Comprehensive plan to inform the design of a national breastfeeding promotion campaign

Prepared by Quigley and Watts Ltd

Louise Thornley, Anaru Waa, Judith Ball

For the Ministry of Health

31st July 2007
Acknowledgements

The authors would like to acknowledge the National Breastfeeding Advisory Committee for providing access to a literature review and stocktake of services which it had commissioned. These documents were in draft form at the time this report was prepared. We would also like to thank Wellington Regional Public Health for supplying an unpublished report that they had commissioned in 2001 on barriers to breastfeeding for Māori women in the greater Wellington region.

Disclaimer:

The views presented in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.
Executive Summary

Breastfeeding is natural and normal, and is part of laying the foundations for a healthy life from infancy and childhood. There is strong evidence for the positive contribution of breastfeeding to nutrition, health and wider wellbeing of babies, mothers and whānau/families. Yet, many infants in New Zealand are not breastfed for the recommended duration (to at least six months exclusively and up to two years or beyond in combination with other foods).

Although New Zealand has breastfeeding rates at birth that are consistent with other OECD countries, rates are low at six weeks, especially among Māori and Pacific women. Exclusive breastfeeding prevalence drops sharply in the first six weeks after birth and then continues to decline as partial and artificial feeding becomes more common.

This report sets out a comprehensive plan that provides advice to inform the design of a national breastfeeding promotion campaign. The Government has funded the Ministry of Health to develop a promotion campaign in order to improve breastfeeding rates and duration, especially for high-need groups, and Māori and Pacific populations. It is envisaged that the Ministry of Health will use the plan presented in this report to develop a more detailed action plan for the proposed campaign. A breastfeeding promotion campaign is an important opportunity to contribute to efforts to improve the long-term health of the population and reduce health inequalities between population groups.

The report draws together several strands of evidence to inform the campaign’s development, including recent qualitative focus group research and a literature review. It recommends that the proposed campaign takes a comprehensive approach and uses a range of strategies and messages to improve support for mothers and to promote and encourage supportive environments for breastfeeding.

Campaign goals: The ultimate goal is to increase the proportion of infants exclusively breastfed to six months, and the proportion of infants partially breastfed beyond six months. Recognising that any shift towards increasing breastfeeding is positive, a secondary goal is to increase the proportion of breast milk (relative to other food sources) consumed by infants to six months. The immediate goal for the proposed campaign is to increase environmental support to initiate and maintain breastfeeding.

Objectives: There are three objectives: 1. Increase tangible support to aid mothers to breastfeed (eg, practical help with latching, assistance from family with household or childcare tasks); 2. Increase emotional support to aid mothers to breastfeed; 3. Increase informational support to aid mothers to breastfeed.

Priority groups: Māori and Pacific peoples have been identified as the key priority groups for the campaign, although it is envisaged that generic elements of the campaign will reach high-need groups of all ethnicities. The needs of Asian people in New Zealand should also be considered in the campaign.
It is recommended that the campaign contributes to achieving whanau ora and reducing inequalities. The campaign must facilitate and support community action around breastfeeding, especially by Māori and Pacific communities, and have strong involvement of Māori and Pacific stakeholders at all stages of planning, development and implementation. Mass communications strategies including public relations and stakeholder involvement should be aimed at Māori and Pacific populations as priority groups.

**Intervention groups:** In order to increase support and change environments, the key intervention groups recommended are: health practitioners, partners/family/whanau, and employers/general public/community decision makers.

**Intervention areas:** Three settings are highlighted as areas for intervention; the health system, family/whānau, and communities including workplaces. A staged approach is recommended, beginning with the health system. These intervention areas need to be responsive to Māori and Pacific Peoples, and deliver services in a way that is effective for Māori and Pacific peoples.

**Key messages:** Some key messages to be used as starting points in developing a campaign are that breastfeeding is a learned skill with common problems and solutions, and that it is everyone’s responsibility to support a mother to breastfeed, especially partners and other family/whānau and peers/other mothers.

Other key themes to consider are:

- breastfeeding is natural and normal
- breastfeeding is important for the baby’s wellbeing
- breastfeeding is associated with being a good mother
- breastfeeding is likely to become easier over time
- when established, breastfeeding is convenient and easy
- help and support from others makes a big difference
- most women breastfeed.
Contents

Executive Summary ........................................................................................................................ 3

1. Introduction and context .......................................................................................................... 7
   1.1 Importance of breastfeeding ............................................................................................. 7
   1.2 Definition of breastfeeding ............................................................................................... 7
   1.3 New Zealand breastfeeding rates and duration ............................................................... 8

2. Development of the plan ......................................................................................................... 9
   2.1 Evidence and theory that informed this report ................................................................. 9
   2.2 Plan development process ............................................................................................... 10

3. Approach to a national breastfeeding promotion campaign ................................................. 10
   3.1 Enablers and barriers to breastfeeding ........................................................................... 10
   3.2 Key messages and audiences ........................................................................................... 12
   3.3 Prioritisation of Māori and Pacific peoples ................................................................. 13
   3.4 Dimensions of support for breastfeeding mothers ....................................................... 13
   3.5 Stages of breastfeeding ................................................................................................. 15
   3.6 Supporting mothers to breastfeed through each stage ................................................ 16
   3.7 Tools available for the proposed breastfeeding promotion campaign ....................... 17
   3.8 Campaign scope ............................................................................................................. 17
   3.9 Systems approach ........................................................................................................... 18
   3.10 Staged approach to implementation ............................................................................ 19

4. Plan to inform the design of a national breastfeeding promotion campaign ...................... 20
   4.1 Priority groups ............................................................................................................... 20
   4.2 Target and intervention groups ...................................................................................... 21
   4.3 Core principles underpinning the plan ........................................................................... 22
4.4 Vision for the campaign ................................................................. 23
4.5 Campaign goals .............................................................................. 23
4.6 Framework for the campaign plan .................................................. 24
4.7 Campaign plan for each intervention area ....................................... 25
Intervention Area 1: Health systems ...................................................... 27
Intervention Area 2: Family/whānau support ........................................ 33
Intervention Area 3: Community and workplace support ....................... 35
5. Mass communications element of the campaign .................................. 38
  5.1 Purpose, messages and audiences for mass communications ............ 38
  5.2 Core elements of social marketing (the four ‘P’s) .............................. 39
6. Overall recommendations ................................................................... 41
Appendix 1: Summary of findings ......................................................... 43
Appendix 2: Māori and Pacific models of health ...................................... 47
Appendix 3: Health promotion and lessons from promotion campaigns .... 50
Appendix 4: Relevant theories and models ............................................. 53
Appendix 5: Further information on mass communications .................... 58
Appendix 6: Alignment with strategies and international documents ......... 60
Appendix 7: Key stakeholders ............................................................... 63
Appendix 8: Breastfeeding rates in New Zealand 1997 to 2006 .............. 64
Glossary ............................................................................................... 66
References ........................................................................................... 68
1. Introduction and context

This report presents advice for the development of a national breastfeeding promotion campaign. The Government has funded the Ministry of Health to develop a breastfeeding campaign in order to improve breastfeeding rates and duration, especially for high-need groups, and Māori and Pacific populations. A national promotion campaign provides an opportunity to contribute to efforts to improve the long-term health of the population, reduce health inequalities between population groups and respond to the recommendations of the Health Select Committee to protect the right to breastfeed. This report draws together several strands of evidence to inform the campaign, including recent qualitative focus group research (Thornley and Ball, 2007) and a literature review undertaken by the National Breastfeeding Advisory Committee.

The proposed campaign will be closely aligned with a range of New Zealand and international strategies, including the Healthy Eating – Health Action strategy, He Korowai Oranga, the Pacific Health and Disability Action Plan, and the Global Strategy for Infant and Young Child Feeding. Appendix 6 provides more detailed information on the links between these strategies and a national breastfeeding promotion campaign.

1.1 Importance of breastfeeding

Breastfeeding is the normal, natural way to feed infants, and is part of laying the foundations for a healthy life from infancy and childhood. A substantial body of evidence shows that breastfeeding contributes positively to nutrition, health and wider wellbeing for babies, mothers and whānau/families. For instance, breastfed infants have increased resistance to illnesses, better cognitive development, and reduced risk of a range of conditions including diabetes and obesity. Benefits for mothers include protection against postpartum hemorrhaging, and breast and ovarian cancer (National Breastfeeding Advisory Committee, 2007).

The World Health Organization (WHO) recommends that infants be fed exclusively on breast milk from birth to six months of age. After that time, appropriate complementary foods should be introduced and breastfeeding continued up until two years of age or beyond (WHO 2003). Breastfeeding is very important in the first six months of life, and its importance continues into toddlerhood. Breastfeeding meets the full nutritional requirements for healthy full-term infants for the first six months and, in conjunction with complementary foods, provides an essential part of child nutrition into the second year and beyond (WHO 2003).

1.2 Definition of breastfeeding

Breastfeeding is more than a physiological process. It is a learned activity that involves a dynamic interaction within a complex set of social, cultural and experiential factors (National Breastfeeding Advisory Committee, 2007).
The following definitions of the extent of breastfeeding, adopted by the Ministry of Health (2002), are used in this report:

- **Exclusive breastfeeding:** the infant has never had any water, infant formula, or other liquid or solid food: only breast milk and prescribed medicines have been given from birth.

- **Full breastfeeding:** within the past 48 hours, the infant has taken breast milk only and no other liquids or solids, except a minimal amount of water or prescribed medicines.

- **Partial breastfeeding:** the infant has taken some breast milk and some infant formula or other solid food in the past 48 hours.

- **Artificial feeding:** the infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

### 1.3 New Zealand breastfeeding rates and duration

Although New Zealand has breastfeeding rates at birth that are consistent with other OECD countries, we have low rates at six weeks, especially among Māori and Pacific women (National Breastfeeding Advisory Committee, 2007). Exclusive breastfeeding prevalence drops sharply in the first six weeks post-partum and then continues to decline as partial and artificial feeding becomes more common.

The 2002 Breastfeeding Action Plan (Ministry of Health 2002) reported that there had been little or no improvement in New Zealand’s breastfeeding rates for the previous decade, and rates for Māori and Pacific peoples have remained consistently lower than rates for New Zealand Europeans.

According to the latest figures from Plunket\(^1\), set out in the table below, there has been a slight increase in exclusive and full breastfeeding to six months, with 25% of infants fully breastfed at six months in 2006 compared with 18% in 2000. However, the overall rates at six weeks (66% in 2006), and three months (55% in 2006) have shown little change in recent years, and lower rates in Māori and Pacific populations have persisted.

In 2006 45% of Māori babies were exclusively and fully breastfed at three months, and 48% for Pacific people, compared with 60% for Other and 55% for All. The relatively lower rates of breastfeeding in Māori and Pacific populations means reduced health benefits for these women, their children and their whānau/families. Plunket figures also indicate that Asian peoples have similar breastfeeding rates to Māori and Pacific at six weeks, and lower rates than European/Other at every stage.

In the last three years, the breastfeeding rates at three and six months have decreased slightly for Māori and Pacific populations (eg, from 47% to 45% for Māori at three months), while the rates for ‘Other’ have remained stable or increased slightly (eg, 60% for other at three months). See the table attached as Appendix 8 for the full data.

It should be noted that data on the initiation and duration of breastfeeding is not currently collected in comparable ways for the entire maternal population of New Zealand (National

---

\(^1\) Unpublished data supplied by Ministry of Health. Note that these figures are based on Plunket clients only, and are not nationally representative.
Breastfeeding Advisory Committee, 2007). This has been identified as a gap in research in this country, and suggests that the data above, particularly ethnic comparisons, should be treated with caution.

**Breastfeeding targets for New Zealand**

In 2002 the Ministry of Health recommended the following New Zealand breastfeeding targets (Ministry of Health 2002).

- Increase the breastfeeding (exclusive and fully) rate at six weeks to 74 percent by 2005, and 90 percent by 2010.
- Increase the breastfeeding rate (exclusive and fully) at three months to 57 percent by 2005, and 70 percent by 2010.
- Increase the breastfeeding rate (exclusive and fully) at six months to 21 percent by 2005, and 27 percent by 2010.

In 2007, the Ministry adopted breastfeeding targets.

- Increase the proportion of infants exclusively and fully breastfed at six weeks to 74 percent or greater, three months to 57 percent or greater, and six months to 27 percent or greater.

2. **Development of the plan**

This report presents a comprehensive plan that provides advice to inform the design of a national breastfeeding promotion campaign. It is envisaged that the Ministry of Health will use the plan presented here to develop a more detailed action plan for the proposed campaign.

2.1 **Evidence and theory that informed this report**

Various strands of information and evidence have been analysed and considered in developing this advice for a national breastfeeding promotion campaign. The rationale and evidence for the advice contained in this report is detailed in the appendices.

Empirical evidence that was drawn on in developing this report included the following.

- Qualitative focus group research (Thornley and Ball, 2007).
- Literature review (National Breastfeeding Advisory Committee, 2007).
- Snapshot of services (National Breastfeeding Advisory Committee, 2007).
- International articles on breastfeeding, including work by the EU and WHO.
- New Zealand research on breastfeeding, eg, consultation on breastfeeding with Māori women and health practitioners (Regional Public Health/Kokiri Marae Hauora, 2001).

A summary of findings from the focus group research and literature review is contained in Appendix 1.

