How Far We Have Come

Welcome to the August newsletter from NZBA. I am writing this whilst waiting in the delivery suite for a baby to make its way into the world. At times like this, I can’t help but reflect on what a difference the Baby Friendly Initiative has made to mothers and babies over the years.

I look back at the birth of my first baby and remember how she was taken immediately away from me, dried on a rough hospital towel and placed over the other side of the room where she had to wait all alone until she had been weighed and staff were ready to help me feed. I knew that I needed to be with my baby and that she needed to be near me.

All the babies in the ward were given regular formula top ups and taken into the nursery overnight. We were told not to bother breastfeeding our babies as we had little milk to give them and as new mums, we believed them.

How far we have come and how much better things are today. Ninety-eight percent of babies are born in a baby friendly facility. We encourage mums to have early skin-to-skin contact and for baby to have his/her first feed at the breast unhurried and uninterrupted—an incredible moment to witness. Mums and babies room-in together and staff are better educated and women are supported with their feeding choices.

We know BFHI is a success and the data that our CEO Julie Stufkens, collated and presented to the WHO shows that New Zealand is a recognized world leader in the field. Whilst we should be incredibly proud of our achievements, we cannot afford to rest on our laurels. It is vital this work continues and that New Zealand women continue to get the best care available. This is what our families deserve and we should never settle for anything but the best.

Debbie Fawcett—Chairperson NZBA Board

PS...we had a boy, enjoying skin-to-skin as I write!
World Breastfeeding Week 1—8 August 2014

This year the WHO will post an article on its website for World Breastfeeding Week highlighting breastfeeding in New Zealand:


Julie Stufkens has also been invited to participate in the World Breastfeeding Week related actions held at the WHO in Geneva from 4-8 August. During the week, Julie will participate in a WBW seminar and present on BFHI, the work of the co-ordinators network and our experience in NZ. She will also contribute to the recording on BFHI, which will be included in a video on global implementation of the initiative.

BFHI Documents

The BFHI Documents for Aotearoa New Zealand are reviewed three yearly and this process has been completed once again.

The NZBA began consultation last year with the BFHI Co-ordinators at the annual meetings held in November. The documents were sent out to all maternity services, NZBA member organisations and BFHI assessors for consultation. Submissions were received from groups and individuals and the feedback provided was used to incorporate the suggestions for change where appropriate.

Once alterations were completed, by the NZBA staff, the documents were sent out to a working party consisting of a maternity manager, midwives and lactation consultants and a consumer representative. Maori representation was included in the group.

Further updating of the documents has now been concluded and these will be placed on our website.

We would like to take this opportunity to thank all of the groups and individuals who reviewed the large set of documents and sent us feedback.

Facilities will not be assessed using the updated documents until after the Co-ordinators workshops. Workshops are planned to update the current BFHI assessors and the BFHI Co-ordinators on the changes (see below).

NZBA Training Dates 2014

BFHI Co-Ordinators Meeting

Christchurch 7 November
Wellington 13 November

BFHI Assessor Updates for use of new BFHI Documents

Palmerston North 18 September
Auckland 14 October
Christchurch 6 November
Wellington 12 November

Train-the-Trainer Workshop

Christchurch 22-24 October
BFCI DOCUMENTS AND PROCESS

The BFCI documents for Aotearoa New Zealand have been recently updated. The changes made enable services or groups to work through the BFCI process. Engagement in the BFCI process is free and permits the services to work through the implementation of the standards at their own pace—requesting external assessment when they feel well prepared.

These documents are divided into three sections:

Section One: Provides context to the BFCI process – a background and overview of BFCI in New Zealand. It also includes a section entitled “Getting Started”, a Register of Intent and the BFCI Standards of Care.

Section Two: is designed to assist a group (or grouping) through the BFCI process. It includes an Action Plan, a Guide to Implementing the BFCI Standards and the Pre-Assessment Evaluation. The Guide to Implementing the BFCI Standards works through each Point—offering advice, recommendations and useful educational resources to assist a co-ordinator in her role.

