IMPLEMENTING THE WORLD HEALTH ORGANIZATION INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Two Discussion Documents:
Health Sector and Industry Sector Self-Regulatory Codes of Practice

PUBLIC HEALTH GROUP
MINISTRY OF HEALTH
APRIL 1996
16 April 1996

Dear Colleague,

CONSULTATION ON IMPLEMENTING THE WHO INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES: HEALTH SECTOR AND INDUSTRY SECTOR SELF-REGULATORY CODES OF PRACTICE

Please find enclosed for your comment a copy of two draft discussion documents on the World Health Organization International Code of Marketing of Breast-milk Substitutes (WHO Code). One document was prepared by Healthlink South (representing the health sector) and the other document was prepared by the New Zealand Infant Formula Marketers' Association (representing industry).

The aim of the WHO Code is to contribute to the provision of safe and adequate nutrition for infants, by protecting and promoting breastfeeding, and by ensuring the proper use of infant formula, when necessary, on the basis of adequate information and through appropriate marketing and distribution.

The WHO Code was adopted by the World Health Assembly in May 1981. By 1983 the Minister of Health announced adoption of the Code in its entirety but "through consensus and discussion rather than through legislation". An advisory committee was also established to monitor compliance with the Code. In 1994 the Public Health Commission distributed a discussion document seeking comment on the interpretation and monitoring of the WHO Code. It was then decided to develop self-regulatory codes of practice - one from the health sector and the other from industry. The draft documents seek to address the following public health objectives:

- To increase full breastfeeding at three months from 60 percent (1991) to 70 percent by 1997 and 75 percent by the year 2000.
- To increase breastfeeding (full or partial) at six months from 55 percent (1991) to 70 percent by 1997, and 75 percent by the year 2000.

If you require further copies of the document for individual staff members, please contact Twyla Burt on telephone (04) 496 2341 or by facsimile at (04) 496 2340 or by letters to the Ministry of Health, PO Box 5013 Wellington. Please note the closing date for submissions is 28 May 1996.

Yours sincerely,

Dr Gillian Durham  
Director of Public Health and  
General Manager, Public Health Group
IMPLEMENTING THE WORLD HEALTH ORGANIZATION INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Two Discussion Documents:
Health Sector and Industry Sector
Self-Regulatory Codes of Practice

PUBLIC HEALTH GROUP
MINISTRY OF HEALTH
APRIL 1996

Preface

These two draft discussion documents (one prepared by the health sector and the other prepared by industry) raise issues and principles derived from the World Health Organization International Code of Marketing of Breast-milk Substitutes (WHO Code). Questions are also raised and in some places options are suggested.

The documents are being widely distributed. The Industry Code has been through an initial consultation process. The Health Sector Code requires consultation. Submissions expressing comment, opinion and advice are invited from interested people, whether representing organisations or as individuals. When sent on behalf of an organisation, the submission should include the position within the organisation of the person making or signing it and an indication of the extent of consultation, discussion and support within the organisation for the opinions and advice expressed.

Submissions should be sent to:

Implementing the WHO Code
Public Health Policy Section
Public Health Group
Ministry of Health
PO Box 5013
WELLINGTON

or faxed to 04 496 2340
(international fax +64 4 496 2340)

The closing date for submissions is 28 May 1996.
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APPENDIX ONE

Submission Questionnaire (8 questions) 29-35
Discussion Document

To enable development of a

Self-Regulatory Code Of Practice For The Health Sector

(Health Sector Code)

Prepared by Gendy Brown
Public Health Service, Healthlink South
Discussion Document for the Development of the Health Sector Code

Introduction

The health worker is responsible for giving consistent and unbiased information to enable women to make infant feeding choices.

Ideally every infant should be exclusively breastfed for the first six months of life. Human milk offers species-specific advantages to the neonate; it contains an optimum combination of nutrients. Both colostrum and mature milk provide host resistance factors against bacterial and viral infection. Breastfeeding assures intimate physical contact between woman and infant, an important factor in the process of attachment and later psychosocial development (Erinberg, 1995).

More women initiate breastfeeding in New Zealand compared to other western countries. However, the Plunket National Child Health Study (Essex et al, 1995), found that whilst breastfeeding rates were high at birth they decline significantly with time after birth. The study concluded that with further education of mothers and health professionals there is the potential for women to exclusively breastfeed for up to six months post partum.

The challenge for New Zealand is not only to further increase the number of mothers breastfeeding, but to increase the duration of exclusive breastfeeding. There are increased health gains to infant and mother with increased exclusiveness of breastfeeding, during the first six months of life (WHO/UNICEF, 1990).

There is no age specification for infants in the WHO Code but in New Zealand the current interpretation is 0-6 months. The infant gains most from exclusive breastfeeding during this time. Therefore, for the purposes of these self-regulatory Codes, infant shall mean a child who has not attained the age of six months.

It is important that health workers support breastfeeding. Hospital policies must not undermine the decision to breastfeed by encouraging formula or water supplementation of breastfed infants. Breastfeeding women must have ongoing support and advice when they encounter difficulties at home. They must be able to address breastfeeding problems during clinic and/or hospital visits or be put in contact with the support services in the community (WHO/UNICEF, 1989).

Health workers must also be aware that there are times when feeding with artificial formula is a matter of physiologic necessity or is electively chosen by the woman. Health workers must be competent to manage this practice and the issues associated with it.

The Health Sector Code will include seven sections, each needs to be addressed when considering the issues involved with the promotion and support of breastfeeding and proper infant feeding practices.
Discussion Document for the Development of the Health Sector Code

Introduction

The health worker is responsible for giving consistent and unbiased information to enable women to make infant feeding choices.

Ideally every infant should be exclusively breastfed for the first six months of life. Human milk offers species-specific advantages to the neonate; it contains an optimum combination of nutrients. Both colostrum and mature milk provide host resistance factors against bacterial and viral infection. Breastfeeding assures intimate physical contact between woman and infant, an important factor in the process of attachment and later psychosocial development (Erinberg, 1995).

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The Health Sector Code will include seven sections, each needs to be addressed when considering the issues involved with the promotion and support of breastfeeding and proper infant feeding practices.
including voluntary unpaid workers.