Māori and Pacific models of health (see Appendix 2), best practice in health promotion campaigns (see Appendix 3), and theoretical models for behaviour change (see Appendix 4) have also been considered and incorporated into this report.
2.2 Plan development process

The process used to develop the plan involved:

- undertaking focus group research among target and priority groups
- analysing findings from the literature review and other sources
- reviewing theories to structure research findings
- applying standard programme planning processes
- consulting with key Ministry of Health personnel.

The National Breastfeeding Advisory Committee's literature review and other sources were invaluable in identifying key evidence-based influences on breastfeeding behaviour, particularly barriers, enablers, and promising strategies for improving breastfeeding rates. The focus group research added depth of understanding to the influences identified in the literature review, and provided information specific to the New Zealand context for high-need, Māori, Pacific and Asian peoples. This rich material facilitated the consideration of motivators and barriers within a holistic context of people's lived experience in their homes, workplaces, communities, and in health care settings.

Theories and frameworks were used to further structure the identified influences into working explanatory models of factors that influence breastfeeding behaviour.

Appendix 4 contains further information on theories and frameworks used. Once developed, these models were used to guide the development of a plan to inform a national breastfeeding promotion campaign. A standard programme planning process was used to identify recommended campaign goals, objectives and strategies. Key programme planning processes and terms are briefly described in the glossary at the end of the report.

Initial plans were presented to Ministry of Health stakeholders for discussion. This proved invaluable as it drew upon additional expertise to refine the plan, allowed consideration of any political imperatives and other issues, and facilitated ownership of the plan. The National Breastfeeding Advisory Committee was also briefed at an early stage in the planning process, and feedback provided by individual members was incorporated where possible.

3. Approach to a national breastfeeding promotion campaign

3.1 Enablers and barriers to breastfeeding

Essentially, the plan seeks to enhance and promote factors that support breastfeeding, and overcome or mitigate the barriers to breastfeeding that have been identified in New Zealand and international research.

The findings from recent research on breastfeeding are summarised in Appendix 1. Some of the key barriers and enablers that were found in both the focus group research (Thornley and Ball, 2007) and other literature are outlined below.
Enablers

- Awareness of the ‘breast is best’ message is high amongst mothers, and breastfeeding is often associated with being a ‘good mother’.

- Knowledge about what to expect, how to breastfeed, and how to avoid or overcome common problems is vital.

- ‘Hands-on’ help with latching and problem solving in the early stages is essential for initiating breastfeeding.

- Breastfeeding is seen by most women as natural and normal, and once established, is seen as cheap, easy and convenient.

- Household help to relieve the mother from childcare and housework is an important enabler, and support from partners, close female family members and friends has been found to be particularly important.

- Cultural norms, role models, encouragement from others and learning from watching others breastfeed can all act as enablers.

- Supportive workplaces and educational settings help women to combine breastfeeding with paid work or study.

Barriers

- Breastfeeding must be learned and initial problems are almost universal.

- Awareness of common problems and solutions is low amongst many women.

- Many women do not have access to appropriate help for overcoming breastfeeding problems when they need it.

- Pain and exhaustion are common reasons for introducing formula.

- Supplementation of breastfeeding with formula is common at all stages and partly accounts for ethnic disparities in exclusive breastfeeding rates.

- Early introduction of solids (from around three months) seems to be common, particularly in Māori and Pacific families.

- Teenage parents, Māori, Pacific peoples, new migrants and people on low incomes experience more intense and/or additional barriers.

- Young people may experience a clash between their identity and lifestyle as a teenager, and the identity and reality of being a breastfeeding mother.

- Pacific and Asian peoples may experience a clash between beliefs and practices in their home culture and medical advice in the New Zealand context.
• Returning to paid employment is a significant barrier to breastfeeding for many women, particularly for low income families.

• Negative attitudes towards breastfeeding from the general public or family members can be a barrier to breastfeeding in public, community or family settings.

The research clearly showed that women generally want to breastfeed and know that breastfeeding is best for their baby, but a range of barriers often get in the way. Therefore it is recommended that a breastfeeding promotion campaign focuses on improving support for women in a range of different contexts including the health system, the home, and community settings as well as workplaces.

3.2 Key messages and audiences

It is recommended that the proposed national breastfeeding promotion campaign uses strategies and messages that will improve support for mothers. The audiences for such a campaign are likely to be:

• health practitioners
• partners, family/whānau members and friends
• wider community members, particularly employers.

Common themes can be addressed using mass communications, whereas other more specific support needs will need to be addressed using other more targeted strategies and actions. Different tools can be used to address different barriers.

The key messages that are likely to be relevant across a range of audiences are the following:

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

As a comprehensive range of strategies need to be employed, it is recommended that communications strategies are an integral part of the campaign. Communications will be the ‘glue’ that holds the campaign together, raising awareness and priming key audiences (eg, health practitioners, employers) for more specific initiatives, and reinforcing the campaign as a whole.
3.3 Prioritisation of Māori and Pacific peoples

Research shows that Māori and Pacific peoples have lower exclusive breastfeeding rates than New Zealand European women at six weeks, three months and six months. In order to address this disparity, it is recommended that the breastfeeding promotion plan prioritizes settings and approaches that will influence Māori and Pacific communities.

Evidence suggests that the ethnic differences between rates may be partially accounted for by earlier introduction of formula and solids for Māori and Pacific babies, since partial breastfeeding rates for Pacific and New Zealand European are almost identical, (although Māori rates are lower). This suggests that a campaign must address the reasons for introducing formula and/or solids before six months. However this is an issue that must be dealt with carefully and sensitively, since there is some qualitative evidence to suggest that introduction of solids at three months may be a cultural norm amongst Māori and Pacific peoples. Further exploration of these issues with Māori and Pacific experts and community leaders is recommended, along with discussion around the importance of endorsing and promoting traditional Māori and Pacific practices in relation to supporting mothers, and the best way that this might be achieved.

It is widely accepted that in order to be successful, public health initiatives for Māori must be grounded within a framework that makes sense for Māori and incorporates Māori values. The same is true of initiatives for Pacific communities, and other cultural groups. Therefore, since Māori and Pacific communities will be key partners and audiences in the national breastfeeding promotion campaign, it is essential that culturally-specific understandings of health and wellbeing are used to inform the planning of the programme (see Appendix 2 for more detail on Māori and Pacific models of health and how they relate to the proposed breastfeeding promotion campaign).

3.4 Dimensions of support for breastfeeding mothers

Qualitative evidence suggests that support is made up of both physical and emotional aspects. Literature on support for breastfeeding (Matich and Sims, 1992) has identified tangible (practical), emotional and informational support as being particularly important for breastfeeding women.

*Tangible* support can be described as ensuring that the mother’s physical needs are met so that she can focus on breastfeeding. This includes relief from normal duties such as care of older children, housework, and paid employment.

*Emotional* support relates to ensuring that mothers receive psycho-social support to maintain motivation and confidence to breastfeed.

*Informational* support refers to mothers having access to all the necessary information and learning opportunities to develop breastfeeding skills and avoid complications. Access to information can include both actively and passively learning breastfeeding skills. An example of the latter is observation of other mothers breastfeeding their infants.
Analysis of the findings from New Zealand and international research revealed that almost all modifiable influences on breastfeeding could be categorised into these three key types of support: tangible, emotional, informational. Support needs could be further categorised according to a mother’s stage of breastfeeding (discussed further below), and the settings or systems which could potentially provide additional support – health system, family/whānau systems, community/workplace systems.

This conceptualisation of the three dimensions of support listed above (tangible, emotional, informational) fits with Te Whare Tapa Wha (see Figure 1 below and Appendix 2 for further discussion) and Pacific models of health (see Appendix 2), and aligns with social cognitive theory (see Appendix 4). An environmental focus is also consistent with the Ottawa Charter’s emphasis on creating supportive environments for health (WHO, 1986).

**Figure 1. Links between support dimensions and Whare Tapa Wha**

A benefit of focusing on support mechanisms is that they are amenable to social change interventions. Such interventions are a focus of health promotion and social marketing disciplines and could be used as tools for the breastfeeding campaign.

The three dimensions of support (tangible, emotional and informational) have been adopted as overarching objectives for the campaign and are described in fuller detail below.

---

2 The pictures depicted in Figure 1 were painted by Robyn Kahukiwa

Produced by Quigley and Watts Ltd for the Ministry of Health, 2007
3.5 Stages of breastfeeding

From a mother’s perspective breastfeeding can be seen as progressing through several stages (see Figure 2). Appraisal of how the influences identified in the focus group research and literature review moderates experience at each stage (according to the type of support discussed above) was used to identify key areas for action for the campaign plan.

**Figure 2. Breastfeeding stages**

```
<table>
<thead>
<tr>
<th>Pre-natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate post-natal (0-4 days)</td>
</tr>
<tr>
<td>Medium post-natal (4 days – 8 weeks)</td>
</tr>
<tr>
<td>Long post-natal (8 weeks – 6 months)</td>
</tr>
<tr>
<td>Beyond 6 months</td>
</tr>
</tbody>
</table>
```

**Pre-natal: preparatory (up until birth)**

This stage can be characterised as a preparatory stage for breastfeeding and includes developing positive breastfeeding attitudes and knowledge about the importance of breastfeeding, establishing baby-friendly environments and support networks (including links to professional supports) to support breastfeeding, learning about how to breastfeed and building confidence to breastfeed. The development of positive breastfeeding attitudes includes viewing breastfeeding as natural and normal as well as feeling motivated to breastfeed. Attitude formation can develop throughout childhood and right up until parenthood. Therefore, while a focus on the pre-natal stage is on the actual pregnancy phase, this stage can also include pre-pregnancy phases.
Immediate post-natal: Initiation (0-4 days)

The immediate post-natal stage can be characterised as a time when a mother has undergone the birth experience, may be dealing with any complications and there is a need to initiate breastfeeding. Initiation of breastfeeding is driven by the need to get vital nutrients into the newborn baby and to enable the mother’s milk to begin to flow. The majority of new mothers will be in a maternity care environment, however, some will be at home during this period.

Short term post-natal: Establishment (4 days to 8 weeks)

The short-term post-natal stage can be characterised as a time when a mother is likely to be transitioning back to their home environment and there is a need to establish breastfeeding behaviour. Establishment of breastfeeding includes learning how to breastfeed properly, maintaining good self-care practices for the mother (including nutrition and rest), developing problem solving skills to overcome any breastfeeding issues and making breast milk the core (preferably the only) food supply for the baby. During this period a mother is likely to face many of the key challenges that threaten continuation of breastfeeding. These challenges can include: lack of sleep, pain, experiences of mastitis and breast engorgement, birth complications and the need to interact in the community. At around six weeks, there is a transition of care from the Lead Maternity Carers (LMC) to Well Child/Tamariki Ora.

Longer term post natal: Maintenance (8 weeks to 6 months)

This stage can be characterised as a time when a mother is likely to have established a breastfeeding routine and is working to maintain this routine. Challenges to maintaining breastfeeding can include a need by the mother to socialise in the community, a need to return to paid work and perceptions of alternative food sources for babies (eg, solids).

Ongoing (6 months)

This stage can be characterised as the time when additional food sources must be added to the baby’s diet, and breastfeeding reduces in frequency.

3.6 Supporting mothers to breastfeed through each stage

From the research it is evident that many mothers find breastfeeding both a challenging and a rewarding experience. Section 3.3 discussed support (tangible, emotional and informational) as a key mechanism to help mothers meet these challenges in a way that allows the continuation of breastfeeding. Research shows that while some support needs are relevant at all stages, others are stage-specific. Relevant support can help a mother cope with the challenges of each stage and, in some cases, avoid challenges reoccurring in the future.

The plan to inform a national breastfeeding campaign contains overarching objectives that cut across all stages, and stage-specific action points to address challenges that arise in each particular stage.


3.7 Tools available for the proposed breastfeeding promotion campaign

Promotion campaigns with social or health objectives tend to fall within the ambit of health promotion, social marketing and/or communications. A range of tools are used in campaigns to influence attitudes, behaviour and environments. (See Appendix 3 for more information on health promotion and lessons learned from promotion campaigns). Examples of tools used for promotion campaigns include:

- influencing legislation, policy and practice
- influencing environmental change
- community development and engagement
- awareness raising and advocacy
- health education and training
- mass communications
- management, planning and evaluation
- social marketing
- facilitation and networking.

Lessons from social marketing with Māori and Pacific peoples include:

- the importance of Māori and Pacific clinical and community leadership
- early engagement with Māori and Pacific stakeholders/communities, and strong involvement of Māori and Pacific peoples in campaign planning and development
- use of existing Māori and Pacific community networks
- recognition of motivators and emotional drivers specific to Māori and Pacific peoples
- use of culturally-specific sites such as marae, kura kaupapa, or Pacific churches, with use of culturally appropriate processes.

Key success features of promotion campaigns in general include:

- long term, comprehensive, multi-faceted approaches
- stakeholder and community involvement including early engagement, collaboration and relationship-building, especially with Māori and Pacific communities
- partnerships with community leaders, especially Māori and Pacific leaders
- partnerships across organisations and sectors
- use of research and evaluation
- use of messages that have personal relevance and are backed up by work to increase readiness for change and other methods such as one-to-one advice
- the information is new and presented in an emotional context
- use of mass media as part of an overall strategy (including face-to-face discussion, personal help and attention to social and environmental factors that help or hinder change).

