



# A POLICY-FRIENDLY ENVIRONMENT FOR BREASTFEEDING

A review of South Africa's progress in systematising its international and national responsibilities to protect, promote and support breastfeeding

January 2018

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Senior policy analyst



**DST-NRF Centre of Excellence  
in Human Development**





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Published in South Africa by the DST-NRF Centre of Excellence in Human Development, University of Witwatersrand, Johannesburg.



DST-NRF Centre of Excellence in Human Development 2018

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### **Suggested citation:**

Martin-Wiesner, Patricia. 2018. A Policy-Friendly Environment for Breastfeeding: A review of South Africa's progress in systematising its international and national responsibilities to protect, promote and support breastfeeding. Johannesburg: DST-NRF Centre of Excellence in Human Development. URL: <https://www.wits.ac.za/coe-human/coe-research-grants/coe-research-and-advocacyon-breastfeeding/breastfeeding-policy-review/>

### **Declaration of conflict of interest**

Patricia Martin-Wiesner declares that she has no financial or other personal interest, direct or indirect, in any matter dealt with in this report.

The DST-NRF Centre of Excellence declares it has no financial or other interest, direct or indirect, in any matter dealt with in this report.

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# ACRONYMS AND ABBREVIATIONS

|                     |  |
|---------------------|--|
| <b>WHO</b>          | World Health Organisation  |
| <b>ACERWC</b>       | African Committee of Experts on the Rights and Welfare of the Child                  |
| <b>ACPF</b>         | African Child Policy Forum   |
| <b>ACRWC</b>        | African Charter on the Rights and Welfare of the Child                               |
| <b>AFASS</b>        | Acceptable, feasible, affordable, sustainable and safe                               |
| <b>APP</b>          | Annual Performance Plan  |
| <b>BFGM</b>         | "Breastfeeding GEAR" model   |
| <b>BFHI</b>         | Baby-Friendly Hospital Initiative  |
| <b>BTWG</b>         | Breastfeeding Technical Working Group  |
| <b>CEDAW</b>        | Convention on the Elimination of All Forms of Discrimination Against Women           |
| <b>CRC</b>          | Convention on the Rights of the Child  |
| <b>DHIS</b>         | District Health Information System   |
| <b>DHS</b>          | Demographic Health Survey  |
| <b>DOL</b>          | Department of Labour   |
| <b>DPME</b>         | Department of Planning, Monitoring and Evaluation                                    |
| <b>DPSA</b>         | Department of Public Services and Administration                                     |
| <b>GSİYCF</b>       | Global Strategy for Infant and Young Child Feeding                                   |
| <b>ICESCR</b>       | International Covenant on Economic, Social and Cultural Rights                       |
| <b>IFA</b>          | Infant Feeding Association   |
| <b>ILO</b>          | International Labour Organisation  |
| <b>IYCF</b>         | Infant and Young Child Feeding   |
| <b>KPIs</b>         | Key Performance Indicators   |
| <b>M &amp; E</b>    | Monitoring and evaluation  |
| <b>M, E &amp; R</b> | Monitoring, evaluation and reporting framework                                       |
| <b>MBFI</b>         | Mother-Baby Friendly Initiative  |
| <b>MNCWH&amp;N</b>  | Maternal, Newborn, Child and Women's Health and Nutrition                            |
| <b>MTSF</b>         | Medium Term Strategic Framework  |
| <b>NDOH</b>         | National Department of Health  |
| <b>NDP</b>          | National Development Plan: Our Future, Make It Work                                  |
| <b>NSDA</b>         | Negotiated Service Delivery Agreement  |
| <b>SACSoWACH</b>    | South African Civil Society Coalition on Women's, Adolescents' and Children's Health |
| <b>SAM</b>          | Severe Acute Malnutrition  |
| <b>SAPMTCTE</b>     | South African Prevention of Mother-to-Child Transmission of HIV Evaluation           |

# EXECUTIVE SUMMARY

South Africa has ratified and committed to implementing a wide range of international child rights and public health instruments and agreements dating back to 1996. Central to these has been a commitment to promote breastfeeding and appropriate complementary feeding practices. South Africa has domesticated its commitments through a host of carefully-constructed legislative instruments, regulations, guidelines, and policies. In recent years, South Africa has re-committed to expedite the adoption of relevant measures to lay the foundations for the healthy development of its children, and in so doing, put in place the building blocks for sustainable social and economic development, the elimination of poverty, and the reduction of inequality in South Africa.