Section Three: is a guide for the Assessors and includes documentation material necessary to complete the assessment process.

The first two sections will be placed on the website for ease of access and to encourage community services to review the information and realise BFCI can be implemented at their own pace—NZBA requiring only a Register of Intent as an indication of interest so support can be offered as required.

ACCREDITATIONS

Since our last newsletter the following facilities have been re-accredited.

BFHI Accreditations
Third time accreditations
Helensville Birthing Centre
Horowhenua Maternity Unit, Levin

Fourth time accreditation
Paraparaumu Maternity Unit, Capital & Coast

BFCI Accreditation
Second time accreditation
“The Fono”, Waitemata DHB
(formerly known as West Fono)
Pictured right

Congratulations to all involved for an almost seamless assessment process. It is evident that these facilities have embraced the BFI concept and it is integral in the day-to-day care of the mothers and babies who use them.
IBCLC EXAM

To all those who recently sat the IBCLC Exam, whether it be the first time or recertifying, NZBA wish you well.

Both Dawn and Dianne were required to resit this year and now have the long wait (end of October) for the results.

Good luck to you all!

MODERNISING PARENTAL LEAVE: CHANGES TO ALLOW GREATER ACCESS AND INCREASED FLEXIBILITY

There is an opportunity to submit ideas on paid parental leave. The Minister has announced a process for reviewing aspects of paid parental leave (PPL).

This consultation is seeking feedback on the discussion document, “Modernising Parental Leave: Changes to allow greater access and increased flexibility”. The discussion document outlines proposals to modernise parental leave by broadening the eligibility to better reflect current work and family arrangements and providing more flexibility to increase choice and support labour market attachment.

We encourage you to submit your ideas and comments to the Minister. Information can be found at:

The deadline for submissions is 25 August 2014.

SAVE THE DATE: SAFE SLEEP DAY
FRIDAY 5 DECEMBER 2014

Whakawhetu National SUDI Prevention for Maori

Safe Sleep Day
Friday 5 December 2014

We hope to continue the successes of 2013 by working to ensure that “every sleep is a safe sleep for all babies”.

If you have any questions please feel free to contact Jeanine Tamati-Paratene at j.tamati-paratene@auckland.ac.nz or whakawhetu@auckland.ac.nz

Website: www.safesleepday.org.nz Facebook: Safe Sleep Day
The New Zealand Breastfeeding Authority was represented at the BFHI Co-ordinators Meeting for Industrialised Countries by Julie Stufkens, Executive Officer and Dianne Powley, BFHI Co-ordinator. The meeting was held in the Town Hall Municipal Chambers in the capital of Lithuania.

Julie Stufken’s Role

As BFHI Network Co-ordinator (2012-2014) I worked with Daiva Šniukaitė-Adner (Country host, Lithuania) and with Carmen Casanovas, WHO representative, in planning the dates for the meeting. The Country report template was updated and the International Code questionnaire developed in consultation with the working group. These were then sent with the invitation to the meeting. The reports were returned for collation and two presentations were prepared. The working group developed the programme and agenda based on feedback from the last meeting and in close collaboration with the participants in order to ensure that the individuals and organizations attending received the maximum benefit.

A three-day meeting was hosted by Lithuania for 58 BFHI coordinators and committee members from 30 industrialised countries to discuss common situations and strategies in the implementation of BFHI in their countries. Participants from international organisations and some observers also attended: WHO, ILCA and members of the Scandinavian NICU special interest group.

We found this year’s meeting stimulating – this could be attributed to the higher standards for presentations, but also because we knew many of the participants from previous meetings and so felt more comfortable mixing and discussing issues with them between sessions. There was a focus on the Code implementation country level and within BFHI.

It is true, we again validated the high level of BFI compliance in New Zealand, but it made us more aware of the differences culture can make on progress and the degree of government support.