3.8 Campaign scope

It must be recognised that some potential strategies for addressing particular barriers or risk factors lie outside the scope of this plan, and outside the scope of a breastfeeding promotion campaign. For example, teenage pregnancy rates in Māori and Pacific are higher than in New Zealand Europeans and teenage mothers are less likely to breastfeed to six months than older
mothers. Therefore, reducing teenage pregnancies among Māori and Pacific peoples may be one way to address the disparity in breastfeeding rates and improve breastfeeding rates in these populations. Addressing teenage pregnancy lies outside the scope of the current plan, however it is possible that other current or planned government or community initiatives that do address teenage pregnancy may tie in with the proposed breastfeeding promotion plan.

Another example of strategies/tools that are outside the scope of this campaign is the use of policy, legislation and regulations to promote breastfeeding. The National Breastfeeding Advisory Committee’s literature review identified a range of national policy and regulatory interventions used overseas to promote breastfeeding, and that could also potentially be used in the New Zealand context, for example, to reduce financial barriers to breastfeeding. There is strong evidence that financial pressure to return to paid work is a major barrier to breastfeeding for New Zealand women. This barrier is likely to disproportionately affect Māori and Pacific families since they are over-represented in low-income families, and is therefore likely to be a mechanism for intergenerational transmission of disadvantage. Therefore policy and regulatory initiatives that enable disadvantaged women to stay out of the workforce longer, such as longer paid maternity leave or a ‘baby bonus’, are likely to extend the duration of breastfeeding at the population level, and reduce health disparities. Again, while use of legislation is outside the scope of the current plan, the breastfeeding promotion campaign may help to build a platform for advocacy in this area.

3.9 Systems approach

A systems approach to the campaign is recommended, as systems incorporate key settings and intervention groups, and reflect the complexity of interactions between individuals and the environments and contexts in which they live.

The plan highlights three key systems within which interventions should be targeted:

- health system
- whānau/family
- communities and workplaces.

In these systems we need to:

- increase the responsiveness to Māori and Pacific peoples
- deliver services in a way that is effective for Māori and Pacific peoples.

Systems include physical settings, people (i.e. intervention groups) and their behavior, and policies/norms and other systemic influences on behavior. This is preferable to a settings approach since it recognises the complex interplay of social, cultural, economic and environmental elements within each system.

Within the health system for example, there are tangible (eg, funding, staff levels), emotional/attitudinal (eg, level of awareness of the importance of breastfeeding) and informational (eg, skills to help women overcome breastfeeding problems) elements which
interact with each other, and influence the level and quality of health system support for breastfeeding mothers. Changing only one element of the system is unlikely to lead to sustainable systemic change overall. It should also be noted that the health system covers several settings including hospital, community-based clinics, and midwifery and Well Child/Tamariki Ora services that are delivered in people’s homes.

Systems can be analysed for their responsiveness to particular population groups, and multiple intervention points can be identified in order to bring about change in the whole system. Not all of the possible intervention points or strategies are likely to be covered within a breastfeeding promotion campaign, underlining the importance of dovetailing with other national and local initiatives.

3.10 Staged approach to implementation

Given the campaign’s complexity and range of stakeholders and intervention groups, it is recommended that the campaign is implemented in a manner that maximises stakeholder ownership and that uses available resources to best effect.

A two-staged approach to implementing the campaign is recommended. A mass communications campaign could lead to excessive and unrealistic demands on the health system if people within this system were not fully engaged and prepared first. Therefore it is recommended that the first stage of the breastfeeding campaign to be implemented is the strategies specific to the health system, followed by a second stage, family/whānau and community/workplaces (Intervention areas 2 and 3), which would be implemented concurrently.

- Stage One: Health systems (Intervention area 1)
- Stage Two: Family/whānau and community/workplaces (Intervention areas 2 and 3)

This approach would mean that mass communications strategies would be initiated following the implementation of strategies to engage the health sector and address workload issues.

Stage One: Health systems

For Stage One it will be necessary for any capacity issues to be addressed. If the campaign is likely to spark an increased demand for breastfeeding support and advice from health practitioners, that demand must be able to be met. From a communications perspective the focus will be on public relations, and in particular, stakeholder management.

Tasks should include:

- compiling a comprehensive list of stakeholders, divided into communication groups. That is, those stakeholders to receive face-to-face meetings, those to receive phone calls, those to receive emailed communication etc.
- developing a schedule of when these communications should take place and who should lead them
- developing generic information about the campaign which could be used in a number of forms – for example, key messages, Questions and Answers, Powerpoint presentations, newsletters etc.
• planning the campaign launch.

At the same time (or subsequently) concrete changes (eg, funding, staffing levels) may need to be made. It is recommended that the Ministry of Health explore necessary changes with key stakeholders, possibly through the stakeholder engagement process described above, and undertake policy and advocacy work required in order to effect the essential health system changes.

Stage Two: Family/whānau and community/workplace support

Communicating with family/whānau, communities and workplaces would be Stage Two of the campaign, and would use a mix of paid advertising, public relations and community development approaches. Resources carrying campaign messages would also be developed to support this stage.

A specific advertising and PR strategy will need to be developed for each audience group, and sometimes for the various sub-groups. For example, communication with the general public will be quite different from communication with employers, and would use different communication channels and key messages.

The paid advertising mix would be determined by the audiences to be reached and by the campaign budget. Paid advertising for a campaign may include a combination of the following: television, radio, print, magazines, internet, billboards/or bus shelter advertising, bus backs, cinema, direct mail, websites, 0800 numbers and narrowcast TV (playing campaign messages on televisions in GP waiting rooms and in other health settings).

The breastfeeding campaign will need to include substantial use of media that is likely to reach Māori and Pacific peoples. For example, if television commercials are developed, versions in Te Reo Māori, Pacific languages and English should be prepared and aired on Māori Television and general television. Radio advertisements can be aired on iwi stations, and advertising placed in magazines such as Mana Magazine.

4. Plan to inform the design of a national breastfeeding promotion campaign

This section gives a brief rationale and overview for the plan to inform the development of the proposed breastfeeding promotion campaign. Please see the appendices for a more detailed rationale.

4.1 Priority groups

Māori and Pacific peoples have been identified as priority groups for the breastfeeding promotion campaign (Refer to page 11 for barriers and enablers for Māori and Pacific peoples). In developing the campaign, consideration should therefore be given as to how each strategy will affect these priority groups and how the campaign will influence the advancement of Māori and Pacific peoples’ health and wellbeing in general. It will be important to bear in mind the complexity of ethnic identity and family makeup, for example, Māori and Pacific babies may not
have mothers who identify as Māori or Pacific. The relatively high rates of teenage pregnancy in Māori and Pacific communities also needs to be borne in mind, along with the additional barriers experienced by these groups.

Improving breastfeeding rates among Māori and Pacific mothers and babies is likely to lead to improved nutrition and reduced inequalities over the life span, and is therefore a key strategy for reducing health inequalities. In addition, in recognition of the Treaty of Waitangi, Māori can be seen as having a right to determine the nature of Māori focused breastfeeding interventions.

It is recommended that the Ministry of Health apply the Health Equity Assessment Tool (HEAT) and/or the Whanau Ora impact assessment tool to the detailed action plan for the breastfeeding promotion campaign, once it is completed in a draft form.

It is important to recognise that there are teenage parents and low income/high need families of all ethnicities, therefore it is recommended that the campaign includes generic elements designed to be effective for the whole target population as well tailored strategies for high risk groups, and specific audiences (eg, employers). In particular, there is evidence that Asian peoples face significant barriers to breastfeeding and may have lower breastfeeding rates than the general population, therefore it is important that generic elements of the campaign reach Asian communities and that the specific barriers experienced by Asian peoples are addressed.

Examples of key barriers to breastfeeding for Asian people were:

- language difficulties/lack of Asian-speaking midwives or other health practitioners
- breastfeeding not seen as a 'norm' in Asian countries, higher visibility of formula feeding
- relative lack of family support - the relative lack of family support was in situations where Asian women had relatively few family members living in NZ – others had good family support where they had extended family living here.

4.2 Target and intervention groups

The focus of the campaign will be on increasing the proportion of babies who are breastfed, the proportion of breastfeeding (in relation to other food sources) for babies less than six months old, and the duration of partial breastfeeding for babies over six months old.

**Target groups:**

Given that these goals are directly influenced by the breastfeeding practices of mothers, the target group for the campaign will be pregnant women and mothers of babies up to six months old. For the purposes of the campaign plan these mothers will be referred to as ‘the target group’. As it is recommended that mothers continue to breastfeed past six months a secondary target group will be mothers of infants over six months old.

Rather than directly addressing these target groups, it is recommended that the campaign focuses on intervention groups that can help to support breastfeeding behavior and create more supportive environments for breastfeeding.
In recognition of the priority groups identified above, an emphasis in each of these target groups will be on Māori and Pacific infants and mothers.

**Intervention groups:**

While the focus of the campaign is on breastfeeding behaviours among mothers it is important to recognise that these behaviours are not determined by the mother alone. It is recommended that the campaign focuses on increasing support and changing environments to be more supportive of breastfeeding, since research clearly shows the role of other people in supporting mothers to breastfeed, and the strong impact of supportive or unsupportive environments. For the purposes of the campaign, the key intervention groups are potential support people (eg, partners/family/whānau and health practitioners) and people who influence environments in which women breastfeed (eg, employers). These intervention groups have been grouped according to the systems or settings that they are associated with.

- **Health system:**
  - Midwives
  - Well Child Providers eg, Tamariki Ora, Well Child
  - Lactation experts
  - Doctors
  - Nutrition experts
  - Community health workers
  - Health promoters
  - Hospital decision makers

- **Whānau/family:**
  - Mothers of infants
  - Partners (focus)
  - Significant other family/whānau members (focus if mother is single parent)
  - Close friends
  - Wider family/whānau members

- **Community systems/settings:**
  - Local councils
  - Retail centre decision makers
  - General public
  - Employers
  - Employees

In developing the detail of the campaign it will be important to prioritise these intervention groups and develop specific strategies to reach them.

**4.3 Core principles underpinning the plan**

It is important to identify core principles that will underpin the proposed breastfeeding campaign. This will aid in maintaining a focus on wellness as an ultimate outcome of the campaign as well as aiding in the selection and prioritisation of campaign strategies.
The following principles were identified with reference to key strategic documents discussed in the previous section and further developed through discussion with Ministry of Health stakeholders. These principles have been used to guide the development of the plan and are recommended as underpinning principles for the proposed national breastfeeding promotion campaign:

- ensure that infants have the best possible start in life
- ensure that outcomes from the campaign will be equitable, particularly among priority groups
- facilitate Māori health advancement\(^3\)
- facilitate Pacific health advancement\(^4\)
- recognise that breastfeeding sits within a wider context of whānau ora
- pragmatism: recognise small achievements (any shift towards improving breastfeeding rates is positive)
- avoid stigmatising women who do not breastfeed.

4.4 Vision for the campaign

An overarching vision for the campaign has been developed that is intended to provide direction for the breastfeeding campaign over the long term, focusing on wellness.

The vision for the campaign is that:

*Every child’s opportunity to be breastfed is promoted and supported by families, health systems, workplaces, communities and society as a whole.*

4.5 Campaign goals

In line with WHO recommendations and research findings that many babies are not exclusively breastfed up to six months of age, the ultimate goal of the breastfeeding campaign is to:

*Increase the proportion of infants exclusively breastfed to six months, and the proportion of infants partially breastfed beyond six months.*

However in recognition of the campaign principle of “Pragmatism: recognise small achievements (any shift towards improving breastfeeding rates is positive)” a secondary ‘ultimate goal’ is to:

---

\(^3\) The primary mechanism for this is suggested as implementing a Whānau Ora approach, including the use of models such as TeWhare Tapa Wha, and working towards recognised Māori health targets.

\(^4\) A primary mechanism for this will be applying Pacific models of health (eg, the Fonofale model) and working towards recognised Pacific health targets.
Under this goal, _any_ increase in the amount of breast milk consumed by infants relative to other food sources is seen as a success.

**Overarching campaign goal**

As discussed above, the focus groups and research literature have highlighted the importance of support to aid a mother to establish and continue breastfeeding. Therefore to achieve the ultimate goals above, the immediate goal is to increase support. As this is the immediate focus and will sit across all the objectives and activities of the campaign the overarching campaign goal (against which the campaign will be evaluated) is to:

*Increase environmental support to initiate and maintain breastfeeding, especially for Māori and Pacific people.*

### 4.6 Framework for the campaign plan

Figure 3 below presents the recommended structure for the campaign plan. All activities of the campaign will sit under the goals and objectives of the campaign. The three objectives (to increase tangible, emotional and informational support for breastfeeding mothers) will be pursued in three key intervention areas or systems:

1. Health systems
2. Family/whānau
3. Communities and workplaces.

The intervention areas will be linked by mass communication strategies which will promote common messages relevant to all three systems and all intervention groups.
4.7 Campaign plan for each intervention area

In the following tables, specific activities have been described for each of the three intervention areas (health system, family/whānau and community/workplace). These could operate as three relatively separate intervention plans, but they would be linked by a mass communications strategy which would promote common messages, and consistency of overarching themes would be provided through use of common campaign logo, strap lines and imagery.

Each table outlines key outcomes sought, links to the overarching objectives of the campaign, areas for action, and examples of specific actions.

The outcomes and areas for action are divided into the various stages of breastfeeding, beginning with an ‘overarching’ outcome that relates to all stages, and followed by the relevant specific stages of breastfeeding – pre-natal, immediate post-natal, short-term and longer-term breastfeeding.