Despite the number and scope of South Africa's commitments and comparatively high levels of compliance with its responsibilities, the country has seen only limited changes in the rates of breastfeeding, appropriate complementary feeding practices, and ultimately the nutritional well-being of young children in the country. Indeed, stunting rates, a key indicator of children's nutritional well-being and development, are high for a middle-income country, and have stayed high for nearly four decades.

Over and above poor nutritional outcomes, there are also inequities in access to services, and resulting disparities in the nutritional status of children across provinces, across poverty quintiles, and across rural and urban areas. Some provinces have made significant progress in implementing national commitments, policies and agreements and, in so doing, have succeeded in improving breastfeeding rates and the nutritional status of children. However other provinces, especially those with high levels of poverty and with historically poor nutritional indicators, have not made the same gains. This fuels the inequities and disparities which lie at the heart of South Africa's development challenges.

*The question that this picture raises is: Why has the massive groundswell in the government's international, regional and national commitments to breastfeeding promotion and its many policies and programmes not translated into significant improvements in breastfeeding rates and nutritional outcomes for young children? Why has there been such limited progress and impact at national level, and why the provincial and related inequities and disparities?*

Signing agreements, crafting resolutions and adopting laws supporting breastfeeding is not enough. The commitments must be fully systematised into public systems, including the health system. Both nationally and provincially, they must be integrated across six core system's building blocks:

1. **Service delivery:** Through evidence-based universal programmes, a full range of services (including infant and young child feeding, maternal and child health, parenting support, child development services, and workplace support) must be provided at all levels so that they reach all, including the most marginalised households, to address all risks to breastfeeding and appropriate feeding practices.
2. **Human resources:** Public systems within responsible government departments must secure sufficient human resources to implement, monitor, correct and oversee the programmes and services.
3. **Financial resources:** Sufficient public financial resources must be allocated and used to deliver and manage programmes.
4. **Technical equipment and infrastructure:** Delivery must be supported by an adequate supply of technical equipment and infrastructure such as clinics, breastfeeding rooms, and scales to weigh babies.

5. **Information management:** All public information management, monitoring, evaluation and reporting frameworks and mechanisms must measure the progress and impact of initiatives to support breastfeeding, and must ensure the results feed into a cyclical planning process aimed at continual quality improvement.
6. **Leadership and governance:** Strong national and departmental leadership and coordination is necessary to ensure the political profiling of breastfeeding and allocation of public resources to ensure the provision of quality programmes and services to protect, promote and support breastfeeding at scale.

The government has taken a number of discernible measures to domesticate its responsibilities. These include:

1. The adoption of the national Mother-Baby Friendly Initiative;
2. The adoption of national regulations governing the marketing of breastmilk substitutes; and
3. The adoption of laws protecting the rights of breastfeeding women in the workplace.

A systemic review of these initiatives, as measured against the preceding systemic building blocks, reveal some strengths, but also a number of fundamental weaknesses. The latter undermine the impact of initiatives on improving breastfeeding rates, nutritional well-being, and development of children in South Africa, especially for those children most at risk.

The limited systematisation of the various initiatives to domesticate South Africa's responsibilities lies at the heart of the yawning gap between commitments and limited improvements on the ground. Progress depends on the effective systematisation of existing commitments and initiatives. The way forward is clear: Strengthen the systemic pillars upon which impact of the relevant initiatives and the holistic breastfeeding framework rest.

# INTRODUCTION

## The problem

South Africa has ratified and committed to most of the relevant international agreements and instruments recognising and promoting breastfeeding. It has further domesticated these through a host of carefully-constructed, compliant resolutions, legislative instruments, regulations, guidelines, and policies. In recent years, through the Tshwane Declaration of Support for Breastfeeding (2011), the country has re-committed itself to expedite compliance with ensuing responsibilities.