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Medical specialist, medical practitioners, midwives, lactation consultants, nurses, dietitians, pharmacists, and plunket nurses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care system</td>
<td>Governmental, nongovernmental or private institutions engaged, directly or indirectly in health care for infant's mothers and pregnant women; and nurseries and child care institutions. It also includes health professionals working in private health.</td>
</tr>
<tr>
<td>Complementary food</td>
<td>Any food, whether manufactured or locally prepared, suitable as a complement to breast milk or infant formula when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called 'weaning food' or &quot;breast milk supplement&quot;.</td>
</tr>
<tr>
<td>Exclusive Breastfeeding</td>
<td>No other food or drink is given to the infant, the infant should be fed frequently and for unrestricted periods.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Feeding at the mother's breast.</td>
</tr>
<tr>
<td>Partial Breastfeeding</td>
<td>Feeding at the mother's breast and this is complemented with other food or drink (such as infant formula).</td>
</tr>
<tr>
<td>Infant Formula</td>
<td>Any food being manufactured or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.</td>
</tr>
<tr>
<td>Infant</td>
<td>There is no age for infants specified in the WHO Code but in New Zealand the current interpretation is 0-6 months. Under this interpretation, follow-on formulas are not covered.</td>
</tr>
<tr>
<td>Support Person</td>
<td>Husband, partner, mother, friend or other family member.</td>
</tr>
<tr>
<td>&quot;Lead&quot; maternity carer</td>
<td>Midwife, a doctor or a specialist</td>
</tr>
<tr>
<td>Early Discharge after childbirth</td>
<td>Discharge up to 48 hours after delivery.</td>
</tr>
</tbody>
</table>
QUESTION 1: WHO Code

la. Do you have any comments on these definitions? If so please state.

lb. Are there other terms that require definition?

Section 2: Education and Practice of Breastfeeding

(Refer to Article 4, 5 & 6 WHO Code: Information and Education, the General Public & Mothers and Health Care Systems)

Health workers when required, must be able to educate the woman, support person and other family members on:

2.1 A Short History of Breastfeeding

This topic will be addressed during the development of the Health Sector Code.

2.2 Benefits of Breastfeeding

The beneficial properties of breast milk, in terms of anti-infective factors, biochemical triggers, facilitation of gut function and developmental progress, have been well documented (Howie, 1990). There are benefits for the woman and infant.

- meeting the full term infant's complete nutritional needs for up to the first six months of life
- a low risk of bacterial contamination
- a less risk of overfeeding or underfeeding
- a high level of nutrient bioavailability

Other benefits for the infant include

- reducing the risk of infectious diseases such as gastroenteritis, respiratory diseases (Howie, 1990)
- protecting against otitis media (glue ear) if exclusively breastfed for at least 4 months (Duncan, 1993)
- reducing the risk of food allergy (Chandra, 1993)
- reducing infant mortality (Cunningham, 1991)
- reducing the risk of sudden infant death syndrome (Mitchell, 1992)
- increasing infant mother attachment (the development of an enduring relationship between infant and mother) (Janke, 1993)
- assisting in jaw development (Bell, 1991)

Benefits of breastfeeding for the woman include

- providing emotional and physical satisfaction
- assisting in returning to her prepregnancy weight
• requiring no preparation before the feed
• a 98% contraceptive effect in the first six months after the baby is born provided the baby is exclusively breastfed and the woman does not resume menstruation (Guilleband, 1991)
• reducing the risk of pre-menopausal breast cancer (protection is exerted only when extended durations of breastfeeding occurs) (Brinton, 1995)
• speeding up the involution of the uterus after birth.

Research conducted over the past decade provides further evidence that human milk feeding promotes optimal brain development. Specific functions for long chain essential fatty acids, present in human milk, have been identified as key components of neural membranes, necessary for optimal brain development (Ricardo, 1995). In addition the act of breastfeeding provides an unique mother-infant interaction, an opportunity that may have important implications for infant growth and development. The development of the Health Codes will be based upon the most recent scientific information.

The health worker when required, must be able to explain and educate the woman, support person and other family members on

2.3 Possible contra-indications of breastfeeding

• situations related to maternal health
  - HIV infection
  - maternal illness
  - medications during lactation
  - drug addiction and alcoholism

• situations related to infant health
  - very rare metabolic conditions such as galactosaemia and maple-syrup urine disease
  - cleft lip and cleft palate - some infants may have difficulty breastfeeding but it depends on the degree of the condition. Each case requires expert assessment and support.

2.4 The Role of Health Professionals (obstetricians, medical practitioners, midwives, nurses, lactation consultants, dietitians, pharmacists, community health professionals).
(Refer Article 7 WHO Code: Health Workers)

The four Regional Health Authorities are responsible for a joint maternity project aimed at improving the maternity services for all New Zealand women. This project will be introduced in April 1996.

One of the most important changes is that women will choose a preferred health professional. This "lead" maternity carer will ensure that all appropriate services are made available to the woman before, during, and after the birth of her baby. The "lead" maternity carer chosen by the woman need not necessarily provide all the services herself, but ensure their provision. Breastfeeding advice and assistance is one of these services.

Submissions to the PHC's Discussion Document on the WHO International Code of
Marketing of Breast-milk Substitutes, established that health professionals often gave negative advice to women causing confusion and contributing to a poor breastfeeding outcome e.g.,

- over enthusiasm when promoting breastfeeding to those who were reluctant, or undecided, often created a negative effect on women.
- some health professionals working with breastfeeding women may have negative feelings towards breastfeeding, because of previous personal or professional experience, and may unconsciously reveal these to the clients.

The health professional shall build a trusting and supportive relationship with the woman. The role of the health professional is to allow for informed decision making. Health professionals should be very conscious of the ethical considerations involved in asking someone to breastfeed when they clearly don't want to, or asking a woman to continue breastfeeding longer than she emotionally and physically desires.

The responsibilities of health professionals

- develop a positive and supportive client/health professional relationship
- recognise the influence they have on a woman's decision to breastfeed
- respect the individual woman and respect her informed choice
- promote and support breastfeeding with positive, consistent and accurate education
- support those who choose not to breastfeed
- provide support for those who have a negative breastfeeding experience minimising feelings of failure
- refer the client to other appropriate health professionals when required e.g. doctor, midwife, lactation consultants, dietitians, community health professional advocate on behalf of their community for public policy that supports and protects breastfeeding
- participate in continuing education to update knowledge and skills
- liaise with training institutions to advise on student training and continuing education for practitioners
- develop a pro-lactation policy for their practice
- develop a bottle feeding policy for their practice.