In some of the intervention areas (eg, family/whānau) similar types of support are required across all the stages, therefore, most of the areas for action are listed under ‘overarching’.

Other intervention areas, especially the health system, provide specialist support related to each
stage, so there are a larger number of areas for action listed under each specific stage of breastfeeding.

The last column of the table links the action areas to the three overarching objectives for the campaign (increasing tangible, emotional and informational support for breastfeeding). It is essential that the campaign addresses all three aspects of support.

The examples of specific actions are suggested options only, rather than prescribed strategies. It is envisaged that a more detailed action plan will be developed by the Ministry of Health containing more comprehensive and detailed actions, and timeframes for completion.

In Setting two, a broad definition of “family/whānau” has been used to describe any person that is related to family support from the perspective of the mother. This may include partners, other primary caregivers, ‘nuclear’ family members, ‘extended’ family members, whāngai children, friends and peers. Partners, female family members and friends (especially other mothers) are especially significant in terms of family/whānau support with breastfeeding.

In Setting three, ‘community’ is defined as key institutions or settings that the mother and baby comes into contact with (excluding family/whānau and health sector). These can either support or inhibit breastfeeding behaviour. Key institutions are likely to include public retail spaces (eg, shopping centres), recreational facilities, and workplaces (for those mothers returning to paid work). The community’s role in supporting mothers increases in the short and longer-term stages of breastfeeding.
## Intervention Area 1: Health systems

### Table 1. Action areas for the health system

<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| **Overarching:** Increased health system support to breastfeed | Encourage and support maternity health care providers to promote:  
- the importance of breastfeeding  
- breastfeeding as a natural behaviour  
- breastfeeding as a learned skill  
- the role of whānau and peers in supporting mothers to breastfeed | Public relations programme to promote breastfeeding to maternity health care providers, eg, stakeholder liaison, community engagement, risk management. Particular focus on Māori and Pacific providers and clinicians, and using existing Māori and Pacific networks. Use of unpaid media such as press statements and opinion pieces, and leveraging off other unpaid communications (eg, information in GP or midwife newsletters, information given to DHB communications staff for internal public relations).  
- Training to upskill maternity health providers in breastfeeding problems and solutions, and communicating with women about breastfeeding | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| | | | |
| | Increase access to information on how to breastfeed and how to address common problems from breastfeeding (for mothers, peer supporters and health practitioners) | Information dissemination programme including pamphlets, videos, tailored resources for various ethnic groups  
- Training to upskill maternity health providers in breastfeeding problems and solutions, and communicating with women about breastfeeding | Obj 3: Increase informational support |
<p>| | Increase quality and consistency of information on how to breastfeed and how to address common problems from breastfeeding. | Ensure that training of health practitioners is consistent and includes 'normal' physiology, common problems and solutions and psycho-social support techniques | Obj 3: Increase informational support |</p>
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| Increase access to high quality and culturally appropriate maternal health support within health systems and from health practitioners. | • Increase the number of Māori, Pacific and Asian health practitioners, especially Lead Maternity Carers (LMCs)  
• Provide incentives for Māori, Pacific and Asian people to train as LMCs  
• Improve cultural competence of mainstream health practitioners  
• Improve responsiveness to Māori, Pacific and Asian peoples  
• Ensure breastfeeding issues (including psychosocial aspects) are covered in the curricula for training of all health practitioners | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Increase access to high quality and culturally appropriate support from community support providers | • Ensure that community support providers receive sustainable funding to provide breastfeeding support services in the community  
• Ensure that breastfeeding issues (including psychosocial aspects) are covered in the curricula for training of all community support providers | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Increase access to breastfeeding supplies/aids | • Provide subsidies for breastfeeding supplies through approved providers | Obj 1: Increase tangible support |
| Improve coordination and collaboration between Lead Maternity Carers (LMCs) and Well Child/Tamariki Ora service providers | • Ensure that training of LMCs and Well Child providers emphasises the need for collaboration and ways to improve coordination  
• At a DHB level, discuss ways to improve coordination and collaboration between LMCs and Well Child providers | Obj 1: Increase tangible support  
Obj 3: Increase informational support |
| Improve breastfeeding promotion coordination and collaboration at local, regional and national levels. | • Clarify and promote the coordination role of DHB HEHA Project Managers in the promotion and support of breastfeeding  
• Encourage inter-agency collaboration | Obj 3: Increase informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| Pre-natal: Increased motivation/active decisions among mothers to breastfeed | Increase access to antenatal education programmes, especially among groups with lower rates of breastfeeding. | • Address barriers to attending antenatal education such as transport, cost and cultural appropriateness | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | Improve antenatal education on how to breastfeed and to develop breastfeeding related problem solving skills (ante-natal classes, LMCs) | • Ensure that training of LMCs and antenatal providers emphasizes techniques, common problems and problem-solving skills | Obj 3: Increase informational support |
|                         | Increase opportunities for social bonding among antenatal class participants | • Place greater emphasis on encouraging and providing opportunities for antenatal class participants to interact and socialise | Obj 2: Increase emotional/psychological support |
|                         | Increase access to culturally appropriate antenatal services for Māori and Pacific families | • Increase the number of Māori and Pacific antenatal providers  
• Provide targeted antenatal education in a range of culturally specific settings such as marae, ethnic-specific churches, iwi and Pacific health providers, youth centres and cultural centres  
• Improve cultural competence of mainstream antenatal providers | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | Increase opportunities to learn about breastfeeding in primary, secondary and tertiary education settings | • Discuss with the Ministry of Education the options for incorporating breastfeeding information in the school health curriculum | Obj 3: Increase informational support |
| Immediate postnatal: Increased proportion of mothers initiating breastfeeding (0-4 days) | Improve information delivered by health practitioners for mothers to enable continued breastfeeding, development of breastfeeding related problem solving skills and mothers to get enough rest and care. | • Provide high-quality training to health practitioners (initial and ongoing training/professional development) | Obj 1: Increase tangible support  
Obj 3: Increase informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| Ensure timely access to health professional expertise on breastfeeding when needed | • Address workload issues, especially shortages of midwives and other LMCs, and recruitment and retention issues  
• Reduce staff-patient ratio on maternity wards  
• Publicise the minimum number of midwife visits that women are entitled to  
• Ensure that professional help is proactively offered to mothers in high need groups, especially teenage mothers | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Increase support for mothers to transition from maternity care settings to home environments | • Address workload issues, especially shortages of midwives and other LMCs  
• Reduce staff-patient ratio on maternity wards  
• Ensure that maternity facilities plan for discharge and work to support a positive transition to the home environment  
• Ensure that training of health staff includes planning for a positive transition from maternity care settings to the home environment  
• Emphasise the importance of whānau/family support in the home | Obj 1: Increase tangible support  
Obj 3: Increase informational support |
| Improve provision of sensitive, practical support from health practitioners for mothers to position and latch their babies when needed | • Provide training for health practitioners and community support workers on practical assistance with positioning and latching | Obj 1: Increase tangible support  
Obj 3: Increase informational support |
| Increase the number of hospitals and other maternity care settings actively implementing the Baby Friendly Hospitals initiative | • Work with DHBs to ensure that all maternity care settings become accredited Baby Friendly Hospitals as soon as possible | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| Improve maternity care settings to be more culturally appropriate for Māori and Pacific mothers | • Increase the number of Māori and Pacific maternity service providers and other hospital staff  
• Improve cultural competence of mainstream maternity service providers and maternity care settings  
• Encourage culturally appropriate environments, e.g., whānau rooms | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support |
| **Short term: Increased proportion of mothers establishing breastfeeding (4 days – 8 weeks)** | Ensure timely access to health professional expertise on breastfeeding, especially LMCs, when needed | • Address workload issues, especially shortages of midwives and other LMCs, and recruitment and retention issues  
• Publicise the minimum number of midwife visits that women are entitled to | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| | Increase access to high quality information on maintaining good nutrition for a baby – including milk supply issues, baby's nutritional needs and weight, use of formula when required, when to introduce solids (also relevant to the next stage – longer term) | • Ensure that maternity service providers are trained to deliver full information on infant nutrition, including milk supply, baby's nutritional needs and weight, use of formula when required, and when to introduce solid foods | Obj 3: Increase informational support |
| | Increase the number of primary care providers actively implementing the Baby Friendly Communities initiative (also relevant to the next stage – longer term) | • Work with DHBs to increase the number of primary care providers settings implementing the Baby Friendly Communities initiative  
• Extend the Baby Friendly Communities initiative to cover a wider range of health and other community settings (e.g., shopping centres, workplaces) | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for health system</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| Longer term: Increased proportion of mothers maintaining breastfeeding (8 weeks – 6 months – beyond 6 months) | Expand provision of health promotion activities to develop baby friendly environments in key community settings | • Work with DHBs to increase the delivery of health promotion aimed at encouraging baby friendly environments in the community | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
**Intervention Area 2: Family/whānau support**

**Table 2. Action areas for family/whānau support**

<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for family/whānau support</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| **Overarching:** Increased family/whānau support to breastfeed | Promote importance of breastfeeding to the wellbeing of children and family/whānau in general. This includes:  
- the reasons why it is beneficial  
- recognising and acknowledging the existing high value of breastfeeding in various cultures, especially among Māori and Pacific peoples  
- promoting awareness of the roles that family/whānau (especially partners) and peers (friends and other mothers) can play in supporting breastfeeding practice, eg, relieving mothers of infants from normal household and childcare duties, recognition and endorsement of existing cultural practices that promote intensive extended family support for new mothers, and prolonging a return to paid work | Mass communications campaign with messages to motivate the general public, including family/whānau and peers, to increase support for breastfeeding mothers (including promotion of breastfeeding role models)  
- Messages should include both emotive and evidence-based messages, and be delivered through both paid and unpaid mass media  
- Media used should be both generic (eg, television, radio, print, internet) and targeted to priority groups (eg, Māori television, radio and publications, Pacific radio and publications)  
- Ensure consistency of overarching themes across campaign intervention areas (health, family/whānau, community and workplaces) through use of common campaign logo, strap lines and imagery | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
<p>| Increase access to information on how to breastfeed and how to address common problems from breastfeeding (for mothers, peer supporters and family/whānau) | Mass communications campaign as above | Obj 3: Increase informational support |</p>
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for family/whānau support</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
|                         | Promote strategies for mothers of infants to take particular care of their health while breastfeeding | • Ensure that maternity health providers are trained to encourage women to take care of their health  
• Include this message in the mass communications campaign, detailed above | Obj 1: Increase tangible support |
|                         | Promote awareness of the important role of peer support (ie, mother to mother) in motivating women to initiate and continue breastfeeding | • Mass communications campaign as above | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | Facilitate increased opportunities for peer support (ie, mother to mother support) | • Expand current peer support programmes such as those run by La Leche League to target teenage mothers, Māori, Pacific and new migrant communities  
• Consider options for encouraging greater use of informal peer support  
• Ensure access to high quality and culturally appropriate antenatal group education | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Pre-natal: Increased motivation/active decisions among mothers to breastfeed | Encourage male partners to attend antenatal classes, especially for those with lower rates of breastfeeding. | • Address barriers to attending antenatal education such as transport, cost and cultural appropriateness | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | NB there are no short or long term stage-specific actions (see above for overarching actions) |                     |                                      |

NB there are no short or long term stage-specific actions (see above for overarching actions)
### Intervention Area 3: Community and workplace support

#### Table 3. Action areas for community and workplace support

<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for community and workplace support</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| **Overarching:** Increased community and workplace support to breastfeeding | Create environments that are more supportive of breastfeeding, and increase public and community acceptance of breastfeeding as natural and normal | • Mass communications campaign with messages to motivate the general public to increase support for breastfeeding mothers (include call to action) and positive breastfeeding messages  
  • Messages should include both emotive and evidence-based messages, and be delivered through both paid and unpaid mass media  
  • Media used should be both generic (eg, television, radio, print, internet) and targeted to priority groups (eg, Māori television, radio and publications, Pacific radio and publications)  
  • Ensure consistency of overarching themes across campaign intervention areas (health, family/whānau, community and workplaces) through use of common campaign logo, strap lines and imagery | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Promote advantages of establishing breastfeeding friendly environments to key stakeholders, especially:  
  • public setting decision makers (eg, local councils, marae, mall managers, church leaders)  
  • employers  
  • public transport providers | Public relations programme to promote breastfeeding to key decision makers and employers, eg, stakeholder liaison, community engagement, risk management  
  • Link with and expand advocacy programmes targeting employers (eg, Women’s Health Action programme) | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for community and workplace support</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
|                         | Facilitate community development initiatives to promote breastfeeding, especially with Māori, Pacific and Asian communities, and with young mothers | • Provide a contestable fund to enable communities to undertake community development initiatives that promote and support breastfeeding | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | Increase prevalence and visibility of breastfeeding role models in key community settings, particularly for Māori, Pacific, Asian and teenage mothers | • Mass communications campaign as above  
• Public relations programme as above | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
|                         | Ensure sustainable funding for community-based support initiatives that promote and support breastfeeding | • Ensure that community support providers receive sustainable funding to provide breastfeeding support services in the community | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| Pre-natal: Increased motivation/active decisions among mothers to breastfeed | Ensure that pregnant women have full access to community settings | • Improve transport options for pregnant women to access key community settings such as marae, shopping centres, churches or urban centres  
• Link with community organisations to improve and promote access to antenatal care | Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
<table>
<thead>
<tr>
<th>Stage specific outcomes</th>
<th>Action areas for community and workplace support</th>
<th>Examples of specific actions</th>
<th>Objectives that actions contribute to</th>
</tr>
</thead>
</table>
| **Short term:** Increased proportion of mothers establishing breastfeeding (4 days – 8 weeks) | Create baby-friendly environments in key community settings (e.g., recreational areas, other public places, marae, churches). | • Provide tailored information and training to key decision-makers in order to help create baby-friendly environments  
• Introduce voluntary charters where employers or councils agree to a set of actions to create a baby-friendly environment  
• Encourage baby-friendly policies such as flexible work conditions for parents  
• Encourage improvements in provision of breastfeeding facilities in workplaces and public spaces such as retail centres  
• Promote positive messages and information relating to breastfeeding to employers, especially managers  
• Promote positive messages and information relating to breastfeeding to employees  
• Encourage or require employers to provide paid breastfeeding breaks  
• Require workplaces to become breastfeeding-friendly | Obj 1: Increase tangible support  
Obj 2: Increase emotional/psychological support  
Obj 3: Increase informational support |
| **Longer term:** Increased proportion of mothers maintaining breastfeeding (8 weeks – 6 months – beyond 6 months) | Provide information for mothers, partners and whānau on returning to work with a young baby, and combining breastfeeding and paid work | • Ensure that maternity service providers are trained to deliver information on returning to work with a young baby, and combining breastfeeding and paid work  
• Provide informational resources, such as pamphlets, videos etc. on returning to work with a young baby, and combining breastfeeding and paid work | Obj 3: Increase informational support |
5. Mass communications element of the campaign

5.1 Purpose, messages and audiences for mass communications

Mass communications will link each of the three intervention areas above (health system, family/whānau, community and workplaces) into an overall campaign and it is expected that activities specific to each intervention area will be consistent with the mass communications element. For example, it is recommended that the three intervention areas use the same logos and strap lines. Specific communications strategies may also be employed in each of the three intervention areas. Examples include communicating directly to health workers through newsletters and provision of information resources to mothers and family/whānau.