Historically, there has been little evidence that these measures have brought about significant improvements in the national rates of early and exclusive breastfeeding, good complementary feeding practices, and the nutritional status of young children. The South African Health Review reported in 2016 that:

In South Africa, available national data suggest that most mothers initiate breastfeeding after birth. However, it has been observed that very few babies are exclusively breastfed during the first six months of life. Many babies also receive complementary foods between two and three months of age, and in some cases, even within a few days of birth. This suboptimal early nutrition profile predisposes South Africans to poor health outcomes in both their infants and young child years as well as in adulthood (Du Plessis et al, 2016, p. 109).

There is a paucity of reliable data on breastfeeding rates in the country, with competing and incomplete data sets, some of which are almost ten years old. The data suggests an upward trend in early initiation of breastfeeding (within one hour of birth) from 45 percent in 1998 to 80 percent in 2012 (Shisana et al, 2013). It is estimated that nearly 43 percent of women practice exclusive breastfeeding at 14 weeks (Shisana et al, 2013). The latest Demographic Health Survey (DHS) confirms this trend. It reflects an increase in exclusive breastfeeding rates for children under the age of 6 months, from less than 7 percent in 1998 to 32 percent in 2016.<sup>1</sup> The increases are significantly higher in the very early weeks and months of life. The DHS recorded rates of 44 percent for infants under the age 1 month, dropping down to 29 percent for those 2-3 months, and down further to 27 percent at 4-5 months (Statistics SA, National Department of Health, SAMRC & the DHS Program, 2017).

However, for many years the evidence suggested that these improvements in early breastfeeding are not sustained, and have had little positive impact on children's nutritional health, well-being and development. According to one report, 7 percent<sup>2</sup> of women continue breastfeeding for 6 months (Shisana et al, 2013). The 2008 South African HIV Prevalence, Incidence, Behaviour and Communication Survey indicated that less than 30 percent of children under 6 months were breastfed, and of these, only 8 percent were exclusively breastfed. Nearly a quarter (22.5%) was exclusively formula fed and 51.3 percent received mixed feeding (Shisana et al, 2008). A number of these trends and poor outcomes were confirmed in the recent DHS.

Whilst the recorded increase in exclusive breastfeeding rates for children under 6 months is positive, the continuing disparities across different reports create uncertainty about the actual progress made. Moreover, as noted above, exclusive breastfeeding increases are largely limited to the very early months, and large numbers of infants and young children continue to be fed inappropriately

<sup>1</sup> This significant increase (more than threefold) is based on a very small sample of the breastfeeding practices of all children falling within the sample of 2 000 children under the age of 5 years that were born in the 2 years preceding the survey. Therefore this does not reflect population-level data and the data and results should be read appropriately.

<sup>2</sup> DHIS Hep B 2nd dose 2013/2014, in Shisana et al, 2013.

and inadequately, especially in the earliest years when poor infant and young child feeding practices impact, either positively or negatively, on children's overall nutritional status, including stunting and their development. The DHS found, for example, that 25 percent of children younger than 6 months were not breastfed at all; 45 percent are fed using a bottle with a nipple; and only 23 percent of young children aged 6 – 23 months receive a minimum acceptable diet of milk and an adequate mix of complementary food from the required food groups to ensure their healthy growth and development. Quite alarmingly, only 16 percent of those aged 6 – 11 months received an adequate minimum mix of milk and complementary food (Statistics SA, National Department of Health, SAMRC & the DHS Program, 2017).

A study of breastfeeding practices in four provinces found that 17 percent of mothers introduced complementary food as early as before one month, and that only one infant in the study received complementary food (out of a total sample of 580 mothers) that complied with minimum standards of dietary diversity (Siziba et al, 2015).

As a result of widespread poor infant and young child feeding practices, longer term nutritional outcomes for children are poor. South Africa exhibits high rates of undernutrition, particularly stunting, which is attributed in part to low breastfeeding rates and poor complementary feeding practices. In 2012, nearly 22 percent of children under five were stunted and 7 percent were severely stunted (Shisana et al, 2013). The DHS recorded an even higher rate of stunting (27%) in children under the age of five years (Statistics SA, National Department of Health, SAMRC & the DHS Program, 2017).

