding support services are advertised and promoted during inpatient stays and outpatient visits
7. All mothers receive the length of stay required to support breastfeeding challenges before discharge
8. The maternity facilities referral pathways are integrated with peer support, community lactation and specialist services
9. Maternity units are involved in the wider breastfeeding support sector, including partnerships through coalitions and development of policies and guidelines
10. DHBs should be a breastfeeding friendly employer, with optimal return to work policies that protect their breastfeeding working mothers

### **Workforce development checklist:**

1. DHBs to provide regular training for differing levels of breastfeeding support competencies and key topics, consider geographical variation in training venues to support the rural workforce
2. DHBs and primary birthing units to extend the invitation of required BFHI training to the community and LMC/WCTO sector
3. Advertise professional development opportunities to a wide range of health professionals, including general practice
4. Communicate professional support opportunities, such as phone based clinical guidance by lactation consultants

### **Data, monitoring and evaluation checklist:**

1. Support national and regional development of consistent data reporting across sectors
2. Monitor Maori service uptake and breastfeeding rates and set goals to improve rates
3. Have comparative data of breastfeeding rates to smoking and SUDI rates
4. Discuss individual breastfeeding rates per LMC/WCTO staff to improve individual performance during performance management reviews
5. Contribute towards an annual Midland breastfeeding report card

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