2.5 The Role of Training Institutions

Training institutions are responsible for

- actively communicating with practitioners, professional associations and the community, to enable them to identify the needs of their students to support and promote breastfeeding
- developing innovative education programmes to impart the clinical relevance and the practice of breastfeeding.

No research has been carried out to date in New Zealand regarding the adequacy of human lactation and breastfeeding education within various training programmes. The breastfeeding of infants is a practical art and this must be considered when designing teaching programmes.
2.6 The Prenatal Period

The health professional shall

• obtain a woman's history - health, social and breastfeeding
• provide a physical examination of the breasts
• provide information about the benefits and superiority of breastfeeding
• prepare for breastfeeding
• explain the detrimental feeds
• give information about the difficulty of returning to breastfeeding once bottle feeding is established
• promote antenatal education programmes, encouraging the participation of the woman's support person
• provide support for breastfeeding and give information about community support for breastfeeding.

The following questions will provide a baseline from which an individualised plan can be designed to correct misconceptions and remove perceived barriers.

• how do you plan to feed your baby?
• what do you see as the advantages and disadvantages of breastfeeding?
• how long do you plan to breastfeed?
• how comfortable do you feel with the idea of breastfeeding?
• how supportive is your support person regarding your decision to breastfeed?
• are you planning to work outside the home after the birth?
• if so, how soon after?
• how do you plan to feed the baby after you return to work?

Health professionals need to develop

• a pro-lactation plan for their practice. A woman's Plan for infant feeding should be thoroughly assessed on the first prenatal visit
• prenatal education programmes that emphasise confidence building. Content should concentrate on the basics. Dwelling on complications and their treatment is counter-productive
• a variety of services including individual instructions, class instruction and peer support groups
• the specialised knowledge needed to provide lactation consultation or refer clients to a lactation consultant existing in the community (Pybus, 1995).

2.7 Postpartum Care

The period after delivery may be viewed as a series of naturally occurring phases through which a woman and her infant pass. A woman's readiness to learn in different phases is a critical element in the successful transition to parenthood.

The importance of the immediate postpartum period for healthy child development has been clarified through scientific investigation since the 1960s (Howie, 1990). This research began on the assumption that this is an 'imprinting' period, a critical and sensitive early phase concerned with sudden and lasting attachment between infant and mother. Most of the many interactions between a mother and her infant in the first hours
of life are closely related to successful breastfeeding (Howie, 1990).

The infant immediately after delivery, when placed on the mother's chest displays a stereotyped innate prefeeding behaviour, culminating at the age of one hour with finding the nipple without any help and the onset of sucking. Olfactory cues seem to guide the newborn to the nipple (Varendi, 1994). Such close contact between mother and child during the first thirty to sixty minutes after birth prolongs the duration of breastfeeding (Salariya, 1978). Even minor separation postpartum or other disturbances will influence breastfeeding negatively. The infant's suckling or even touching the mother's areola region during the first two hours after birth seems to make her more attentive to the needs of her baby. When in close contact with the mother during the first 90 minutes postpartum, the baby is quiet, whereas a baby separated from the mother during this period shows persistent spans of crying similar to the 'separation distress call' seen in several mammals (Winberg, 1995). Interference in these pre-programmed maternal and infant behaviours may cause behavioural disturbances and negative long term effects on breastfeeding performance (Winberg, 1995).

In general, infants especially newborns have very irregular feeding intervals. They may feed at unevenly spaced intervals from six to twelve times, or as many as eighteen times, in a twenty-four hour period. Women may need reassurance that this early phase of very frequent breastfeeding is likely to settle into more predictable routines as lactation is established. Indeed, lactation will be more speedily established if the mother and infant are encouraged to feed often and as long as the infant wishes to do so. Correct positioning of the infant is important to prevent nipple trauma.

**Health professionals, during the first immediate postpartum phase shall**

- give the woman and infant time together so that the infant may spontaneously breastfeed
- encourage cuddling and skin to skin contact
- encourage the presence of the support person and other family members
- assist with correct breastfeeding techniques
- assist woman to breastfeed on demand
- encourage 24 hour rooming-in for institutional care.

**Health professionals during the remaining postpartum phase shall**

- assist the woman to exclusively breastfeed on demand
- facilitate the woman's transfer to home
- give support and twenty-four hour care after birth
- identify problems regarding the physical environment, family or other psycho-social problems, when required refer client to appropriate person/s or agency for assistance
- arrange an effective transfer of responsibility from the 'lead' maternity carer to the community health professional
- give contact numbers for support in the community
- promote realistic expectations
- identify early warning symptoms of postnatal depression and know where to get assistance.
2.8 The Practice of Breastfeeding

The practice of breastfeeding is well explained in the New Zealand College of Midwives Handbook, 'Protecting, Promoting and Supporting Breastfeeding' (NZ College of Midwives, 1992). The Health Sector Code will approach this topic by stating the problem situations that can arise when breastfeeding and explain their management. Suggested topics are:

- nipple problems
- milk supply problems
- eczema/contact dermatitis, psoriasis
- engorgement
- blood in the breastmilk
- post natal depression
- breast abscess
- lactose intolerance
- gastro-oesophageal reflux
- bowel motions
- expressing and storing breastmilk
- lactation failure
- teenage issues
- multiple births

QUESTION 2

2a History and incidence of Breastfeeding
Is this topic important to include in the Health Codes? State Why.

2b Benefits and Possible Contraindications of Breastfeeding
Are there other benefits/situations/contraindications that should be included there?

2c Health Professionals (medical practitioners, midwives, nurses, lactation consultants, dietitians, pharmacists, community health professionals)
Health professionals should be accountable for their client education. How and to whom are health professionals going to be accountable?

2d Are there other key responsibilities that should be included?

2e Training Institutions
Is the topic adequately covered in the various health professionals training curriculum?

2f What alternatives would you suggest?

2g Is the trainee health professional given enough practical experience in the clinical situation to be able to manage the practical aspects of breastfeeding in their practice?
2h Make suggestions for improving practical experience for trainee health professionals.