It is not only undernutrition that is a problem. Increasing numbers of children are overweight or obese. Girls and urban children are at greater risk than boys and those in rural areas. For example, in 2012, 7 percent of girls (2-14 years) were obese, compared to 5 percent of boys (Shisana et al, 2013). More recently, the 2016 DHS found that 13 percent of children of all ages are overweight – twice the global average.

The picture varies from province to province. Some have made significant progress in implementing national commitments, policies, and agreements. For example, in 2015/16, 95 percent and 98 percent of public health facilities in KwaZulu-Natal and the Western Cape respectively, were accredited as Mother-Baby-Friendly. However, some provinces have not made the same gains. For example, only 17, 45 and 72 percent of facilities in the Northern Cape, Free State and North West were accredited, and the national average, at 75 percent was close to 20 percentage points lower than the better-performing provinces.<sup>3</sup>

*The question that this picture raises is: Why have the government's extensive international, regional, and national commitments to breastfeeding promotion and the adoption of subsequent laws, policies and programmes not translated into the universal roll out of national programmes in all provinces, and not led to larger and sustained improvements in breastfeeding rates, feeding practices and nutritional outcomes for young children? Why has there been such limited progress / impact at national level, and why the provincial differences?*

<sup>3</sup> Information provided by Ann Behr, Directorate: Child, Youth and School Health, National Department of Health, November 2016. Based on a 2008 evaluation of the BFHI conducted by the University of the Western Cape (commissioned by UNICEF and the DOH).

This question is not unique to the breastfeeding or child nutrition arena, and is also not unique to South Africa. The 2016 African Report on Child Wellbeing, an annual regional child-friendliness monitoring publication found that “African governments are disposed towards adopting the right laws and policies for children ... [however] narrowing the gap between policy and practice is the major challenge to the promotion of child rights and child wellbeing in Africa.” The report concludes that the underlying reasons for this gap are the failure by government to systematise their laws and policies. Notably, it states that the systems necessary to translate high-level political commitments captured in policies and laws into effective programmes – human capacity, coordination mechanisms, budgets and monitoring and accountability systems – are not in place, nor strong enough.

South Africa is not exempt from this criticism. The African Committee of Experts on the Rights and Welfare of the Child (ACERWC, 2016) recently concluded that, whilst South Africa has adopted a substantial number of child-friendly policies and laws, it has not adequately realised the rights of children protected by these instruments. The Committee attributed this to delivery failing, which was in turn attributed to the lack of systematisation of the relevant services within the public service delivery platforms. The Committee expressly directed the South African government to remedy this shortfall. Notably, it called for the adoption of awareness-raising and capacity-building measures, as well as the allocation of budgets necessary to ensure the implementation of programmes (African Committee of Experts on the Rights and Welfare of the Child, 2016).

Viewed comparatively, the breastfeeding agenda is plagued by the same gaps between policy and practice. “Internationally ... the overall consensus is that there are many commitments, guidelines, policies and strategies in existence, yet the implementation of these has not been progressive enough.” Why? Because, whilst there is willingness (commitment) “to address infant and young child feeding ... the ability (capacity) to improve the situation is lacking in certain environments” (Du Plessis, 2013, p.120).

A landscape analysis of the adequacy and preparedness of South Africa’s health system concluded that it has the “potential and resources to accelerate key nutrition interventions to reduce maternal and child undernutrition ... although there is political commitment ... many challenges still remain, primarily because some commitments have not been translated into concrete action” (Du Plessis, 2013, p 123).

## The goal posts and required solution

The African Committee of Experts, in its recent concluding observations, further expressed concern about the high levels of under- and malnutrition among children in South Africa. It called on the government to take all necessary measures to realise children’s rights to basic nutrition, specifically to “to promote exclusive breastfeeding at least for the first six months ... and to effectively regulate and control the promotion of alternatives to breast milk” (African Committee of Experts on the Rights and Welfare of the Child, 2016, para 48, p. 11).