As discussed earlier in this report, key messages for mass communications and all three intervention areas are:

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

While the campaign will be aimed at the priority groups within the population (Māori and Pacific), it should have broad appeal for other population groups, including Asian peoples. These groups include:

- The community (with a focus on Māori and Pacific communities)
  - local councils
  - retail centre decision makers
  - general public
  - employers
  - employees.

- Family and friends of pregnant/breastfeeding women (with a focus on Māori and Pacific families)
  - mothers of infants, including teenage mothers
  - partners (particular focus), including teenage/young fathers
  - significant other family/whānau members (particular focus if mother is a single parent)
  - close friends
  - wider family/whānau members.

- Health practitioners (with a focus on those who work with Māori and Pacific families)
  - Midwives
  - Well Child Providers eg, Tamariki Ora, Well Child
  - lactation experts
  - doctors
  - nutrition experts
  - community health workers
- health promoters
- hospital decision makers.

5.2 Core elements of social marketing (the four ‘P’s)

In developing mass communications strategies to promote breastfeeding, it is useful to draw on the core elements of social marketing. The four ‘P’s of social marketing are key components that comprise a marketing mix to encourage people to adopt a new behaviour. The four key elements are product, price, place and promotion, and are based on exchange theory. Product relates to the idea that is being ‘sold’, from the receiver’s perspective. Price relates to the perceived costs and benefits of adopting a new behaviour versus continuing an old behaviour. Place refers to where people can access the product. Promotion refers to the processes through which intervention groups are made aware of the product (eg, advertising).

Product and price: Develop campaign messages to motivate the general public to increase support for breastfeeding mothers

For the breastfeeding campaign the actual product will depend on the perspective of the various intervention groups to which the campaign will seek to communicate. From the mother’s perspective the actual product will be breastfeeding and taking steps to establish and continue breastfeeding for at least six months and beyond. From the perspective of all other intervention groups, the actual product will be provision of support (tangible, emotional or informational) to breastfeeding mothers. The perceived product is how the behaviour (either breastfeeding or supporting mothers to breastfeed) is perceived by the intervention groups. How the product is perceived is often a motivating factor that encourages intervention groups to adopt a new behaviour. The focus groups and literature review undertaken to inform the campaign plan identified a number of ways in which breastfeeding and supporting breastfeeding can be perceived. These perceptions can be divided into emotive and informational6. Emotive themes included:

- breastfeeding is natural and normal
- breastfeeding is important to a baby’s physical, psychological and spiritual wellbeing
- breastfeeding is associated with being a good mother.

Informational themes included:

- breastfeeding is a learned process that is likely to become easier with time
- breastfeeding is good for the health of the baby
- when established, breastfeeding is convenient and easy
- help and support from others makes a big difference
- most women breastfeed.

Given the broad nature of these themes it is suggested the mass communications campaign should be developed in order to resonate with the wide range of campaign audiences identified above. Therefore, it is recommended that these themes are further tested and developed into

---

6 These should not be confused with ‘emotional’ and ‘informational’ sources of support for breastfeeding mothers.
key campaign messages. These messages would be used to inform the creative elements for any advertisements, strap lines and associated public relations activities. Effective campaign messages are ideally associated with a ‘call to action’ whereby motivating messages are accompanied by specific actions that audiences can undertake. Given the broad range of audiences it would be challenging to identify specific calls to action that are relevant for each group. At the mass communications level it is suggested that a broad call to action is developed that relates to everyone having a responsibility to support breastfeeding. Specific actions can be given in relation to the specific areas of intervention (health system, family/whānau and community and workplaces) described above.

As part of the message development process, consideration should be given to price in terms of the perceived costs and benefits of adopting a new behaviour. For example, a perceived cost of a mother's family/whānau becoming more supportive of a breastfeeding mother may be additional workload for the family. On the other hand, a perceived benefit may be a strengthened and more positive family/whānau environment. Using the perceived product discussed above, the benefits should outweigh the drawbacks from the perspective of the intervention group.

It is also important to develop messages that are effective for Māori and Pacific audiences. This should include emotive and informational themes that are of specific relevance to these groups and translating into strap lines or logos in appropriate languages.

**Promotion: Deliver key messages through paid and unpaid mass media**

In general it is recommended that:

- paid advertising in the mass media uses an appropriate mix of media based on best reach to target audiences
- public relations using unpaid media is used to explain key messages in more detail to target audiences
- informational resources are developed to support the campaign. This should follow a stocktake of information currently available and identification of gaps, and should involve an understanding of the best way to provide information to specific groups
- the campaign is associated with a logo and/or strap line (slogan). These could either be developed from existing slogans or developed specifically for the campaign.

Appropriate mass media should be identified that has the potential to reach the most people identified within the various intervention groups. This is typically television. However, consideration should be given to those media where people are most likely to attend to advertising (or unpaid media content) and are able to enact any recommended behaviours within a relatively short timeframe.

Consideration should also be given to media that are most likely to reach Māori and Pacific audiences. For example, for Māori this could include:

- Māori television
- Māori print material
- Māori radio and radio programmes
• generic media that has relatively high Māori audiences.

For Pacific this could include:
• Pacific television programmes
• Pacific print material
• Pacific radio and radio programmes
• generic media that has relatively high Pacific audiences.

Place: Deliver messages to specific audiences within the various intervention areas (health system, family/whānau, community and workplaces)

The mass communications campaign will promote messages primarily to the priority groups, Māori and Pacific populations, as well as to other population groups. As there are a broad range of intervention audiences, the place(s) where they will be able to adopt the desired behaviours (breastfeeding, supporting others to breastfeed) will vary. Therefore, place(s) according to systems and intervention groups are described in detail under each of the intervention areas below. For each type of group, a specific place (eg, home or hospital) is described.

6. Overall recommendations

In summary, it is recommended that the campaign to promote breastfeeding:
• takes a comprehensive approach to breastfeeding promotion that couples promotion of breastfeeding with support to breastfeed at all levels including individual, family, health system, workplaces and community contexts
• is developed in consultation with health practitioners (including Māori and Pacific health practitioners, especially midwives and other lead maternity carers) and other key stakeholders (eg Māori and Pacific leaders)
• is pre-evaluated using the Health Equity Assessment Tool (HEAT) and/or Whanau Ora Impact Assessment tool before implementation
• explains why breastfeeding is beneficial and clearly promotes the specific advantages of breastfeeding compared with artificial feeding
• employs thorough and on-going liaison with stakeholders, to guide the development of the campaign and ensure messages given at a personal health level complement campaign messages
• highlights and reflects the importance of Māori and Pacific clinical and community leadership
• facilitates and supports community action around breastfeeding
• strives to engage Māori and Pacific stakeholders/communities early in the development process, and maintain strong involvement of Māori and Pacific peoples throughout campaign planning and development and implementation
• uses existing Māori, Pacific and Asian community networks
• recognises motivators and emotional drivers specific to Māori, Pacific and Asian peoples
• addresses specific barriers experienced by teenage mothers, and uses strategies and
messages to reach this group
• uses culturally-specific settings such as marae, kura kaupapa, or Pacific churches, with use
of culturally appropriate processes.
Appendix 1: Summary of findings

Findings from Focus Group Research and Literature Review
As discussed in the introduction to this report, the proposed breastfeeding promotion plan has been informed by a major focus group research project exploring the factors that influence duration of breastfeeding (Thornley and Ball, 2007), and existing New Zealand and international research findings (Ministry of Health, 2002; National Breastfeeding Advisory Committee, 2007). The various information sources were broadly congruent and this section provides an explanation of how some of these findings relate to the proposed plan.

Consistent with the literature review, the focus group research found that the majority of participants had positive attitudes towards breastfeeding and were aware that ‘breast is best’. Where women had given up breastfeeding or introduced formula early, this was usually due to lack of support rather than lack of desire to breastfeed, and was often associated with feelings of guilt or failure. Therefore, it is recommended that the promotion campaign should primarily address the support needs of women, rather than ‘preaching to the converted’ or adding further pressure on mothers to breastfeed without changing environments to make breastfeeding easier. The campaign should also enhance and promote existing motivators and protective factors, such as family support and desire to give babies the best start in life.

For the purposes of the proposed plan, ‘support’ is defined very broadly and is based on research participants’ accounts of what helps and hinders breastfeeding. It includes tangible support, emotional/attitudinal support, and informational support provided by a range of people (eg, family, friends, health practitioners, employers, general public) and in a range of settings (eg, hospital, home, shopping centres, marae, churches, workplaces and other community settings). Research shows that some support needs are particular to certain stages since the challenges of each stage are distinct, whereas other support needs and motivators are constant throughout. Stages identified in the focus group findings were the preparation stage (prenatal), the initial phase when latching is learned and milk comes in (birth to three or four days), the establishment phase where breastfeeding becomes routine and care is transferred from midwives to Well Child/Tamariki Ora (approx four days to eight weeks), the medium term where both mother and baby become more independent and active (approx eight weeks to six months), and long term where solid foods should be introduced and mothers are likely to be returning to paid work if they have not already (six months and on).

Common barriers identified in the literature review and in the recent qualitative research such as latching problems, pain, exhaustion, lack of time to breastfeed due to pressure of other household tasks, and barriers associated with return to paid work can be conceptualized as failures in support. That is, if appropriate supports were put in place, current barriers would largely be prevented, mitigated or removed. The various aspects of support (type, source, setting and stage) are described further below, with examples of research evidence from the focus group research and literature review showing how they relate to breastfeeding duration.
This is not a comprehensive account, but gives a sense of how the major research findings have been translated into recommendations for a breastfeeding promotion campaign.

**Health system**

Research shows that health practitioners, particularly midwives, play a major role in providing informational and emotional/attitudinal support during pregnancy and the early days and weeks after birth. Women who had good access to such support described midwives and other health practitioners as having a major positive influence on their motivation to breastfeed, as a source of knowledge, as teachers of latching skills and as encouragers who helped women overcome initial problems and build confidence. Some research participants, particularly Māori and Pacific women, described receiving the above support from family members rather than practitioners, while others did not receive this kind of support from anyone and were likely to give up breastfeeding within a few days. Lack of rapport and cultural difference between mothers and practitioners and lack of assertiveness in asking for help were barriers to access for some participants, particularly teenage mothers. Therefore improving access to supportive, culturally appropriate and proactive antenatal care and hands-on support in the days immediately after birth is recommended as an important strategy for improving breastfeeding rates.

A strong theme that came out of the qualitative research was that participants were not prepared for the realities of breastfeeding. Because they were not prepared for common problems, the unexpected difficulty of breastfeeding often undermined their confidence, and some women tended to personalize this, feeling that there was something wrong with *them*. Some participants explained that because they were embarrassed or ashamed about the problems they were experiencing (eg, sore nipples) they were hesitant to ask for help. This points to the importance of ensuring that women are well informed about what to expect, and how to prevent or overcome common problems. It is important not only to improve access to antenatal care, but to make sure the content of the information provided is practical and helpful.

**Whānau/family systems**

Research shows that immediate family and wider family and friends support breastfeeding in a variety of ways. For example, families provide role models, opportunities for observational learning, and hands-on advice. When family members breastfeed, children grow up believing breastfeeding is the norm, and through watching and hearing discussions, young people learn about common problems and how to overcome them. Qualitative research evidence suggests that Māori and Pacific women, in particular, often learn from watching others and may rely heavily on family members for advice. There is also evidence that young mothers in particular are strongly influenced by their friends. This suggests that the visibility of breastfeeding should be promoted, that wider family and friends need access to up-to-date and accurate information about the importance of breastfeeding and about how to overcome problems, and that training lay-people as breastfeeding supporters may work well within Māori and Pacific communities.