2i **Prenatal and Postpartum Care**
Are the strategies given in 2.6 and 2.7 appropriate? If not, what points do you not agree with? What alternatives would you suggest?

2j **The Practice of Breastfeeding**
State other topics to do with the practice of breastfeeding which you think should be included?

2k Is this the appropriate way to address the topic 'practice of breastfeeding' for the Code of Practice? What alternatives would you suggest?

### Section 3: Psycho-Social Issues that may be Barriers to Breastfeeding

For the development of the Health Sector Code psycho-social issues, that may be barriers to successful breastfeeding, will be addressed in detail. The most recently completed and ongoing New Zealand research will be included.

The "lead" maternity carer shall be able to identify the following potential barriers to breastfeeding:

- client/health professional relationship
- unrealistic expectations of the woman/health professional/society
- lack of consistent information and continuity of care
- supplementation of breastfed infants in hospital
- conflicting advice regarding technique
- painful, inconvenient, embarrassing breastfeeding
- lack of support and resources
- negative attitudes of 'significant other'
- lactation failure
- perceived milk insufficiency
- maternal perceptions of successful breastfeeding
- effects of early discharge from maternity care
- effects of returning to paid employment
- smoking
- woman's/support person's/society's perception of sexuality
- drug abuse
- sexual abuse
- use of dummies/pacifiers
- depression/psychiatric illness
- physical/intellectual disability
- socio-economic status, educational attainment and woman's age
- lactation failure
- early introduction of solid/supplementary foods

Health workers should be aware that the woman does not have an exclusive relationship
with the infant. A recent Canadian study showed that the arrival of a new baby results in major changes in the woman's day to day life. These include changes in the amount of time available to the woman and the nature of the activities that fill this time, changes in the woman's body and changes in the woman's personal needs. These changes constitute a substantial and often disconcerting shift in lifestyle (Maclean, 1989). In New Zealand society of the 1990s, many families have high expectations of the woman as the caregiver, housekeeper and wage earner. These expectations have an effect on her attitude to breastfeeding.

It is the "lead" maternity carer's responsibility to identify and assess the woman's psycho-social problems and assist her with her infant feeding choice. When necessary the woman should be referred to the appropriate support people or group for assistance.

**QUESTION 3: Psycho-social Issues which may be Barriers to Breastfeeding**

3a Are there other topics that should be addressed? If so, state them.

3b Do you know of any research on the above topics being carried out in New Zealand?

**Section 4.- Cultural Aspects**

Health professionals need to become familiar with the belief systems of the various cultures they work with.

Consultation is in progress with Maori and Pacific Islands groups on their attitudes, beliefs, customs and problems associated with breastfeeding. For the Health Sector Code it is intended to have this section written by representatives from these communities.

The cultural preferences and problems of the Maori and Pacific Islands people will be addressed in the Health Sector Code.

**Maori Aspects**

The relevant historical events that led to an exclusively breastfed community becoming a partially breastfed community should be included in all breastfeeding training modules for health professionals.

The compliance of breastfeeding cessation was one remedy used to stop the spread of Tuberculosis amongst Maori.

The importance of mother infant bonding cannot be underestimated in a culture that values the notion of health as encompassing mental, spiritual and physical wellbeing - not merely the absence of disease (Tregonning P, personal communication, 1994).

The introduction of breast milk substitutes ie: cows' milk and canned milk combined with the conservative nature of the British and their attitudes towards breastfeeding in public did little to support Maori breastfeeding. The adoption of bottle feeding by Maori has
had a critical impact on Maori infant mortality.

*Education and Practice*

Although cultural support plays a significant role in the decision to breastfeed, there are other contributing factors that are influencing the early cessation of breastfeeding.

- Most importantly are the ideologies, beliefs and prescriptive practices being purported about breastfeeding by Western society.
- With significant urban changes in the whanau structure and a high incidence of single Maori parents, Maori women are losing the intimate support of an experienced female relative and partner.
- With Maori breastfeeding role models, Maori women tend to fall prey to many myths and misconceptions about breastfeeding.

These factors, along with the ever increasing demands of employment and household responsibility are weakening the resolve of even the most determined Maori women.

*Benefits and Advantages of Breastfeeding*

The benefits of breastfeeding for infants is well recorded. The benefits for mother and whanau are not so readily promulgated. School health promotion initiatives need to incorporate positive parenting messages about breastfeeding, within the context of Well Child Health long before pregnancy.

*Antenatal, post partum and postnatal care/role of the Maori health worker*

Antenatal, post partum and postnatal services need to be seamless in their delivery. A quality model of care may second skilled Maori grandmothers and mothers to deliver these services to Maori clients. This option would likely minimise perceived barriers. Antenatal, post partum and postnatal care for Maori needs to be done in the right environment, with the right people who are armed with the right information and skills (Maori breastfeeding specialists).

Every facility providing maternity services and care for new born infants should train all health care staff to an acceptable level in the practical application of breastfeeding. Frontline health professionals are continually being reported as dangerously inexperienced and culturally unacceptable amongst many Maori women.

*Consistent information with a balance*

Oversaturation of breastfeeding information by leading experts (some conflicting), and inability to access Maori breastfeeding specialists can be related to a decreased sense of maternal confidence. The strongest predictors of successful breastfeeding are confidence and maternal self esteem.

Enabling factors are those that either support a change in behaviour or support the behaviour continuing. Presently it would seem that there is little available to Maori
women that would encourage a change in behaviour. The establishment of a more supportive breastfeeding environment, community education about the value of long term breastfeeding from a Maori perspective, and the availability of culturally safe advice with matching support service would be effective agents for change.

Socio-cultural that may be barriers to breastfeeding

Research shows that Maori use primary health care services differently from non-Maori often not accessing general medical services until health problems have become exacerbated (Pomare et al, 1995).

The presence of Maori personnel is invaluable and cannot be overemphasised. Skilled Maori women who have successfully breastfed their children remain a source of untapped energy. The presence of Maori personnel may encourage women to stay in hospital long enough to obtain the life saving information required to raise their new born infant.