Measured against global nutrition and breastfeeding targets, it is evident that South Africa has a considerable way to go. The size of the gaps calls for a rapid scaling up of the country’s breastfeeding support initiatives, specifically those proven to make a substantial difference to coverage and impact on practices and nutritional outcomes for children.

## How big is the gap?

The World Health Organisation (WHO) has set long-term global nutrition targets that require, and in turn, depend on universalised prescribed breastfeeding practices. South Africa has committed to achieving these through their integration into its national health policies and planning and performance management systems (World Health Organisation, 2015).

| World Health Assembly Targets by 2025  | 2025 Goal   | 2016 status   | How far to go?   |
|--|-------------|---|--|
| <b>Increase the rate of exclusive breastfeeding in the first six months up to at least 50%</b> | 50%         | Using the different data sources, the rate of exclusive breastfeeding between 0 – 6 months varies from 8 to 32%. <sup>4</sup>       | Increase the proportion of exclusively breastfed infants by between 42 and 18 percentage points.<br><br>This requires that between 100 000 and 200 000 mothers – who are currently not – are supported to practise exclusive breastfeeding. <sup>5</sup> This requires, at a minimum, that all new mothers (of the more than half a million babies under 6 months each year) receive quality counselling, and that of these, between 100 and 200 000 at risk of mixed feeding, receive additional, high quality support so that they may refrain from mixed feeding. |
| <b>Delay introduction of solid foods until 6 months</b>  | 0%          | 64% of infants are given solid or semi-solid foods before 6 months. <sup>6</sup>  | Delay introduction of solid foods in 64% of children under 6 months (335 000).   |
| <b>40% reduction in the number of children stunted under five</b>                              | 100 million | Between 25 <sup>7</sup> and 27 % of children under five are stunted.<br><br>Amounts to more than 1.5 million children. <sup>8</sup> | Reduce the number of stunted children under 5 by 625 000. <sup>9</sup><br><br>This requires additional, specialised, quality nutritional counselling and support for more than half a million mothers and caregivers at risk of poor feeding practices (in addition to the provision of universal counselling for all parents).  |

<sup>4</sup> Shisana et al (2008); Statistics South Africa, National Department of Health, South African Medical Research Council, the DHS Program (Maryland, USA) (2017).

<sup>5</sup> Calculated as follows: In 2014 (Stats SA, General Household Survey) there were 1 046 000 children under the age of one year in SA. Assuming 50 percent are under the age of 6 months, 42 percent of this population is 209 200.

<sup>6</sup> Shisana et al (2013).

<sup>7</sup> Shisana et al.

<sup>8</sup> Statistics South Africa, National Department of Health, South African Medical Research Council, the DHS Program (Maryland, USA) (2017).

<sup>9</sup> Calculated as follows: In 2014, there were 6 259 000 children 0 - 5 in SA. 25 percent of this population (1 564 750) is stunted. 40 percent of this population amounts to 625 900 (Stats SA, 2014 General Household Survey).

## What measures are necessary to secure lasting impacts?

The evidence is clear. Despite the proven benefits of breastfeeding and global commitments to universalise the practice, many women are prevented from doing so. Determinants “operate at multiple levels and affect breastfeeding decisions and behaviours over time ... [they are] affected by a wide range of historical, socio-economic, cultural and individual factors in the public domain, the workplace, and in the health care setting” (Rollins et al, 2016, p. 492).

The factors that prevent breastfeeding can be effectively addressed through a range of interventions which are proven to protect, promote or support improved breastfeeding. Given the multi-faceted and sectoral nature of the determinants, responsibility for delivery of the interventions is a “collective, societal responsibility” (Rollins et al, 2016, p. 491). The following diagram depicts the interrelated and multi-faceted nature of the problem, and the required complex solutions.