Another important role for families is to take over household tasks such as cooking, cleaning and care of older children in the first few weeks or months after a baby is born. Pacific research participants described this kind of support as customary, and it was generally performed by
female relatives and/or the women of the community. A gap identified by some Pacific and Māori women in the qualitative research was lack of support from the father of the baby. However some Māori male participants felt that their role had been displaced by female relatives, and they preferred to defer to their expertise.

Some research participants, particularly Asian and Pacific peoples whose close family did not live in New Zealand, had very little family support. This suggests that traditional Māori and Pacific customs in relation to caring for new mothers should be celebrated and promoted, but it should not be assumed that all New Zealanders have supportive networks of family and friends around them. Where family support is not available, access to culturally appropriate peer-support networks and professional services is vital. Some family members, particularly male partners, may need guidance about how best to help, perhaps via media role models. There are policy initiatives that would also support a partner's ability to support breastfeeding, eg, paid paternity leave.

**Community and workplace systems**

As mothers and babies become more mobile, new barriers come into play in relation to breastfeeding in public and community settings and workplaces. Some focus group participants felt comfortable to breastfeed in public, but many felt that people were staring at them disapprovingly, and a few had been asked to leave a place due to breastfeeding. A few were uncertain about whether they were legally 'allowed' to breastfeed in public, and in some cases (particularly for Asian and Pacific participants) cultural norms prohibited breastfeeding in certain situations (eg, church), often out of respect for elders. The influence of family members’ attitudes had a significant impact on participants’ feelings and practices regarding breastfeeding in community settings. This suggests that promotion to improve attitudes to breastfeeding in public should be directed at the general public and to family members (particularly males), and that the right to breastfeed in public should be promoted to all.

Returning to paid work has been identified as a significant barrier to breastfeeding in the literature and in the recent qualitative research. Many participants returned to work within six months of their baby's birth, some only a few weeks after the baby's birth. Research shows that in 2005/2006 only two-thirds of employed mothers were fully eligible for paid parental leave, and Māori and Pacific peoples are over-represented in those not eligible (Department of Labour, 2007). Some workplaces were described by participants as flexible and supportive of breastfeeding, but other participants faced a range of barriers including: negative or unsupportive attitudes of supervisor and/or workmates, lack of time and an appropriate place to breastfeed or express, and milk supply problems due to stress. Therefore it is recommended that a breastfeeding promotion campaign contains specific strategies to address workplace barriers (particularly in workplaces where Māori and Pacific peoples are over-represented), and to extend the period women are able to spend out of the workforce (particularly those currently not covered by paid maternity leave provisions).
Motivators and protective factors

The breastfeeding promotion campaign will seek to enhance and promote existing motivators and protective factors, as well as mitigate barriers by improving environmental support and support systems.

Many qualitative research participants said they were motivated to breastfeed because they knew it was best for their baby, and this was a motivator common to every stage. However a few mothers doubted the ‘breast is best’ message, and many did not necessarily know why breast is best, so reinforcement of the message with the inclusion of reasons is recommended.

A related motivator is the consistency between self-identity as a ‘good mother’ and the behavior of breastfeeding. Most mothers self identify as a good mother, and since breastfeeding is associated with good mothering, mothers are motivated to breastfeed. There is some qualitative evidence that this may be the case more often for mature mothers than teenage mothers, who may have difficulty reconciling the identity of ‘mother’ with ‘young person’. This suggests that a campaign directed at young people should promote breastfeeding in a way that allows teenage mothers to position themselves both as a normal, attractive young woman, and also as a breastfeeding mother.

Another motivator to continue breastfeeding that was described by research participants was reassurance from others that it was normal to have problems at the beginning, but that breastfeeding gets easier as time goes on. The enjoyment and bonding that breastfeeding provides in the medium and long term was described as a motivator by some women.
Appendix 2: Māori and Pacific models of health

Māori Models
There are a variety of Māori models of health. Two of the better-known models are Te Whare Tapa Wha and Te Pae Mahutonga. The descriptions of these models below are drawn from a New Zealand research report (McKerchar, 2003).

A widely used Māori model of health is Te Whare Tapa Wha or the four-sided house model, first proposed by Durie in 1982 (Durie, 1994). The Whare Tapa Wha model describes health as being made up of four dimensions; taha tinana – physical dimension, taha hinengaro – mental dimension, taha wairua – spiritual dimension and taha whānau - family dimension. Each dimension represents a side of the house and together they make a whole.

Durie argues that taha wairua is generally felt by Māori to be the most essential requirement for health. Durie states that belief in God is one reflection of wairua, but it is also evident in relationships to the environment especially to mountains, lakes, rivers and the sea.

It is important to note that in tikanga Māori, food and eating has significance not only for nourishing the physical body (taha tinana), but also has spiritual significance (taha wairua) and is an important aspect of maintaining social relationships (taha whānau). Te Whare Tapa Wha suggests that a breastfeeding promotion campaign for Māori must take into account the important role of breastfeeding in providing food and sustenance within contemporary Māori culture.

While Te Whare Tapa Wha highlights the relationship between the individual, other people and the natural environment, it does not specifically conceptualise the relationship between people and other environmental factors that play a major role in breastfeeding, such as workplace policies, social norms and advertising. Te Pae Mahutonga, another model developed by Durie (1999), does provide this wider context and may be the most appropriate model to consider in relation to breastfeeding promotion, since consideration of the economic, built and social environment is crucial.

Te Pae Mahutonga is a symbolic representation for the Southern Cross, with the four stars representing the four key tasks of health promotion, navigating the way to Māori wellbeing.

The first aspect is Mauriora – Access to te Ao Māori. This relates to the need for secure identity and confidence as Māori, including access to health-promoting aspects of the Māori world such as language and knowledge, culture and cultural institutions, and to Māori economic and social resources such as land, fisheries, Māori services and networks.

The second principle is Waiora – Environmental Protection, which is about the relationship Māori have with the wider environment, both in terms of spiritual connections, but also interactions with the natural, social and built environments that can either enable or inhibit Māori health.
The third star relates to Toiora – Healthy lifestyles. This is based on the premise that there are modifiable lifestyle risks that present major threats to Māori health, and impact on the ability of Māori to fulfil their potential. Toiora is about harm minimisation, targeted interventions, and addressing ‘upstream’ causes within a framework that is culturally relevant, builds on strengths and focuses on positive development.

The final star is Te Oranga – Participation in Society. Given the inextricable link between socio-economic position and health outcomes, Te Oranga is a principle that reflects on the extent to which Māori are able to benefit from their participation in the economy, education, employment, decision making, and other aspects of society. It relates to the type, nature and delivery of services for Māori, inequalities of access to and outcomes from wider societal benefits, and includes issues such as Māori autonomy and control over their own circumstances.

Te Pae Mahutonga also includes the ‘Two Pointers’ that are part of the Southern Cross constellation, which are described in the framework as Nga Manukura – leadership, and Te Mana Whakahaere – Autonomy. These principles refer not only to the importance of Māori leadership and autonomy to pursue community aspirations, but the need to nurture, support and build Māori leadership and autonomy through appropriate processes, the sharing of skills and knowledge, effective partnerships and alliances, workforce development, community ownership and self-governance for example.

Te Pae Mahutonga encourages an approach that addresses the environmental factors that encourage or inhibit Māori health. In a similar way that the Health Sponsorship Council’s Auahi Kore programme has reflected on Māori identity and linked this to smokefree lifestyles utilising Māori values around whānau, whakapapa, and manaaki, breastfeeding promotion may be able to draw on these values.

Pacific Models
Pacific communities also tend to have a holistic view of health and wellbeing, but each of the 22 Pacific nations represented in New Zealand has its own unique culture, history and worldview. This diversity has led to the development of a wide variety of Pacific models of health and research methodologies, for example the Cook Islands Tivaevae model, the Samoan Fonofale and Fa’aafaletei models, and the Tongan Kakala model to name a few that have been documented. It should be noted that many Pacific models, eg, the Vaka model (Tokolauan), Niu model (Niuean), and Tauhi e Va Ke Lelei (Tongan), while well known within the relevant community, are not extensively documented in academic or medical literature.

It is beyond the scope of this review to explore each Pacific culture’s view of wellbeing, but two prominent and potentially useful Pacific models of wellbeing are presented here. These are drawn from a fono in 2006 that discussed these models in relation to harms from gambling (National Pacific Gambling Stakeholders Fono, 2006) and the Mental Health Foundation’s ‘Mind Your Health’ guide to health promotion (Mental Health Foundation, 2004).

One well-known Samoan model of health is the Fonofale model, developed by Karl Pulotu Endemann, using the traditional Samoan meeting house as a metaphor. It was originally developed in relation to mental health, but may also be useful for conceptualizing the support
components for breastfeeding for Pacific peoples. The fale’s roof represents how the philosophies and methodologies of traditional and adapted cultural values and beliefs can be a shelter for people. For example Samoan practices around taking care of a new mother and her baby (and equivalent practices in other Pacific cultures) are protective of breastfeeding and of family wellbeing. The fale’s foundation is the immediate and extended family – the fundamental basis of Samoan social organisation and support, and it is these support networks that are crucial for providing tangible, emotional and informational support to breastfeeding mothers. The four posts represent spiritual beliefs; physical and biological wellbeing; mental and emotional strength and wellbeing; and other influences such as gender, sexuality, education, employment, income and age. Research with Pacific peoples clearly shows how each of these factors can influence breastfeeding. These four dimensions are interwoven, each being reliant on the others.

Surrounding the fale are: time (including impact, difference and difficulties of living in New Zealand); environment (including tension between the Samoan and New Zealand ways of life); and context (such as differences experienced by New Zealand-raised and Samoan-raised peoples). Again, the influences of these factors on breastfeeding are strong themes in qualitative research. In particular there seem to be tensions around traditional practices for introducing solids, and medical advice in the New Zealand context. This model provides a comprehensive and culturally appropriate summary of the key influences on the health of New Zealand Samoans, and thereby gives a guide to the personal, interpersonal, and environmental elements that need to be considered in the development of programmes and interventions for and with Samoan communities.

A Tongan research framework, Fakalotofale’ia, developed by Seluvaia Tu’itahi-Tahaafe, might also usefully inform the development of a breastfeeding promotion campaign. This model was originally developed in relation to her research with Tongan people with disabilities and their families. It describes ‘the way (faka) inside the heart (loto) of the household (fale’ia)’ and is based on a number of Tongan values and principles such as ‘ofa (love or compassion), fetokoni’aki (interdependence), makefetl’aki (reciprocity), uouangataha (collective), faka’apa’apa (respect), and fe’ofo’ofani (harmony, and looking out for each other). Such a model may be useful in the planning of interventions and programmes for the Tongan community, particularly in the family/whanau setting, since it highlights the Tongan worldview and the unique motivators and barriers that Tongan individuals and families are likely to experience in relation to breastfeeding.

As well as the range of Pacific cultures and worldviews of the different nations, diversity also results from the length of time people have lived in New Zealand. This ranges from those newly arrived in this country right through to families who have been here for several generations, each facing different issues, barriers and motivations in relation to breastfeeding. What works for one group may not necessarily work for another. It is therefore essential that this heterogeneity is taken into account when working alongside and developing programmes with Pacific peoples.
Appendix 3: Health promotion and lessons from promotion campaigns

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

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

Health messages and information can come through the mass media in several different ways.

- Planned, deliberate health promotion – mass media (eg, advertising on television and radio, posters or advertisements in newspapers and magazines).
- Health promotion by advertisers and manufacturers of ‘healthy’ products and services.
- Books, documentaries and articles about health issues (eg, television programmes and magazines).
- Discussion of health issues as a by-product of news items or entertainment programmes.
- Health (or anti-health) messages conveyed covertly or incidentally (eg, well-known personalities or fictional characters smoking or not smoking.) In some cases associates an action with benefits rather than costs.
- Planned promotion of anti-health messages (eg, tobacco advertising).
- Sponsorship of health-promoting events and services by organisations or commercial companies – either health or anti-health (Ewles and Simnett 2003).

Mass media channels of communication to large numbers of people include television, radio, the Internet, magazines and newspapers, books, displays and exhibitions.

Lessons from promotion campaigns

A report for Counties Manukau District Health Board (DHB) has drawn out some key lessons for Māori and Pacific communities from New Zealand’s experiences of social marketing (Sheehan, 2005). It is also useful for highlighting generic lessons from promotion campaigns.

Overall, effective campaigns were most likely to use comprehensive, integrated approaches that employed multiple intervention strategies and communication channels. For example, a comprehensive campaign might both raise public awareness and address environmental barriers to change. This can make evaluation, monitoring and tracking more difficult, as there
are multiple outcomes of interest, and it can be difficult to tease out the components of the intervention mix that have been most effective and reasons for their effect. However, evaluation, monitoring and tracking are essential components for success. This is backed up by the learning from New Zealand promotion campaigns, such as the Like Minds Like Mine campaign.

Other features of effective promotion campaigns include targeting a range of audiences. This is consistent with general public health approaches, where targeted ‘high risk’ approaches can be used with particularly vulnerable groups to ensure that inequalities in health are not maintained or widened. Yet a high risk approach by its nature often does little to improve overall population health, as the number of people targeted is generally low (as a proportion of the total population). Therefore, a whole population approach is required to ensure that the general populations’ health is improved, as well as a targeted approach for high-risk populations.