Breastfeeding barriers include

- over-worked health workers, (who often do not have children of their own), who rush the initiation of breastfeeding due to prescriptive work schedules
- over-zealous health workers who touch the woman unnecessarily during breastfeeding initiation
- breastfeeding perceived as being difficult and painful due to past experiences
- breastfeeding women are expected to eat a perfect diet and avoid many foods that can compromise the babies health
- lack of suitable role models leaves many Maori women open to conflicting information about breastfeeding
- media advertising for infant formula is extremely influential
- use of supplemental feeds in institutions
- lack of culturally appropriate prenatal care and lactation education.

The World Health Organization has said that education alone is insufficient to establish breastfeeding successfully and that it requires the support of the community as well.

Maternity leave and return to paid employment

Between 1986 and 1990, the Maori unemployment rate was consistently around three times that of non-Maori. In 1986 the Household Labour Force Survey (HLFS) indicated that Maori women had an unemployment rate of 11.5% compared to a rate of 4.0% for non-Maori women. The rate in 1986 for Maori men was 10.4% and for non-Maori men it was 2.9%. Maori made up 23.7% of the unemployed, and 8.7% of the labour force. By 1990, the major changes were the extent to which unemployment had increased (Manatu Maori, 1991).

The issue here is employment versus unemployment. It is difficult to consider issues such as maternity leave and paid employment when Maori are still attempting to address the issue of unemployment. Indeed unemployment has been noted as a barrier to breastfeeding.
Support service and social support include

Maori are renowned for their literal adherence to the Whanaungatanga philosophy. Within these whanau networks are much support and care. Urbanisation has in many ways dislocated these networks and Maori attempt to bridge these gaps by offering vicarious help where and when they can.

Specific breastfeeding support groups in New Zealand are La Leche League and lactation consultants. Other groups such as midwives, Karitane and Plunket include breastfeeding within a broader health care delivery service. Some reasons these organisations are not readily accessed by Maori are:

- groups are predominantly non-Maori
- information is specific and not holistic
- lactation consultants may charge

The capacity of Maori providers to impact on the adverse health statistics of Maori and make measurable gains in Maori health status requires services to be diverse and responsive, but above all, accessible (Ministry of Health, 1995).

Changing attitudes and behaviours towards breastfeeding (institutional policy and policy makers)

Policy makers need to invest enough importance on breastfeeding to influence breastfeeding policy that assists in the promotion and support of breastfeeding. The well known Breastfeeding Hospital Initiative is one programme that could be incorporated. Breastfeeding initiatives such as this will assist in creating a comfortable breastfeeding environment.

To assist and support those who choose to bottle feed

It is interesting to note that many professionals assume that active breastfeeding promotion tends to make a mother feel inadequate when she is unable to breastfeed her child. Many cases of breastfeeding failure can be traced back to ill-experienced and ill-informed breastfeeding helpers.

Freedom of choice must come from informed choice for Maori. If infant formula is preferred then information which expounds the nutritional value of the formula should be explained in such a way that parents are able to make an informed choice about the type of formula that will best suit their new born child.

Methods for preparing and feeding with infant formula would need to be taught prior to leaving the hospital otherwise some home help will be essential for early hospital leavers.

The Treaty of Waitangi, confirms and guarantees to the Chiefs and Tribes of New Zealand active protection of all their treasures. Numerous well known Maori proverbs and quotes such as this perpetuate the absolute importance of the people.

'He aha te mea nui i te Ao He Tangata, He Tangata, He Tangata'.
Central therefore to the Maori culture and its healthy maintenance is the health of Maori children. Breastfeeding plays a critical role in the establishment of Maori child health.

QUESTION 4: Cultural Aspects - Maori Aspects

4a Do you have any concerns about the way this topic is being approached? If so, please state them.

Pacific Island Aspects

In consultation with the Pacific Island community and the Ministry of Health Pacific Islands Advisor, the Pacific Island aspect will be addressed in the Health Sector Code.

QUESTION 4: Cultural Aspects - Pacific Island Aspects

4b Do you have any concerns about the way this topic is being approached? If so, please state them.

Section 5: Public Policy Makers and Institutional Policy

(Refer to Article 6 WHO Code: Health Care Systems)

5.1 Public Policy Makers

An examination of policy documents that consider breastfeeding reveal that it has been conceptualised almost conclusively as a nutritional issue, and incorporated into initiatives connected with dietary guidelines (Morrow, 1993).

This has occurred despite the WHO's identification of the wider socioeconomic issues surrounding breastfeeding. The nutritional aspects of breastfeeding are undoubtedly important but a range of non-nutritional considerations also play a crucial role in infant feeding choice. Social, economic, cultural and environmental factors need to be acknowledged by those making policy if promotional strategies are to be made more effective. It should be acknowledged that complex logistic and political considerations constrain the efforts of health promoters.

Further steps should be taken to assist women to breastfeed for as long as they wish. Research into barriers to breastfeeding may illuminate directions for policy makers to take. Education and media programmes can make a real contribution to the establishment of breastfeeding. The Joint WHO/UNICEF Statement of 1989 recommends we work towards a "breastfeeding culture".

The promotion of breastfeeding is about changing attitudes at all levels of society. It will take time and the energy by health professionals to encourage institutional and public policy makers to identify barriers to breastfeeding and suggest policy changes.
Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice (WHO, 1986).

5.2 Institutional Policy

There is now considerable evidence that the influence of the hospital environment is an important factor in the establishment and maintenance of breastfeeding. Although most women have made up their minds about how they would like to feed their infant prior to the time of delivery, the actual outcome and progress in the following months is influenced by the experience and support of the first few days after birth (UK Dept of Health and Social Security, 1988).

Winnikoff (1980), has listed a wide range of hospital intervention studies that are associated with subsequent improvements in the rate of duration of breastfeeding.

These include

- staff education on the importance of breastfeeding
- attention to hospital routines in the delivery room, such as skin to skin contact in the delivery room to encourage breastfeeding
- exclusively breastfeed and avoid rigid routines
- baby and mother rooming together
- encouragement of breastfeeding throughout the 24 hour period
- attendance at antenatal classes.

The concept of early discharge from hospital following childbirth is a primary health care initiative, part of the WHO strategy of Health for All by the Year 2000.

Supported planned early discharge can confer

- high levels of psychological satisfaction
- lower incidence of postnatal depression
- strengthened family relationships and
- minimised sibling rivalry
- establishment of long term breastfeeding.

All of these factors are beneficial not only to women, babies and families, but also to society as a whole (Kilgour, 1990).

