THE CONVENTION ON THE RIGHTS OF THE CHILD

REPORT ON THE SITUATION OF BREASTFEEDING IN NEW ZEALAND

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See references within document

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IBFAN: International Baby Food Action Network

Infant and young child feeding in New Zealand

1) General points concerning reporting to the CRC

- New Zealand is being reviewed by the CRC Committee for the 3rd and 4th time. At the last review, in September 2003 (session 34), IBFAN sent an alternative report to the CRC Committee.
- In 2003, the CRC Committee made indirect recommendations on infant and young child feeding, by focusing on the high rates of infant mortality and the disparity of health indicators between ethnic communities.
- In paragraph 36 of the Concluding Observations the Committee recommended ***" that the State Party: …(b) take all necessary measures to ensure universal immunisation coverage and develop preventive health care and guidance for parents and families, which effectively address the relatively high rates of infant mortality and injuries…"***

Concerning these recommendations:

- In November 2009, the New Zealand Government's, Health Committee started an *Inquiry into how to improve completion rates of childhood immunisation*[1], which is still ongoing.
- New Zealand's Ministry of Health is promoting breastfeeding through a comprehensive breastfeeding advertising campaign, including TV advertisements.
- New Zealand has ratified CEDAW and is reporting this month to the Committee its 7th report; the NGO organisation the *National Council of Women New Zealand*[2] leads an alternative report which IFANZ has made input into.
- New Zealand has human rights enshrined in law: the Human Rights Act 1993 and the New Zealand Bill of Rights Act 1990. Breastfeeding is protected within the Human Rights Act, and the NZ Human Rights Commission has a paper specifically on the issue[3].
- New Zealand has NOT ratified ILO Convention No. 183 (2000) on maternity protection at work.

2) General situation concerning breastfeeding in New Zealand

General data

The number of children in New Zealand has been steadily increasing. The following are estimates as at the 31 December from Statistics New Zealand[4]:

[1] www.parliament.nz
[2] www.ncwnz.org.nz
[3] http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/04-Aug-2005_22-49-29_RighttoBreastfeed.pdf
[4] www.stats.govt.nz

Total infants, children 0-12 months:	2002 = 54,970	2009 = 63,180
Total children under 2 years:	2002 = 111,200	2009 = 127,150
Total children under 5 years:	2002 = 281,210	2009 = 305,750
Infant mortality rates, slowly decreasing	2002 = 5.55	2008 = 5
The latest maternal mortality rate		2008 = 13.7[5]

Breastfeeding data

Collection of data for breastfeeding comes from different sources because of how the maternity health system works. Pregnant women are seen by "Lead Maternity Carers", who are predominantly midwives.

"Initiation of breastfeeding" data is not a required field in the New Zealand system. The New Zealand College of Midwives, which is a professional body for a large number of midwives in New Zealand, found that out of their data for 21,975 births in 2007, 70% of the records provided initiation data within the first hour to be 95%.

The Ministry of Health conducted a comprehensive health and nutrition survey, the first of its kind, in 2006/2007, which gives the following information[6]:

Exclusive breastfeeding:	
at 3 months:	55.8%
at 6 months:	7.6%
The mean age of complementary feeding:	5.5 months
Continued breastfeeding at 12 months:	28.3%
Mean duration of breastfeeding:	8.6 months

Maori (our indigenous population) children were more likely than children in the total population to have been given solids before four months of age. European and Asian children were less likely.

Children living in the most deprived areas were over three times more likely than children in the least deprived neighbourhoods to be given solids before four months of age.

The main cause of death among infants is from SUDI (Sudden Unexpected Death in Infancy) and one of the preventative measures is to breastfeed.

[5] www.pmmrc.health.govt.nz

[6] http://www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health

3) Government efforts to encourage breastfeeding

The International Code of Marketing of Breastmilk Substitutes (the Code)

New Zealand has a **voluntary Code** of practice for implementing the Code. It is substantially watered down and has four different mechanisms: *The Infant Formula Marketers Code of Practice* for infant formula, 0 - 6 months; the *Health Workers Code* for 0 – 12 months; the *Advertising Standards Authority* for solids (any age) and over 6 months formula, follow on, Toddler milks and bottles and teats; and the *New Zealand Food Safety Authority (NZFSA)* for composition and labelling[7].

Currently the Ministry of Health is reviewing the Code in New Zealand; a telephone survey is being conducted at present in preparation for the government to complete a review in early 2011.

Monitoring the Code

The IBFAN group, IFANZ, does monitoring and sends in complaints. Please see attached our LWTD 2010 which has many NZ violations and explains the situation here.

There is no official monitoring by the government; they are reliant on civil society to make complaints to the Ministry of Health for violations against the Infant Formula Marketers Code of Practice and the Health Workers Code. Complaints can be sent to the Advertising Standards Authority against solids, bottles, teats and formula over 6 months. The NZFSA can be approached for complaints against composition and labelling.