Timeframes for promotion campaigns are important, with research and experience from social marketing within New Zealand suggesting that ‘years’ are required for success. Larger campaigns often move through phases, going from raising public awareness in initial phases to attempting specific behaviour or environmental change in later phases.

To achieve a broad reach, effective promotion campaigns used a coordinated approach across government, industry and voluntary sectors. This allowed a national overview to be presented that was supported by coordinated local action. Strong partnerships between agencies were considered essential for success within many of the included studies, and it was considered resource intensive to develop these. Again, this is backed up by the learning from other social marketing campaigns, where Like Minds Like Mine demonstrates a strong partnership between the advertising agency and research companies, and both QuitLine and Like Minds Like Mine demonstrate the importance of a national overview that supports local community-based service delivery. Effective features of One Heart Many Lives include partnerships with community figures and community organisations. QuitLine also benefited from the personal nature of the helpline by using trained counsellors, and the counsellors’ work was further reinforced by environmental shifts such as law and price changes.

Many of the effective social marketing campaigns were notable for their development of appropriate messages for specific target groups. Culturally tailored social marketing interventions that include community control, community participation and leadership are critical features of effectiveness. This is backed up by learning from other social marketing campaigns, where Like Minds Like Mine demonstrates strong partnerships with mental health service users and providers, including specific attention being paid to Māori and Pacific peoples.

**Specific learning for Māori communities**
To summarise here, the Counties-Manukau report emphasised the importance of Māori clinical and community leadership, and the integration and engagement of Māori in all levels of social marketing campaigns (Sheehan, 2005). For instance, in the Quitline campaign, mainstream ads are reinforced by a specifically targeted Māori campaign, “It’s about whānau”. Engagement with
Māori is likely to be especially effective when sites that are connected to Māori communities are utilised (Sheehan, 2005), such as marae or kura kaupapa schools.

**Specific learning for Pacific communities**

Relevant lessons in relation to Pacific groups included the need to use existing Pacific networks and to have credible leadership including Pacific clinical leaders.

The church is viewed as a positive tool for engagement with Pacific peoples, but it is essential to use an appropriate process. Use of Pacific media is important, as well as good understanding of Pacific cultural protocols and sensitivities (Sheehan 2005).

**Breastfeeding promotion**

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

- women perceive the messages as being beneficial, feasible and socially acceptable
- messages are targeted towards the breastfeeding mother, her family, health providers and community in which they interact
- attitudes of the target audience are identified to ensure messages are appropriate
- barriers to the behaviour change are identified and influenced (National Breastfeeding Advisory Committee 2007).

Television campaigns have led to improved attitudes towards breastfeeding where newspaper advertisements were not effective. Locally developed media campaigns are likely to increase initiation across all groups of mothers, especially if used in conjunction with a local clinical programme. Social marketing campaigns for increasing local businesses and services to develop a supportive environment for breastfeeding have been shown to be effective when personal engagement of businesses is used (face to face visits, promotional stickers and inclusion in list of breastfeeding friendly services). There is no published evidence about the effectiveness of a ‘national breastfeeding week’ (National Breastfeeding Advisory Committee 2007).

A study by Ferreira-Rea and Morrow (2004) found there was a lack of health promotion directed towards mothers in paid work. Campaigns targeted towards working mothers are more likely to be effective if they are linked with increased support to encourage breastfeeding in workplaces and childcare facilities. Reviews by the European Union concluded that locally-run media campaigns aimed at national or regional social culture(s) were likely to increase breastfeeding initiation across all groups of mothers, especially if used in conjunction with a local clinical programme (cited in National Breastfeeding Advisory Committee 2007).
Appendix 4: Relevant theories and models

Stage of change (Transtheoretical) model
Stage of change theory has emerged from the study of addictions. This ‘theory’ can perhaps be better described as a framework that aids in identifying levels of motivation and behaviour in relation to making a behaviour change. This model typically comprises five stages:

1. Pre-contemplative
2. Contemplative
3. Preparation
4. Action
5. Maintenance.

This framework can be applied to the issue of breastfeeding.

   Pre-contemplative stage: eg, a pregnant woman who does not give much consideration to whether or not she intends to breastfeed prior to giving birth.

   Contemplative stage: a mother may be actively considering whether she should breastfeed their baby in the pre-natal stages or considering whether they should continue breastfeeding following birth. She may be engaged in a process of weighing up the pros and cons of breastfeeding versus other options.

   Preparation stage: mothers may be actively preparing to breastfeed during their pre-natal stages or preparing to use formula during their post natal stages.

   Action stage: mothers may be actively breastfeeding their newborn baby.

   Maintenance stage: breastfeeding has been established and mothers are continuing to breastfeed their child.

People may not always progress sequentially along the stages of this model or may become ‘stuck’ at various stages. An advantage of the stage of change model is that it segments intervention groups according to their motivation to change. Each stage requires different types of interventions to aid in transition to the next.

Social cognitive theory
This theory has evolved from social learning theory and recognises that individual behaviour can be the result of the individual and their interactions with their social environment. This theory is widely used in health and social interventions and has six key constructs:

- skills
- confidence
- social learning
- expectations
- reinforcements
- reciprocal determinism.
Skills relating to new behaviours often require new skills in order for them to be adopted. The easier skills can be adopted, in terms of access to opportunities to learn them and the ease with which they can be learnt, the more likely people will learn them.

Confidence refers to once someone has learnt new skills, do they feel confident in being able to apply them. For instance, mothers need to feel confident that they can continue to breastfeed their baby.

Social learning recognises that a key means by which people learn new behaviours is through watching the behaviours of others. This component of the theory highlights the need for relevant role models, such as breastfeeding mothers who influence normative beliefs regarding breast feeding and provide an important source of information in relation to how to breastfeed and feeding in different settings.

Expectations refer to the perceived costs or benefits of a new behaviour. In this case it is expected that a mother will weigh up the costs and benefits of breastfeeding compared to other options.

Reinforcements refer to whether the actor receives any positive or negative rewards as a result of new breastfeeding. In the case of breastfeeding mothers this could be in the form of encouragement from others or feelings of being a ‘good’ parent.

Reciprocal determinism describes the interactive nature between individuals and their environment. For example, a breastfeeding mother’s attitude may be influenced by the environment or their own behaviours. However, if a mother, or group of mothers start to actively breastfeed in settings where this may not have occurred previously the setting may change. This construct highlights the interaction between individuals and their social and physical environment as being a two way process.

Theory on Self-efficacy
Self-efficacy is self-judgment of one’s ability to perform a task in a specific domain (Bandura, 1982). Four phenomena that affect self-efficacy are:

Mastery experiences: personal experience with success or failure for a given task. For example, being able to successfully initiate breastfeeding.

Vicarious experiences: Observation of the experiences of others. Mothers who are able to observe their peers successfully initiate breastfeeding are more likely to be able to believe they can initiate breastfeeding. More over they can ‘imitate’ their role models behaviour (source of informational support).

Verbal persuasion: Exposure to positive verbal feedback encouraging or convincing a person that they can successfully accomplish a task. For example, reassurances to a mother that she is doing well and that it gets easier over time.

Physiological state: Reactions such as anxiety and nervousness can occur when learners face challenges that require competence to overcome. These reactions are thought to reflect a
learner’s perceptions of their self-efficacy, which in turn, can affect their performance. For example, a mother who is tired and trying to feed a crying baby may become anxious, this may affect her ability to breastfeed.

If a person is experiencing low-self efficacy this can be improved by:

Feedback: Encouragement and in-depth, informative feedback from experts and emotional support people.

Modeling: Exposure of learners to non-expert models (peer model) who are conquering challenges successfully. A complimentary approach is to enhance self-efficacy by observing models solving problems with specific strategies or skills. This may be of limited use to a mother initiating breastfeeding as they have a relatively narrow opportunity to acquire the skill. Modeling may be useful pre-natal and post the initial breastfeeding initiation phase.

Successful experience: A successful experience is the most important source of fostering self-efficacy. Successfully latching a baby and getting them to feed. It may be useful to recognise ‘small’ successes on the way to fully acquiring breastfeeding skills (eg, latching, recognising hungry signs, avoidance of pain, etc.

Community level theories
Community level theories recognise that social and health related issues are strongly influenced by the social environment and social structures. The following theories and models are not ‘behaviour change’ models as such, but are different frameworks for understanding health and the components/determinants that underpin community wellbeing. These have been included because they describe understandings of health that underpin public health action, including promotion campaigns, and provide a much broader remit for action than that offered by the dominant biomedical model of health.

Three sets of theories or models are briefly reviewed here: ecological and social models, diffusion of innovations, and community planning and development.

Ecological and Social Models
Due to the limited success of individual-level psychosocial models, ecological and social models have generated substantial interest in health promotion in recent years. We all live in environments or ecologies with physical and human or social aspects. The ways that environment affects health are complex as the environment is multilevel (neighbourhood, region, city, country), multi-structural (physical, socio-economic, social capital), multi-factorial (diet, physical activity, stress) and multi-institutional (family, society, government) (Baranowski, Cullen, Nicklas, Thompson, and Baranowski, 2003). Examples of environmental change include legislation and national policy changes, or changes in workplace policies.

Diffusion of innovations
This theory describes the process through which new ideas are introduced within a community. As the name suggests this theory suggests that new ideas ‘diffuse’ through a community. By
understanding this process of diffusion social and health issues can be promoted as ideas that bring about community change. In summary, the process of change is described as being carried through five sets of groups:

- innovators
- early adopters
- early majority
- late majority
- laggards.

The innovators are characterised as those people who are responsive to new ideas and willing to give them a try. Sometimes the ‘new idea’ has positive results and sometimes negative. In a sense these people are seen as risk takers. Early adopters are those people who, after observing innovators try a new idea with success, decide to adopt a new idea. Sometimes these people are characterised as ‘opinion leaders’. Their actions influence others and adoption of a new idea by early adopters can sometimes signal what is often described as the ‘tipping point’ – the point at which an idea suddenly becomes accepted and rapidly diffuses throughout society. Following the early adopters are the early majority and then the late majority – both groups are influenced by observing that a new idea is being rapidly adopted and becoming a norm. The final group are the ‘laggards’ – this group is resistant to change and is often described as conservative. Obviously this theory has a number of overlaps with other theories, especially social cognitive theory. A key means of how the idea is diffused is through communication and observing others.

A number of characteristics have been identified that are associated with an idea being successfully adopted within a community:

- compatibility with existing beliefs and behaviours of the adopter
- clarity of the relative advantage of the innovation
- simplicity of the innovation (the ease with which it can be adopted)
- trialability – the higher the risk the less likely someone will adopt the idea
- observability of the results of trying a new innovation (similar to expectations described under social cognitive theory above).

**Community planning and community development**

Community planning refers to a structured process through which a community is engaged on an issue and collectively identifies resolutions to rectify the issue. It comes under a wider framework of ‘community organisation’, which is the process by which community groups are assisted to identify common concerns or goals, mobilise resources, and develop and implement strategies to achieve their goals.

Compared with other similar models such as social action or community development, community planning is characterised as being task orientated and expert driven. The community planning approach produces tightly organised and planned programmatic responses. It tends to draw on epidemiological analysis of issues. Professional ‘planners’ are
closely involved in developing and implementing solutions, taking a role of ‘fact gatherer and analyst’.

In reality, many community development projects draw on a mix of models such as community planning, social action and community development approaches. Theories and models of community development continue to evolve, and early approaches have been criticised for being overly focused on ‘problems’ and dependent on ‘experts’. Contemporary models of community development emphasise self-determination and *empowerment* of communities, with a strong emphasis on developing *community leadership and capacity*.

Minkler has defined empowerment as a social action process by which individuals, communities and organisations gain greater control in their lives in the context of changing the social environment to improve equity and quality of life (cited in Nutbeam and Harris 2004).

Rissel (cited in Nutbeam and Harris 2004) has suggested a continuum of empowerment, which describes several distinct stages of empowerment in a health promotion context.

- Health practitioners work with people in ways that increase individuals’ confidence in their own capacity to create positive change.
- Involvement in peer support, self-help or social action groups builds and expands social networks and increases critical awareness of wider social forces. Such involvement builds skills and increases capacity of communities.
- As a community becomes more empowered, it will work on particular issues, link with other groups, or engage in collective political or social action.

Community capacity has four broad domains:

1) network partnerships (relationships between groups in a community or network).
2) knowledge transfer (development, exchange and use of information within and between groups).
3) problem solving (ability of groups and the community to identify and solve problems).
4) infrastructure (level of tangible and non-tangible investment in a network or community by its constituent groups, including financial and social capital, and policy and protocol development).

In summary, the most effective and sustainable community organisation approaches are those that:

- are based on an assessment of community needs
- engage and empower communities, and
- contribute to increased community capacity.

A community level approach has the advantage of dealing explicitly with social, economic and environmental determinants of health in relation to local conditions. The goal of reducing inequalities in health suggests a need to invest extra resources in communities that are disadvantaged or marginalised in order to build capacity for change.
Appendix 5: Further information on mass communications

The following process is generally followed in the development of a communications campaign:

- a brief is developed, containing background research and campaign goals and objectives
- a Request for Proposal document is developed and notified
- an advertising/PR company is selected to develop the campaign
- creative ideas are presented by the advertising company, and pre-testing takes place
- a creative idea is selected and further developed
- a public relations plan is developed and signed off
- filming or the development of print, radio and other advertising takes place
- public relations activities take place (and are ongoing)
- advertising is placed where it will best reach the target audience – for example, in media that reaches Māori and Pacific peoples
- advertising runs
- the campaign is evaluated and further developed taking the evaluation findings into account.