For the woman and infant to derive maximum benefit from early discharge, the decision must be a voluntary one, accompanied by supporting services such as continuity of service from community midwives with a primary health care philosophy, offering consistent and responsive postpartum care (Kilgour, 1990).

Health professionals shall assist public and institutional policy makers to change political, social and health policies to promote good infant feeding practices and support breastfeeding.

In 1991 in an effort to motivate health care facilities, the WHO and UNICEF jointly sponsored the "Baby Friendly Hospital Initiative" based on the 'Ten Steps to Successful
Breastfeeding' (1989). The initiative provides an opportunity for hospitals to engage in both self-evaluation and assessment by consultants, to determine how these institutions promote, protect, and support breastfeeding. Each of these ten elements has been found to influence breastfeeding promotion, protection and support in hospitals and other institutional settings. For example, written policies on breastfeeding often direct health care training and practice.

"THE TEN STEPS TO SUCCESSFUL BREASTFEEDING"

Every health facility providing maternity services and care for newborn infants should

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breast-feed and how to maintain lactation even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk unless medically indicated.
7. Practice rooming-in. Allow mothers and infants to stay together 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (e.g. dummies, soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from hospital or clinic.

5.3 Health professionals

The health professional in institutions and in organisations shall

• reorient health services and their resources towards the promotion of appropriate infant feeding practices and in particular the promotion of breastfeeding
• encourage and assist research into barriers to breastfeeding
• gather accurate statistics on institutional practices and procedures and compare these with duration of exclusive and partial breastfeeding
• gather accurate information on the reasons for infant feeding choice
• encourage changes in attitudes in training institutions that will assist in supporting and promoting breastfeeding.

5.4 Position Statements

New Zealand health professionals could assist policy makers by publishing Breastfeeding Position Statements from their professional associations. These statements should be drawn up after widespread consultation within each profession to recognise the importance of promoting and supporting breastfeeding. Each professional member would be required to stand by their professional body's statement, especially on topics that might be controversial.

The New Zealand Paediatric Society published a Position Statement on Breastfeeding in 1992. The New Zealand College of Midwives has a Position Statement in draft form and
hopes to have it finally ratified in March 1996. The New Zealand Lactation Consultants Association are in the process of developing a Position Statement.

5.5 Support Services and Social Support

All women need appropriate support services, including family and social agencies, to breastfeed their babies.

This topic will be appropriately addressed in the Health Sector Code.

QUESTION 5

5a Ten Steps to Successful Breastfeeding

Do you think these steps are relevant to the New Zealand situation? Any other comments?

5b Position Statements

Has any other professional group published a Position Statement on breastfeeding? If "yes", where and when was it published?

5c Support

What are your ideas for "appropriate support"?

Section 6 - Issues Surrounding Successful Infant Formula Feeding

(Refer to Article 1 & 4 WHO Code: Aim of the WHO Code & Information & Education)

Health workers shall assist and support those who choose to bottle feed.

If a woman has decided to bottle feed her baby, then she needs education on how to do this correctly. One of the aims of the WHO Code is to ensure the proper use of infant formula and it is the responsibility of the health worker to provide this information.

Issues to Consider

Health workers should give information about infant formula feeding to mothers who choose to formula feed their infants.

In antenatal classes any information on formula feeding should always be presented in the context that breast milk is best.

Information can be given on a one to one basis but also in a class situation to those who have chosen to formula feed.
Mothers who are breastfeeding may also need information on how to sterilise bottles and teats if they choose to give their infant expressed breast milk by bottle and teat.

Health workers can give information about different types of formula such as cow's milk versus soy milk. However no brand name information is to be given.

Representatives from a formula company may give factual, educational information on products or infant nutrition in general.

Information that should be given to those who choose to Formula Feed

Cleaning and sterilisation of bottles and teats
How to make up an infant formula
How to feed a baby
Additional fluids
Introduction of cow's or goat's milk.

QUESTION 6:

Formula feeding

6a Has this topic been adequately covered?

6b Are there areas which you would like improved?

The WHO Code Monitoring Process (April 1996)

(Refer to Article 11 of the WHO Code: implementation and Monitoring)

The Ministry of Health retains overall responsibility for monitoring the WHO Code. Any enquiries/complaints may be addressed in writing to -

Senior Advisor (Nutrition)
Public Health Group
Ministry of Health
PO Box 5013
WELLINGTON

In general, non-compliance with the Code is usually associated with a lack of knowledge about the existence or contents of the WHO Code. It is believed that the development of Codes of Practice will result in an overall awareness about the WHO Code and its intention.

QUESTION 7

Do you have any other comments/ideas to make on this Draft Discussion Document?
REFERENCES


Duncan et al. Exclusive breastfeeding for at least four months protects against otitis media. Paediatrics 1993; 91:967-72.


Kilgour R. Early Discharge after Childbirth, Health Research Services,Wellington: Department of Health, 1990


Pybus M (1995). Personal Correspondence. Senior Lecturer, Department of Nursing and Midwifery, Massey University.


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New Zealand Infant Formula Marketers' Association

(NZIFMA)

Self-Regulatory Code of Practice

(Industry Code)

Prepared by David Forsythe,
Executive Director, NZIFMA
INTRODUCTION

It is recognised that breastfeeding is, in normal circumstances, the optimal method of infant feeding for the normal infant from birth and should be encouraged wherever possible.

It is also recognised that women have the fundamental right to choose how they wish to feed their infants and every effort should be made to ensure that all the facts are made available to them.

The NZ Infant Formula Marketers' Association (NZIFMA) accepts that in the present climate of opinion about infant feeding, some mothers will choose to give artificial feeds and some may have to do so for one reason or another. We recommend that proprietary infant formula should be the alternative to breastmilk for feeding infants up to at least the age of six months, and that the use of proprietary formulas throughout the first year of life is preferable if the infant is not breastfed.

It is agreed also that proper and suitable educational facilities be given to those mothers who do not wish to, or are unable to, breast-feed their infants. These educational facilities must be provided by the health care system with the co-operation, where appropriate, of the marketers of infant formula. It is essential that adequate instruction on the use of infant formula is given to mothers, both within the health care system, and in the educational literature and labelling provided by the manufacturer. It is agreed that instructions provided by the manufacturer must be simple and easy to comprehend.