Our midwifery system lends itself to a ‘mother-friendly’ environment that other countries can only dream of – and our unique organisational set-up (made-up of stakeholders) encourages wide ‘buy-in’ which eludes many countries.
WHO/UNICEF 8TH MEETING OF BFHI COUNTRY CO-ORDINATORS—6-8 JUNE 2014—VILNIUS, LITHUANIA

In the countries represented compliance to the global BFHI standards and the Code of Marketing of Breast-Milk Substitutes is variable and showed varying degrees of implementation. It became obvious the range of requirements definitely is impacted by the degree of infant formula involvement in funding the country’s health services. It is therefore important to distinguish between Baby Friendly services accredited with Global standards and those who meet lower national standards.

Being held every two years, this reunion aims at supporting actions in industrialised countries for the implementation of the Baby-Friendly Hospital Initiative and baby-friendly care in settings other than hospitals and mater- nities. This year, 32 countries had completed exhaustive questionnaires before the meeting on the situation of BFHI, baby-friendly care and the Code in their countries. These data were compiled and presented at the meeting by Julie Stufkens from New Zealand, acting as coordinator for the group over the last two years. See pages 10-12 of this newsletter.

WHO UPDATE ON GLOBAL DEVELOPMENTS FOR INFANT AND YOUNG CHILD FEEDING & BABY-FRIENDLY HOSPITAL INITIATIVE

Global Action Plans
Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (65th WHA, 2012)
Six global targets and indicators
Five priority actions for Member States and other implementers
Every Newborn Action Plan (67th WHA, 2014)
Two global goals – ending (1) newborn death (2) stillbirths
Five strategic objectives with key actions
Global Nutrition Targets
- Reduction in the number of children under 5 who are stunted
- 50% reduction of anaemia in women of reproductive age
- 30% reduction in low birth weight
- No increase in childhood overweight
- Increase the rate of exclusive breastfeeding in the first six months up to at least 50%
- Reduce and maintain childhood wasting to less than 5%

Every newborn Action Plan
Five strategic goals and objectives - every newborn action plan
- **Strengthen and invest in care** during labour, birth and the first day and week of life
- **Improve the quality** of maternal and newborn care
- **Reach every woman and every newborn**; reduce inequities
- **Harness the power** of parents, families and communities
- **Count every newborn** – measurement, tracking and accountability

BFHI crucial to achieving these and both fit in well with the goals of BFHI. There is the potential to use human rights to strengthen accountability of care for under-fives. BFHI improves child development and human capital is an application of human rights (see UN Human Rights Council and UN Committee of the Rights of the Child). Applying human rights to strengthen accountability, under 5’s mortality is not just a public health concern, but is also a human rights issue. WHO is working towards technical guidelines on application of HRBA to health - what are the legal responsibilities of states to provide effective health care.

BFHI Update of Materials
- Integration of 2010 guidelines on HIV and infant feeding
- Updating includes all Sections
- Main changes in the module on HIV
- Product expected by 3rd quarter 2014

Implementation and Monitoring
- Marketing of complementary foods for infants and young children
- Monitoring the implementation of the International Code of Marketing of Breast-milk Substitutes
- WHO Code report
- Global Network for Monitoring the Code

Five criteria can be considered to evaluate if promotion is inappropriate:
1. It undermines recommended breastfeeding practices;
2. It contributes to childhood obesity and noncommunicable diseases;
3. The product does not make an appropriate contribution to infant and young child nutrition in the country;
4. It undermines the use of suitable home-prepared and/or local foods;
5. It is misleading, confusing, or could lead to inappropriate use.
WHO UPDATE ON GLOBAL DEVELOPMENTS FOR INFANT AND YOUNG CHILD FEEDING & BABY-FRIENDLY HOSPITAL INITIATIVE (Cont.)

Global Monitoring Network for the Code Vision
World where all sectors of society are protected from inappropriate and unethical marketing of BMS though adoption, monitoring and enforcement of national legislation in full compliance with the Code.