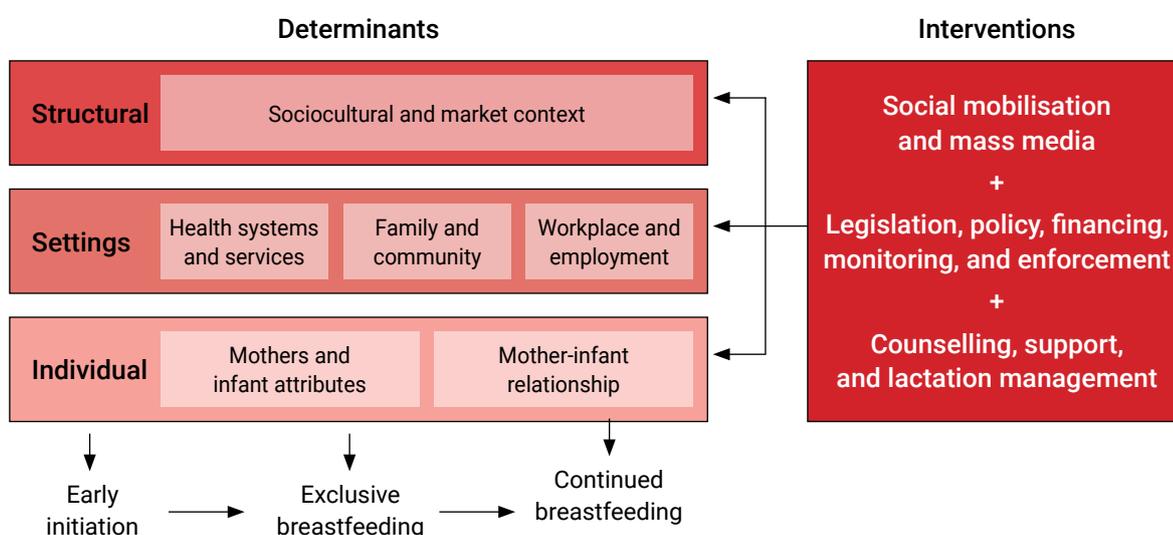


Figure 1: The components of an enabling environment for breastfeeding - a conceptual model (Rollins et al, 2016)

In sum, the nature of the problem means that the provision of effective support for the protection and promotion of breastfeeding is the responsibility of role players operating at all levels of society – in communities, the workplace and in health settings.

What are the measures that must be taken, and what should they look like at these different levels? Guidance is provided by UNICEF and the WHO’s most recent **Baby Friendly Hospital Initiative (BFHI) Background and Implementation Guidelines**. They emphasise that achieving sustainable and impactful solutions requires robust strengthening of the breastfeeding support system – or systematisation of the full complement of breastfeeding support initiatives aligned to the country’s responsibilities (United Nations Children’s Fund & World Health Organisation, 2009).

The guidelines stress that:

Only a comprehensive, **multi-sector, multi-level effort** to protect, promote and support optimal infant and young child feeding, including legislative protection, social promotion and health worker and health system support via BFHI and additional approaches, can hope to achieve and sustain the behaviours and practices necessary to enable every mother and family to give every child the best start in life (UNICEF & World Health Organisation, 2009).

The World Health Organisation's (WHO's) Health System Framework provides concrete guidance on what a health system is, what and who makes up the health system, and what steps must be taken to systematise interventions (World Health Organisation, n.d.).

### **There is consensus:**

*Proven interventions to promote, support and protect breastfeeding must be scaled up and sustained at all levels – the home, community, workplace, and facilities. The only way to secure interventions at scale that make a lasting impact is to fully systematise programmes and responses across the full operational spectrum.*

It emphasises that a health system does not only consist of health facilities or health workers. Rather, it consists of all organisations, people and actions responsible for, or committed to the promotion, restoration or maintenance of health (World Health Organisation, 2011). As such, the health system embraces the clinical settings and role players, as well as the role players operating in the social, economic and cultural settings which are determinative of health. In the context of breastfeeding, it embraces all three settings envisaged in the conceptual framework depicted above. In consequence, the duty to systematise measures to protect, promote and support breastfeeding, rests not only with the clinical health care sector, but also the broader corporate and social sectors responsible for regulating trade, commercial activity and the workplace.