This is a self-regulatory Code of Practice. Acceptance and observance of the provisions will be monitored by the Ministry of Health in accordance with a Letter of Understanding between the Ministry and the NZIFMA.

The Industry Code applies to the marketers of infant formula products available in New Zealand. The marketers who are members of NZIFMA and have already been consulted include: Abbott Laboratories (NZ) Ltd, Bristol-Myers Squibb, Douglas Pharmaceuticals Ltd/Nutricia, J. Wattie Foods Ltd and Wyeth (NZ) Ltd. This industry code is in the process of being endorsed by the industry marketing feeding bottles and teats.

Article 1 Aim of Industry Code

The aim of the Industry Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of infant formula, when this is necessary, on the basis of adequate information and through appropriate marketing.

Article 2 Scope of Industry Code

The Industry Code applies to the marketing in New Zealand of infant formula as suitable to provide the sole source of nourishment for an infant, or to replace part of a breastfeed.
### Article 3 Definitions

For the purposes of the Industry Code the following expressions have the meanings hereby assigned to them:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Artificially-fed</td>
<td>Those infants fed with infant formula, either exclusively or as a supplement to breastfeeding.</td>
</tr>
<tr>
<td>Complementary</td>
<td>Any food, whether manufactured or locally prepared, suitable as a complement to breastmilk or infant formula when either becomes insufficient to satisfy the nutritional requirements of the infant.</td>
</tr>
<tr>
<td>Distributor</td>
<td>A person, corporation or any other entity engaged in distributing and marketing infant formula, at wholesale or retail level, in the course of trade or business.</td>
</tr>
<tr>
<td>General advertising</td>
<td>The communication to the general public of a promotional message through mass media, including television, national or local newspapers, magazines and radio or at point of purchase. Price information only at the point of purchase is excluded from this definition.</td>
</tr>
<tr>
<td>Health care system</td>
<td>Governmental, non-governmental, or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women, including nurseries or child-care institutions and health workers in private practice.</td>
</tr>
<tr>
<td>Health worker</td>
<td>A person working in the field of health, under the authority of the health care system.</td>
</tr>
<tr>
<td>Infant</td>
<td>A child who has not attained the age of six months.</td>
</tr>
<tr>
<td>Infant formula</td>
<td>Manufactured products (either in ready to-feed, or in concentrated liquid or dry form) which, after reconstitution if necessary, can be used as the sole source of nourishment for an infant. It does not include follow-on infant formula for infants over six months of age or products used as complementary foods, as defined below.</td>
</tr>
<tr>
<td>Follow-on formula</td>
<td>An infant formula which is designed for, and marketed as suitable for, infants aged 6 months and over.</td>
</tr>
<tr>
<td>Labelling</td>
<td>Words, particulars, trade marks, brand names, pictorial matter or symbols relating to, and appearing on the packaging of, products that are</td>
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</table>
offered for retail sale.

Marketer A person, corporation or any other entity engaged in the business of marketing infant formula, whether directly or through an agent.

Marketing Promotion, distribution, selling, advertising, product public relations, and information services.

Sample A single package or small quantity of infant formula provided without cost to the recipient.

Supplies Quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

Article 4 Information and education

4.1 Any information or educational equipment or material provided by marketers or distributors should be in conformity with the overall policies promoted by the health care system.

4.2 Informational and educational materials provided by the marketers of infant formula, whether written, audio or visual, dealing with the feeding of infants with infant formula, should always emphasise the benefits and superiority of breastfeeding, without however using terms which could cause anxieties to those mothers who are unable or unwilling to breastfeed their infants.

4.3 Explicit instructions must be given to guide mothers on the appropriate and correct use of infant formula. Members of the health professions, and those members of the public who request it, must be provided with accurate and relevant information about infant formula, which should accurately reflect current knowledge and responsible opinion.

Article 5 Marketing of infant formula to the general public

5.1 There should be no general advertising of infant formula by NZIFMA companies through mass media, including television, national or local newspapers, magazines and radio or at point of purchase.

5.2 NZIFMA will inform retailers of the provisions of the Industry Code and encourage their adherence to it.

5.3 Advertising for follow-on infant formula should not imply that the product is equivalent or superior to the milk of a healthy mother, or carry such words or pictures as are referred to in Article 4.2 of the Industry Code.

5.4 Labelling or educational literature should not imply that either infant formula or follow-on formula are equivalent or superior to the milk of a healthy mother, or include words or pictures designed to discourage a mother from breastfeeding, or
suggest by any means that artificially-fed infants are more likely to be contented or to grow faster or larger, than adequately breastfed infants.

5.5 NZIFMA companies may only provide samples or supplies of infant formula to customers (pregnant women, mothers of infants or their families), with the direct approval of the customer's health practitioner. NZIFMA companies will be required to record all of these requests.

5.6 Gifts of utensils or other articles that may discourage a mother from breastfeeding her infant should not be distributed to pregnant women or mothers of infants.

5.6 Educational services and information related to infant formula should be provided only through the health care system and by appropriately trained personnel, but without prejudice to the rights of mothers, as consumers, to seek information from manufacturers or distributors on infant formula and on artificial feeding with infant formula. Manufacturers and distributors may meet such requests for information, provided that they pay particular concern to the provisions of Articles 4 and 5 of the Industry Code.

Article 6 Marketing of infant formula to the health care system

6.1 Scientific, factual and relevant information regarding infant formula may be supplied to the health care system, provided that only appropriately trained personnel are used for this purpose.

6.2 The distribution or display of information and educational materials which meet the requirements of Article 4 of the Industry Code may be allowed in the facilities of the health care system, but this will be at the discretion of the health care system authorities concerned whose agreement must be obtained.

6.3 The demonstration of the correct preparation and use of infant formula to all mothers who need this should be the responsibility of the health care system. Any assistance for this purpose may be given by personnel employed by marketers or distributors, if requested by and used under the supervision of the health care system authorities.

6.4 Infant formula may not be given by manufacturers and distributors to institutions or organisations within the health care system, whether intended for use in the institution or organisation or for distribution for use outside it.

6.5 The donation to the health care system of equipment and materials, including those referred to in Article 4.1 of the Industry Code, should be made only in accordance with the normal policies of the health care system. Such equipment or materials may only bear the donating company's logo.