Goal
Strengthen Member States and civil society capacity to monitor the Code; and Member State’s Code legislation and enforcement by bringing a group of committed partners to support this process.

Preliminary meeting held on 10-11 April 2014

WHO and Implementation of the Code
WHO reports to WHA on Code implementation status every other year-
WHO report based on information provided by countries
WHA Resolution 65.6 (May 2012) requests WHO to support Member States in the monitoring and evaluation of policies and programs ….. and to report to the Sixty-seventh World Health Assembly (2014) on implementation of the International Code of Marketing of Breast-milk Substitutes and related Health Assembly resolutions
WHO report on the Code is the first WHO publication documenting actions taken by countries

Legislation

Reporting countries with full implementation of the Code
13 out of 43 countries in Africa (30%)
8 out of 30 countries in America (27%)
7 out of 20 countries in the Eastern Mediterranean (35%)
2 out of 41 in Europe (5%)
4 out of 10 in South-East Asia (40%)
3 out of 21 in the Western Pacific (14%)
Total: 37 out of 165 reporting (1 in 5)

Key Provisions – Advertising to the Public
Prohibition of advertising breast-milk substitutes
80 countries provided information
69 countries (35%) fully prohibited advertising
119 countries didn’t answer/clearly stated whether there was prohibition

Prohibition of sales promotion
68 countries (34%) fully prohibit sales promotion
119 countries did not answer/clearly stated their stand on prohibition
Key Provisions – Promotion in Health facilities

Prohibition of free/low-cost supplies

119 countries did not answer/clearly state their stand on prohibition of free/low-cost supplies

62 out of 79 countries reporting completely prohibited free/low-cost supplies

Prohibition of materials/gifts to health workers and health facilities

64 countries completely prohibited gifts to health workers

12 countries did not prohibit materials/gifts for health workers

120 countries did not answer/clearly state their stand in prohibition

Functioning implementation and monitoring system

Criteria for monitoring mechanisms

- independence and transparency
- freedom from commercial influence
- empowerment to investigate code violations
- empowerment to impose legal actions

Countries responses

117 countries did not answer or did not clearly state whether they had a functioning implementation and monitoring system

45 countries reported having a functioning implementation and monitoring system

27 countries reported NOT having such system.

Specific issues and concerns

Laws/regulations and information dissemination

(48 out of 53 countries)

- Identification of gaps in existing national legislation
- Processes necessary for adaptation of the Code into national measures
- Poor information dissemination among health care providers and district officials
- Need to ensure wider target audience in systematic education programmes

Training (12 out of 53 countries)

Call for setting-up common procedures for training, providing training to health workers

Code monitors (14 out of 53 countries)

- Weak or poor monitoring system
- Irregular monitoring activities
- Inadequate mechanisms for reporting violations (lack of funds and capacity)

Industry (14 out of 53 countries)

- Consistent, repeated, systematic violation
- Very aggressive direct marketing or indirect advertisement to mothers

Provisions and regulatory mechanisms (3 out of 53 countries)
### Improving Code Implementation and Monitoring

**Strengthening information on and knowledge of the Code**
- Capacity building of all relevant stakeholders
  - WHO/UNICEF e-course on the Code and subsequent relevant WHA resolutions
  - WHO statement on Follow-Up Formula and the Code
- Improving access to information on Code status in countries
  - WHO/GINA database and Code implementation status in Member States

**Strengthening monitoring and enforcement mechanisms**
- Increase knowledge on bottlenecks/barriers to functioning monitoring and enforcement mechanisms in countries
- Expand and coordinate monitoring/implementation stakeholders in countries
- Global Network on Monitoring of the International Code (Net Code)
- Utilise international human rights and accountability mechanisms

### 2014 Country Reports

**Of Babies Born in Maternity Services the percentage born in BFHI Accredited Facilities by Country**
### 2014 Country Reports

#### Percentage of BFHI Maternity services in the Country

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2014 COUNTRY REPORTS (CONT)

Most Recent National Data
Exclusive Breastfeeding—Birth to Discharge

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50 YEARS LA LECHE LEAGUE NZ

50 YEARS LA LECHE LEAGUE NZ—Breastfeeding Support: Our Foundation, Our Future

3-5 October 2014—Waipuna Hotel & Conference Centre, Auckland

At this year’s conference we are reflecting on our history and looking forward to our future as we celebrate fifty years of La Leche League in New Zealand.