A public relations campaign usually consists of the following:

- stakeholder liaison – in the case of breastfeeding there may be a particular focus on Māori and Pacific providers and clinicians and using existing Māori and Pacific networks
- unpaid media – developing and releasing/pitching media statements, opinion pieces, letters to the editor. As with the paid advertising, the PR strategy will focus on targeting media consumed by Māori and Pacific peoples
- leveraging off other unpaid communications – for example, providing information for GP newsletters and to DHB communications staff for use locally
- community engagement – working with local providers to ensure they have the necessary knowledge and resources to promote key messages at a local level. This will include partnerships with community leaders and organisations
- risk management.

A PR campaign takes campaign key messages and unpacks them in a variety of media settings – in the newspaper, on radio (news and talkback) and on television. The PR component of a campaign with a particular focus on Māori and Pacific families will often be managed by Māori and Pacific PR experts.

Resources such as pamphlets, posters, fact sheets and collateral (for example branded pois, fridge magnets) are often developed to support a communications campaign. This process often starts with a stocktake of existing resources, with identified gaps. Then the resources and/or collateral to be developed are agreed, and the development process begins. This process should include pre-testing of resource concepts with target audiences.
The material developed in this case may also include information to be given out by health practitioners to breastfeeding mothers and their families. For example, on the benefits of breastfeeding, how to breastfeed, problems that may arise and how to overcome them (latching problems, pain, exhaustion, lack of time to breastfeed etc), where to go for help and support, baby’s nutritional needs; information on baby/breastfeeding-friendly venues etc. The resource development process, like the advertising and PR campaign, is often contracted out to an individual or company with appropriate expertise.
Appendix 6: Alignment with strategies and international documents

The proposed campaign is closely aligned with the Healthy Eating – Healthy Action (HEHA) strategy to improve nutrition, increase physical activity and achieve healthy weight for all New Zealanders. Breastfeeding features in the HEHA strategy as an important element of healthy nutrition, and is also a high-level health target for the Government. A key action from the HEHA strategy is to develop policies and campaigns to promote and support breastfeeding, with a particular emphasis on high-need groups and Māori and Pacific peoples who have lower rates of breastfeeding than the European population.

Breastfeeding supports five of the 13 population health objectives in the New Zealand Health Strategy:

- improving nutrition
- reducing obesity
- reducing the incidence and impact of cancer
- reducing the incidence and impact of cardiovascular disease
- reducing the incidence and impact of diabetes.

He Korowai Oranga, the Māori health strategy, requires an approach that recognises and builds on the strengths and assets of whānau, a broad concept of family, encouraging whānau development and whānau ora. The strategy’s goals and pathways for action are relevant to the development of a national breastfeeding promotion plan, as the plan will work to reduce disparities in breastfeeding rates, recognise and build on Māori models of health, and conceptualise breastfeeding as a key component of whānau ora with significance for spiritual, cultural and emotional wellbeing of the family, as well as providing physical health benefits for mother and baby. Improving Māori provider capacity and capability in relation to breastfeeding support, and improving the responsiveness of mainstream services to the needs of Māori in relation to breastfeeding are likely to be important strands of a national breastfeeding promotion campaign.

The Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. The plan prioritises the health of children and young people, and recognises that ‘good antenatal care is one of the most effective strategies for improving child health’. The plan notes that nearly a third of Pacific women are not linked with primary care or maternity care providers until late in their pregnancy or until the birth, and recommends a focus on ensuring that pregnant women are healthy and connected with services as a way of ensuring that outcomes for Pacific infants are improved.

The proposed breastfeeding campaign plan aligns with the Pacific Health and Disability Plan in that both plans aim to reduce health inequalities for Pacific peoples and improve Pacific child health. The principles of the Pacific Health and Disability Plan are also applicable to a
breastfeeding promotion campaign: recognition of the dignity and sacredness of life, active participation of Pacific peoples at all levels, recognition of the integral roles of Pacific leadership and Pacific communities, and entitlement to co-ordinated, culturally competent and clinically sound services.

*Breastfeeding: A guide to action* (2002) sets out the Ministry of Health's plan of action for improving the initiation and maintenance of breastfeeding throughout New Zealand during 2002/03. The Breastfeeding Action Plan specifies the continued monitoring and strengthening of existing initiatives, and in particular calls for the provision of consistent, up-to-date breastfeeding information, and a nationwide focus on achieving accredited Baby Friendly Hospitals. The National Breastfeeding Advisory Committee is currently working on a National Plan of Action for breastfeeding, which will provide the overall strategic approach to breastfeeding for New Zealand and will supersede the 2002 *Guide to action*. This report draws on information contained in the 2002 document, along with other sources of evidence, in order to make recommendations for a national breastfeeding promotion plan. As breastfeeding promotion will be one component of the overall approach, the proposed campaign will need to be closely aligned with the National Plan of Action.

The *International Code of Marketing of Breast-milk Substitutes* was adopted by New Zealand in 1983 and includes various requirements and restrictions in relation to marketing and distributing breast-milk substitutes. The Ministry of Health undertook a review in 2004 to assess whether two self-regulatory codes of practice, introduced here in 1997 as part of New Zealand's interpretation of the code, were still relevant and continuing to meet their objectives within a changing social and commercial environment. The review resulted in eleven action points, agreed by the Ministry of Health, to provide a framework for refining and strengthening New Zealand's interpretation of the World Health Organization's International Code of Marketing of Breast-milk Substitutes. Ongoing work to action these eleven recommendations in relation to the marketing of formula represents a separate work stream to the development of a national breastfeeding promotion campaign. This work is outside the scope of the proposed breastfeeding promotion campaign, but is complementary to it.

The *Global Strategy for Infant and Young Child Feeding* (WHO, 2003) is a guiding document for breastfeeding protection, promotion and support strategies in New Zealand and internationally. The strategy calls for action in the following areas.

- All governments should develop and implement a comprehensive policy on infant and young child feeding, in the context of national policies for nutrition, child and reproductive health, and poverty reduction.

- All mothers should have access to skilled support to initiate and sustain exclusive breastfeeding for 6 months and ensure the timely introduction of adequate and safe complementary foods with continued breastfeeding up to two years or beyond.

- Health workers should be empowered to provide effective feeding counselling, and their services be extended in the community by trained lay or peer counsellors.
• Governments should review progress in national implementation of the International Code of Marketing of Breast milk Substitutes, and consider new legislation or additional measures as needed to protect families from adverse commercial influences.

• Governments should enact imaginative legislation protecting the breastfeeding rights of working women and establishing means for its enforcement in accordance with international labour standards.

The WHO Global Strategy is evidence-based and builds on past initiatives, in particular the Innocenti Declaration on the protection, promotion and support of breastfeeding (originally adopted in 1990, and updated in 2005) and the Baby-friendly Hospital initiative, which outlines ‘ten steps to successful breastfeeding’.
Appendix 7: Key stakeholders

Examples of potential key stakeholders for the campaign are listed below. It is recommended that further investigation and consultation is undertaken to identify other key stakeholders.

National organisations

- National Breastfeeding Advisory Committee
- NZ Breastfeeding Authority, Baby Friendly Hospital Initiative (BFHI) and Baby Friendly Community Initiative (BFCI)
- La Leche League
- Nga Maia midwives, College of Midwives, Royal New Zealand College of General Practitioners (RNZCGP)
- Paediatric Society of New Zealand
- Other organisations eg, Employers Federation, Work & Income, national church organisations, national childcare organisations

Health practitioners and organisations

- Health Practitioners/Providers & Practitioners bodies
  - Community Midwives
  - DHB employed midwives
  - Lactation consultants
  - Hospital-based maternity profs
  - DHBs and HEHA Project Managers
  - Child health units/children's hospitals
  - Nutrition practitioners
  - Primary care providers incl. Māori & Pacific PHOs
  - Community based providers: Plunket, Well Child/ Tamariki Ora, Family Start, Youth health providers

- Ministry of Health (across all directorates)

Cultural leaders and organisations

- Māori and Pacific community leaders and organisations
  - eg, Māori Women’s Welfare League, local iwi authorities, PASIFIKA, Pacific church leaders.
## Appendix 8: Breastfeeding rates in New Zealand 1997 to 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>54</td>
<td>54</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>56</td>
<td>60</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>57</td>
<td>56</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>57</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>55</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>59</td>
<td>61</td>
<td>68</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>62</td>
<td>62</td>
<td>49</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2004</td>
<td>60</td>
<td>59</td>
<td>55</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2005</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>2006</td>
<td>59</td>
<td>57</td>
<td>55</td>
<td>70</td>
<td>66</td>
</tr>
</tbody>
</table>

**Exclusive and full Breastfeeding at six weeks**

<table>
<thead>
<tr>
<th>Year</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>54</td>
<td>54</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>56</td>
<td>60</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>57</td>
<td>56</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>57</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>55</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>59</td>
<td>61</td>
<td>68</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>62</td>
<td>62</td>
<td>49</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2004</td>
<td>60</td>
<td>59</td>
<td>55</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2005</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>2006</td>
<td>59</td>
<td>57</td>
<td>55</td>
<td>70</td>
<td>66</td>
</tr>
</tbody>
</table>

**Exclusive and full Breastfeeding at three months**

<table>
<thead>
<tr>
<th>Year</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>54</td>
<td>54</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>56</td>
<td>60</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>57</td>
<td>56</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>57</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>55</td>
<td>57</td>
<td>68</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>59</td>
<td>61</td>
<td>68</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>62</td>
<td>62</td>
<td>49</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2004</td>
<td>60</td>
<td>59</td>
<td>55</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>2005</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>2006</td>
<td>59</td>
<td>57</td>
<td>55</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Year</td>
<td>Māori</td>
<td>Pacific</td>
<td>Asian</td>
<td>Other</td>
<td>All</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>---------</td>
<td>-------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>1997</td>
<td>12</td>
<td>13</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>14</td>
<td>17</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>13</td>
<td>18</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>13</td>
<td>17</td>
<td>20</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>13</td>
<td>17</td>
<td>21</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>16</td>
<td>20</td>
<td>25</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>16</td>
<td>19</td>
<td>20</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>2004</td>
<td>18</td>
<td>20</td>
<td>22</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>2005</td>
<td>18</td>
<td>19</td>
<td>23</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>2006</td>
<td>17</td>
<td>19</td>
<td>25</td>
<td>29</td>
<td>25</td>
</tr>
</tbody>
</table>
Glossary

Programme plan definition

The term programme plan refers to a planned set of activities that aim to address an identified issue. A focus of the planning process is identifying what the main issue is, what causes the issue to occur and what can be done about the issue.

Components of a programme plan

Programme plans are generally made up of goals, objectives, strategy objectives and strategies.

Goal development

The goal of a programme reflects the central issue that programme is intended to address. In relation to breastfeeding the central issue is related to babies not being breastfed up to six months. As part of the programme process the central issue is focused on the behaviours that need to change to increase breastfeeding.

In general, goals are characterised as being longer term and generally not achievable as a result of the programme alone. The purpose of a goal is to provide clear and ongoing direction for a programme. A goal that is readily achieved would mean that the programme would quickly become directionless.

Objectives

Objectives are clear and concise statements regarding what a programme will actually aim to achieve in relation to its goal. Ideal objectives are often referred to as ‘SMART’:

Specific: Specify what the programme will achieve

Measurable: To be able to measure whether you are meeting the objectives or not

Achievable: Objectives are achievable and attainable

Realistic: Takes into account available resources and timeframes

Time: When should they be achieved by?

In addition, objectives should generally refer to physical changes in behaviour or settings.

Generally, objectives are identified through a systematic assessment of evidence, theory and experience to identify what causes the central issue (restated as the goal) to occur. Key influences or risk and protective factors are identified and these become the immediate focus for a programme. Evidence is used to identify known risk factors that research has identified as
being causally associated with the issue. Theory is used to assess how known risk factors are causally associated with the central issue and identify any areas where there is no available evidence but theory suggests there may be an influencing factor. Both theory and evidence are used to develop an ‘explanatory model’ that explains the processes through which an issue is caused.

Finally ‘experience’ is used to translate these known and theoretical risk factors into objectives. A single objective may also have a number of sub-objectives that contribute to it.

Apart from setting a clear direction for an intervention, goals and objectives are also essential for evaluations that assess the impacts of an intervention. Objectives are typically used to identify key programme ‘success measures’ and are, therefore, a focus of outcome evaluations.

**Strategy objectives**

Strategy objectives generally refer to a set of activities undertaken to achieve a specific objective. As discussed above, these objectives refer to a change in the behaviour of an individual or environment. The strategy objectives should describe how this change will occur. To do this requires an understanding of how change can occur and the process for achieving this. This is sometimes described as a programme’s theory of change. For example, one of the tenets of social cognitive theory is that people learn behaviour by watching others.

At a practical level *strategy objectives* can be viewed as ‘projects’. Using a project planning approach strategy objectives can be implemented as projects during a financial year (or longer) and be described in an organisation’s Statement of Intent and Annual Plans.

**Strategies**

Strategies are those discreet activities (or ‘tasks’) that need to be undertaken to complete a strategy objective. Using the strategy objective example above, a strategy could be to establish a role model register.
References