Article 7 Marketing of infant formula to health workers

7.1 Information provided by manufacturers and distributors to health workers regarding infant formula should be restricted to scientific and factual matters and such information should not imply or create a belief that bottle feeding is
equivalent or superior to breastfeeding. Such information should include that specified in Article 4.3. of the Industry Code.

7.2 No financial or material inducement to promote infant formula should be offered to health workers or members of their families. However, articles of general utility may be distributed to members of the health care system, provided they are inexpensive and relevant to the practice of medicine and general health care.

7.3 Samples of infant formula, or of equipment or utensils for the preparation or use of infant formula, should be provided only for the purposes of professional evaluation and research, or for the education of mothers.

Article 8 Persons engaged in marketing

8.1 Marketers and distributors should appraise persons employed by them in marketing of the provisions of the Industry Code and of their responsibilities under it.

8.2 Persons engaged in marketing infant formula should not perform educational functions in relation to pregnant women or mothers of infants, unless requested to do so by and under the supervision of the health worker.

Article 9 Labelling

9.1 Labelling of infant formula should comply with the requirements of the WHO Code.

9.2 Labelling of infant formula should be designed to provide the necessary information about the appropriate use of the product and to conform to the provisions of Article 5.2 of the Industry Code.

9.3 Each container of infant formula offered for retail sale should comply with the appropriate food regulations and carry a clear and conspicuous message:

(a) stating the superiority of breastfeeding;
(b) recommending that personnel of the health care system should be consulted about infant feeding;
(c) giving clear and precise instructions on the use of infant formula; and
(d) warning against the hazards of inappropriate preparation.

9.4 Specialised infant formula for metabolic disorders are exempt from the provisions under Article 9.3 of the Industry Code.

Article 10 Compositional quality

10.1 Infant formula must comply with the general provisions of the Food Regulations 1984 and Amendments.

Article 11 Implementation

11.1 The NZIFMA shall be responsible for monitoring the provisions of the Industry
Code in accordance with the formal agreement between the Association and the Ministry of Health.

11.2 All persons concerned in any way with the marketing of infant formula should cooperate with the NZIFMA in order to ensure that the provisions of the Industry Code are applied and enforced as effectively as possible.

**Article 12 Complaints Process**

12.1 Any complaints about the possible contraventions of the Industry Code should be in writing and sent to the Ministry of Health who will direct them to the Executive Director of the NZIFMA. The Executive Director is independent of the five NZIFMA companies.

12.2 If it appears that a contravention has occurred, he shall inform the NZIFMA company concerned of the substance of the complaint, inviting the company to reply within 20 working days stating whether the substance of the complaint is valid or to give any answer or explanation that may be necessary.

12.3 If the Executive Director decides that a contravention of the Industry Code has occurred he should recommend what steps the NZIFMA company should take to remedy the matter, which may include obtaining a written undertaking from the company that the practice in question, if not already discontinued will be discontinued on or before a certain date.

12.4 If an NZIFMA company or a complainant disagrees with the decision of the Executive Director, the complaint can be considered by an independent adjudicator whose decision will be final and binding if the independent adjudicator believes there is good reason for final adjudication.

12.5 The Executive Director will be required to report at least twice yearly to the Ministry of Health on all complaints received and actioned (including appeals).

**Question 8**

Are there any comments on the Industry Code of Practice?
Submission Questionnaire

of the

Draft Discussion Document for the Development of the Self Regulatory

Codes of Practice for the Health and Industry Sectors

Date: ............................................................
Completed by: .............................................
Position: ..................................................
Organisation: ............................................
Address: ..................................................

Submissions include the input of:

..........................................................

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Please continue overleaf or use extra sheets as necessary.

QUESTION 1: WHO Code

1a Do you have any comments on the definitions used in the Discussion Document?

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........................................................................................................................................
lb Are there other terms that require definition?


QUESTION 2

2a History and Incidence of Breastfeeding
Is this topic important to include in the Health Sector Code? State Why.


2b Benefits and Possible Contraindications of Breastfeeding
Are there other benefits/situations/contraindications that should be included here?


2c Health Professionals
Health professionals should be accountable for their client education. How and to whom are health professionals going to be accountable?


2d Health Professionals
Are there other key responsibilities that should be included?
2e. Training Institutions
Is the topic adequately covered in the various health professionals training curriculum (medical, nurses, midwives, pharmacists, plunket nurses, dietitians)?


2f. Training Institutions
What alternatives to the training would you suggest?


2g. Training Institutions
Is the trainee health professional given enough practical experience in the clinical situation to be able to manage the practical aspects of breastfeeding in their practice?


2h. Training Institutions
Make suggestions for improving practical experience for trainee health professionals.


2i. Prenatal and Postpartum Care
Are the strategies given in 2.6 and 2.7 of the Discussion Document appropriate? If not, what points do you not agree with? What alternatives would you suggest?


2j The Practice of Breastfeeding
State other topics to do with the practice of breastfeeding which you think should be included?

2k The Practice of Breastfeeding
Is this the appropriate way to address the topic 'practice of breastfeeding' for the Codes of Practice? What alternatives would you suggest?

QUESTION 3: Psycho-social Issues which may be Barriers to Breastfeeding
3a Are there other topics that should be addressed? Is so, state them.

3b Do you know of any research psycho-social barriers being carried out in New Zealand?

QUESTION 4: Cultural Aspects-Maori Aspects
4a Do you have any concerns about the way this topic is being approached? If so, state them.
Cultural Aspects - Pacific Island Aspects

4b Do you have any concerns about the way this topic is being approached? If so please state them.

QUESTION 5

5a Ten Steps to Successful Breastfeeding Do you think these steps are relevant to the New Zealand situation? Any other comments?

5b Position Statements
Has any other professional group published a Position Statement on breastfeeding?

If "yes", where and when was it published?

5c Support
What are your ideas for "appropriate support"?
QUESTION 6 - Issues Surrounding Successful Infant Formula Feeding

6a  Has this topic on support been adequately covered?

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6b  Are there areas which you would like improved?

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QUESTION 7 -
Are there any further comments you would like to make on this Health Sector Draft Discussion Document? Please state.

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QUESTION 8 - Industry Code.
Are there any comments on the Industry Code of Practice?