Join us in Auckland in October for a great selection of local and international speakers, all experts in their field, and each passionate about breastfeeding.

It is a chance to truly experience a breastfeeding culture..

Need more information? lalecheleague.org.nz/news-a-events

Facebook LLLNZ Conference

General Enquiries conference2014@lalecheleague.org.nz

Registration Enquiries Rowena (0275) 752 782

BREASTFEEDING ESSENTIALS FOR PHYSICIANS: WHAT EVERY DOCTOR NEEDS TO KNOW

Friday 3 October 2014—Waipuna Hotel & Conference Centre, Auckland

To view programme and register go to

RECENT RESEARCH

INFANT FEEDING KNOWLEDGE, ATTITUDES AND BELIEFS PREDICT ANTENATAL INTENTION AMONG FIRST-TIME MOTHERS IN QUEENSLAND

Newby Ruth, Brodribb Wendy, Ware Robert S., and Davies Peter S.W.


ABSTRACT

Aim: This study assessed infant feeding knowledge, attitudes, and beliefs among women from Queensland, Australia, in their first pregnancy. Antenatal feeding intention in this group was described, and the hypothesis was tested that antenatal knowledge, attitudes, and beliefs about infant feeding are associated with antenatal intention for the duration and exclusivity of breastfeeding for the infant’s first year.

Subjects and Methods: The Feeding Queensland Babies Study is a prospective survey of infant feeding attitudes and behaviors among first-time mothers in Queensland, Australia. Data on infant feeding knowledge, attitudes, beliefs, and intention were collected antenatally, and an Infant Feeding Attitudes Score was calculated.

Results: Although 85% of respondents endorsed breastfeeding as most appropriate for infants, 11% valued formula feeding equally. Intention to give any breastmilk during the first weeks was 98%, but it fell to 18% during the second year. More than one-quarter of women reported intention to introduce foods other than breastmilk before 5 months of infant age. The infant feeding attitudes and beliefs score correlated positively with feeding intention for breastfeeding and the introduction of complementary solids.

Conclusions: Enhancing women’s knowledge of recommendations and their understanding of breastfeeding’s specific benefits and the reasons for recommended scheduling of feeding transitions may positively impact breastfeeding exclusivity and duration and the age-appropriate introduction of complementary solids. Communication of detailed feeding recommendations for the infant’s first year and specific information about the health benefits of breastfeeding should be a goal of healthcare providers working with pregnant women.

EXPERIENCE OF THE FIRST BREASTFEEDING SESSION IN ASSOCIATION WITH THE USE OF THE HANDS-ON APPROACH BY HEALTHCARE PROFESSIONALS: A POPULATION-BASED SWEDISH STUDY


ABSTRACT

Objective: The aim of this study was to investigate the prevalence of healthcare professionals’ use of the hands-on approach during the first breastfeeding session postpartum and its possible association with the mothers’ experience of their first breastfeeding session.
Materials and Methods: This was a population-based longitudinal study conducted at Uppsala University Hospital, Uppsala, Sweden, of all women giving birth at the hospital from May 2006 to June 2007. Six months postpartum, a questionnaire including questions regarding breastfeeding support, caregiving routines, depressive symptoms, and the woman’s experience of the first breastfeeding session was sent to the mothers. The main outcome measures were use of the hands-on approach

Results: In total, 879 women participated in the study. Thirty-eight percent of the women received the hands-on approach during the first breastfeeding session. High body mass index, primiparity, and having the first breastfeeding session postponed were all independently associated with the hands-on approach. Women who received the hands-on approach were more likely to report a negative experience of the first breastfeeding session (odds ratio=4.48; 95% confidence interval, 2.57–7.82), even after adjustment for possible confounders (odds ratio=2.37; 95% confidence interval, 1.02–5.50).