Food law in New Zealand prohibits health claims and is under review. Since March 2010 when IFANZ made a complaint about Wyeth making a health claim, there has been no action to prosecute. This inaction is perceived to be a delaying tactic to prevent prosecution when a new law is pending.

Breastfeeding training courses

The BFHI have in-house training for breastfeeding as per their requirements. La Leche League run peer counsellor training for practitioners in community health; this is in its infancy.

HIV/ and infant feeding training is sidelined in New Zealand with a clear mandate from the Ministry of Health to formula feed.

4) Baby Friendly Hospital Initiative (BFHI)

NZ have 71 of the 76 applicable maternity units accredited as BFHI hospitals, that is, 93.4%. Two have lost accreditation and are working to regain it.

Also of note is the one hospital that has the largest number of births annually (Middlemore Maternity Facility), in the highest deprivation area, has never been and is not yet accredited.

[7] http://www.moh.govt.nz/moh.nsf/indexmh/breastmilksubstitutemarketingcode

Baby Friendly designated hospitals and training

For a maternity facility to pass, the staff must have a minimum of 80% meeting the education requirements. In many services there are well over 80% for each category. There are three levels.

- *Level 1 is those staff with a clinical role (Specialist).* In line with the new international UNICEF/WHO BFHI documents, NZ requires staff who have a clinical role to complete 21 hours training (18 hours education plus 3 hours clinical supervision). This means all midwifery and nursing staff to pass accreditation.
  In the 71 services there were 2397 staff in this category and 2145 of them fully met the criteria = 89.5%.
- *Level 2 limited clinical role (Generalist).* 4 hours of education with 2 hours ongoing education each year is required.
  In the 71 services there were 404 staff in this category and 358 met the full standards = 88.6%
- *Level 3 no clinical role (Awareness).* 3 hours training is required initially with 1 hour annually.
  In the 71 services, there were 868 staff in this category and 802 of them met the requirement = 92.45%

We also have a category Level 4 (Expert) and this group have skills over and above the requirements for BFHI. People in this category are able to deal with complex or difficult breastfeeding problems and are often used in staff training. Eg IBCLC's

The maternity facilities undergo a full BFHI assessment every three years. Also required is an annual BFHI survey to be completed and returned. This involves them sending in their annual breastfeeding data, staff education records and a sample of mother interviews to see if the service is complying with the standards for each of the Ten Steps.

BFHI reassessment systems are incorporated in national plans

The maternity services in New Zealand are required to be accredited BFHI and we certify them for 3 years. They must undergo a full reassessment every 3 years as well as completing an annual survey and sending that to the NZ Breastfeeding Authority.

In 2005 all maternity facilities were required to become accredited as Baby Friendly by the Ministry of Health. The first three units were accredited in 2002 and since then there has been steady progress.

2003 = 6	2005 = 29	2007 = 57	2009 = 69
2004 = 16	2006 = 50	2008 = 63	

5) Maternity protection for working women

Specific labour force information from the last Census

The 2006 Census found that there were 55,509 mothers with a child under one year of age. Of these, 20,199 (37%) were in employment, 2,983 (4%) were unemployed and seeking work, and 32,864 (59%) were not in the labour force.[8]

1 April 2009, a new law came into being – Section 69Y of the Employment Relations Act 2000: Employers are required, as far as is reasonable and practicable, to provide appropriate breaks and facilities for employees who wish to breastfeed their infants or express milk during work hours. This time is not paid.

Special Leave: one week entitlement (two weeks if employed by same employer for 12 months), for ante-natal visits before the birth and is unpaid leave. Paid by employer.

Unpaid paternity leave: Fathers have two weeks off when the baby is born, if they meet the 12 months working for the one employer criteria or one week if they have worked for 6 months.

Paid parental leave is for 14 weeks, under the condition that the woman worker had an average minimum of 10 hours work a week for the same employer for six months; this is an automatic right of the birth mother, however she may transfer all or part to her partner **(meaning that a woman can have a baby and not have any paid leave at all even after the birth if so she chooses).** For an adoption the couple chooses the main carer and can then transfer all or part of leave to the other partner.

Though parental leave is in theory a shared leave, in most cases the mother takes the whole leave. The leave can commence before birth.

Weekly amount is gross weekly wage or $441.62 - whichever is the lower. This is paid by the government. For self-employed women, it is $127.50, also paid by the government.

Two employee groups are entitled to special considerations. Doctors and teachers have paid parental leave even if they have different employers over the six month period that is required for qualifying. Some consider this discriminatory, as these professions are less underpaid than others. Concerning breastfeeding, such a provision gives women working in less advantageous conditions a difficult start as, statistically, there are those most likely to stop breastfeeding.