Conclusions: This study indicates that the hands-on approach is commonly used during the first breastfeeding session and is associated with a more negative experience of the first breastfeeding session. Consequently, caregivers need to question the use of this method, and further research about breastfeeding support is required.

Breastfeeding Duration and Early Parenting Behaviour: The Importance of an Infant-Led, Responsive Style

ABSTRACT

Background: Popular parenting literature promotes different approaches to caring for infants, based around variations in the use of parent-led routines and promoting infant independence. However, there is little empirical evidence of how these early behaviours affect wider parenting choices such as infant feeding. Breastfeeding often requires an infant-led approach, feeding on demand and allowing the infant to regulate intake whilst conversely formula feeding is open to greater caregiver manipulation. The infant-led style associated with breastfeeding may therefore be at odds with philosophies that encourage strict use of routine and independence. The aim of this study was to explore the association between early parenting behaviours and breastfeeding duration.

Methods: Five hundred and eight mothers with an infant aged 0–12 months completed a questionnaire examining breastfeeding duration, attitudes and behaviours surrounding early parenting (e.g. anxiety, use of routine, involvement, nurturance and discipline). Participants were attendees at baby groups or participants of online parenting forums based in the UK.

Results: Formula use at birth or short breastfeeding duration were significantly associated with low levels of nurturance, high levels of reported anxiety and increased maternal use of Parent-led routines. Conversely an infant-led approach characterised by responding to and following infant cues was associated with longer breastfeeding duration.

Discussion: Maternal desire to follow a structured parenting approach which purports use of Parent-led routines and early demands for infant independence may have a negative impact upon breastfeeding duration. Increased maternal anxiety may further influence this relationship. The findings have important implications for Health Professionals supporting new mothers during pregnancy and the postpartum period.

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Abstract
The World Health Organization and the United Nations International Children’s Emergency Fund recommends that mothers and newborns have skin-to-skin contact immediately after a vaginal birth, and as soon as the mother is alert and responsive after a Caesarean section. Skin-to-skin contact can be defined as placing a naked infant onto the bare chest of the mother. Caesarean birth is known to reduce initiation of breastfeeding, increase the length of time before the first breastfeed, reduce the incidence of exclusive breastfeeding, significantly delay the onset of lactation and increase the likelihood of supplementation. The aim of this review is to evaluate evidence on the facilitation of immediate (within minutes) or early (within 1 h) skin-to-skin contact following Caesarean section for healthy mothers and their healthy term newborns, and identify facilitators, barriers and associated maternal and newborn outcomes. A range of electronic databases were searched for papers reporting research findings published in English between January 2003 and October 2013. Seven papers met the criteria.

This review has provided some evidence that with appropriate collaboration skin-to-skin contact during Caesarean surgery can be implemented. Further evidence was provided, albeit limited, that immediate or early skin-to-skin contact after a Caesarean section may increase breastfeeding initiation, decrease time to the first breastfeed, reduce formula supplementation in hospital, increase bonding and maternal satisfaction, maintain the temperature of newborns and reduce newborn stress.

Keywords: skin-to-skin contact (SSC), kangaroo care (KC), Caesarean/Cesarean section, Baby Friendly Health Initiative (BFHI), breastfeeding, operating theatre, operating room.
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Ashburton Maternity staff receiving their BFHI Certificate

Members of the Toi te Ora Group, Taranaki receiving their BFCI Certificates. Toi te Ora includes Plunket Taranaki, Tui Ora and La Leche League.