- Example: Doctors can have multiple District Health Board employers (Public hospitals – which are most of our hospitals are run by District Health Boards so they are the employers) over the six month eligibility criteria period and Teachers can have multiple Board of Trustee employers (schools in NZ are run by board of trustees, they are the employers) over the six months.[9]

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[8] The work situation of the remaining women was unknown. Source: Statistics New Zealand, *Work and Labour Force Status of Female Parent by Age of Youngest Child in Family for Census Usually Resident Population Count of Females in a Parental Role,* Prepared for Louise James, Women's Health Action, Reference Number: ROM16092.

[9] Dept of Labour, NZ: **Special Rules for Junior Doctors and Teachers:** If you are a junior doctor working for a district health board (DHB) or a teacher employed by a school board of trustees the following rules apply:

- If you are a junior doctor and you are required to rotate between different DHBs as part of your compulsory training, your length of service with each employing DHB will be added together for the purposes of determining whether you meet the six or 12 month criteria for leave and payments. You will still need to meet the hours of work test.

- There is no such provision for seasonal, or service industry workers (informal economy) who are more likely to have multiple employers and not have continuous employment with the same employer. For example, a mother working for different cleaners can not count her total number of hours as a total and therefore does not meet the eligibility criteria period!–

Extended leave of 52 weeks (inclusive of paid parental leave) can be taken unpaid if employed by the same employer for a year prior. This is available for partners as all or part share if they have met the one year working for the same employer criteria.

In other words, the maternity protection law in NZ is rather weak. Though there is a provision allowing for 14 weeks paid leave for some categories of workers, if the woman so chooses, she can "give" it entirely to her partner and therefore does not have it in absolute.

6) HIV and infant feeding

HIV/AIDS in New Zealand is considered to be 'low level', at 5%. There were 28 notified cases in 2009, two of them being paediatric HIV (previously known as mother-to-mother transmission), from mothers who were not tested in pregnancy.

New Zealand has a National Ante-natal HIV screening implementation advisory group http://www.nsu.govt.nz/health-professionals/1126.asp

The information below is from one of the consumer representatives on the advisory group.

- Testing is available for pregnant women to see if they are HIV infected. Some mothers have been tested for HIV without their knowledge; partners are not asked to be tested; and some men refuse to give permission for their partners to be tested.
- New Zealand has a policy document, Ministry of Health (2008) Food and Nutrition Guidelines (0-2 years) which has one sentence on the subject stating that Mothers with HIV infection should not breastfeed.[10]

7) Obstacles and recommendations

The following <u>obstacles/problems</u> have been identified:

- New Zealand is a huge dairy producing country and the industry has the ear of the government which makes it difficult to have in law anything that may restrict the infant formula industry.

- If you are a teacher employed by multiple boards of trustees during the eligibility period, those jobs are counted together in determining whether you meet the six or 12 month criteria for leave and payments. You will still need to meet the hours of work test.

[10] Ministry of Health. 1999. *HIV/AIDS Information for Health Professionals*. Wellington: Ministry of Health.

- Codes of practice in New Zealand are self-regulatory and the government digs its feet at any suggestion of change in this area.
- The main well-child provider in NZ – Plunket[11], in New Zealand who does health checks for infants and young children is sponsored by a major baby food company and endorses their solids for 4-6 months.
- Breastfeeding is not counted in the GDP of the country, yet infant formula is. The economic growth of the country takes precedence over public health.
- Breastfeeding needs support, protection and promotion. In New Zealand we have support systems in place and the Ministry of Health does their advertising of breastfeeding. However the national Code is very weak so we fall down on protection. Allowing the formula companies to abuse the Code in New Zealand with their own take on it, in a voluntary capacity, waters down the impact the advertising of breastfeeding could have on breastfeeding rates.

***Our recommendations* include:**

1. Breastfeeding data should be collected systematically, including on exclusive breastfeeding at 3 months and 6 months.
2. Setting up a multi-sector Breastfeeding Committee separate (and independent) from the Ministry of Health.
3. Legislating the Code and making provisions for monitoring, compliance and education.
4. Allocating additional funding to Middlemore maternity facility specifically, to help them achieve BFHI accreditation.
5. Strengthening maternity protection provisions: first by changing the eligibility criteria (possibility of having more than one employer during the 6-month period of work) so as to extend paid parental leave to seasonal workers, workers in the service industry, informal economy, etc.; providing a period of “maternity” leave for mothers alone, without the possibility of sharing it with the partner; entitling mothers to paid breastfeeding breaks; ratifying ILO Convention 183 (2000).
6. Providing adequate funding for the NZ Plunket service in order for them to drop the sponsorship of the baby food company.
7. The Corrections (mothers with Babies) Amendment Act 2008 No.88 has to “be commenced” (to come into force), for the provision of incarcerated mothers to have their babies and young children with them to breastfeed.
8. The Department of Education should equip and mandate Early Childhood Services to implement the draft Breastfeeding Guidelines for early Childhood Centres (2009).

[11] New Zealand’s largest provider of support services for the development, health and wellbeing of children under the age of 5years – their first visit to mothers is usually around 4 weeks.