The duty to systematise interventions that protect, promote and support breastfeeding across all settings has been accepted by government. It has committed itself to global initiatives such as the WHO/UNICEF Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding Call for Action<sup>10</sup>, the International Code of Marketing of Breastmilk Substitutes<sup>11</sup> and the Global Strategy for Infant and Young Child Feeding<sup>12</sup>. These instruments obligate the systematisation of measures to protect, promote and support breastfeeding within commercial settings, clinical, community settings, and the work place.

Systematisation is further required by the recognition of breastfeeding as a fundamental right by, for example, the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). Only through systematisation is it possible to meet the legal duty to ensure universal access and equity in coverage of measures to protect, promote and support breastfeeding (See Annexure A for a comprehensive list of international, regional and national instruments and associated obligations to protect, promote and support breastfeeding).

The systematisation of the required multiple and multi-sectoral measures is further supported by the Breastfeeding Gear model<sup>13</sup> (BFGM) (Perez-Escamilla et al, 2012). The BFGM is essentially a system's strengthening model. Its premise is that systematisation within the national governance framework is absolutely essential to secure delivery of the multi-sectoral interventions at the scale required to make a positive impact on breastfeeding. It is premised on a number of interlinking (systemic) gears or enablers of successful and sustained programmes, as depicted in the following figure.

<sup>10</sup> UNICEF & World Health Organisation (1990).

<sup>11</sup> World Health Organisation (1981). International Code of Marketing of Breast-Milk Substitutes.

<sup>12</sup> World Health Organisation (2015). [http://www.who.int/nutrition/topics/global\\_strategy/en/](http://www.who.int/nutrition/topics/global_strategy/en/).

<sup>13</sup> Derived from an analysis of breastfeeding programmes in 28 countries.



Figure 2: GEAR Framework adapted from Peres-Escamilla et al (2012)

Read together, the BFGM gears and the WHO's health system building blocks provide concrete guidance on what actions are required by government to promote, protect and support breastfeeding in the home, community, workplace and facility settings.

The duty created is that all planning, provisioning, delivery and monitoring of breastfeeding support and services in all settings (commercial, clinical and the workplace) must be systemised across the following levels:

1. **Leadership, governance and advocacy:** Governance is "(1) the exercise of political, economic and administrative authority in the management of a country's affairs at all levels, comprising the complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences. The process of creating an organisational vision and mission ... in addition to defining the goals and objectives that should be met to achieve the vision and mission... articulating the policies ... to achieve the desired outcome; and adopting the management necessary for achieving those results and a performance evaluation of the managers and the organization as a whole" (World Health Organisation, 2011). This requires that:
  - a. Strategic **policies** are in place combined with effective oversight, coalition-building, regulation, attention to system-design and accountability;
  - b. Clarity as to **roles and responsibilities** of role players, their relationships with each other and effective coordination of such roles and responsibilities;
  - c. **Administrative systems** for evidence-based planning, resourcing, and monitoring implementation of programmes developed to achieve the goals and objectives.

The GEAR Framework highlights the need for advocacy and political leadership to drive the systematisation of responsibilities. Without advocacy and political leadership the leadership and governance requirements would not be met. As noted in KZN's case study of its successful breastfeeding initiative, "[a] healthier and life-saving environment for mothers and children does not happen by chance. It requires strong political leadership and technical expertise to put the policies in place to achieve these goals" (Department of Health, Province of KwaZulu-Natal, 2015).

2. **Public financing:** Adequate funds allocated to ensure the universal delivery of quality breastfeeding support services to ensure that people can use the services and will not be impoverished by having to pay for them.
3. **Workforce:**
  - a. Sufficient numbers to provide the breastfeeding support and service/s in question;
  - b. Fairly distributed workforce;
  - c. Competent (well-qualified);
  - d. Responsive and productive (managed and overseen).
4. **Products and technology:** Sufficient quantities of products and technologies to support delivery of the service are available to ensure universal availability and access.
5. **Service delivery:** Full continuum of services is provided at all levels – from home, to community, to facility, and in the workplace.
6. **Information and research:**
  - a. An information system that ensures the production, analysis, dissemination and use of reliable and timely information to develop policies, plan, determine progress in quantities and quality and progress against goals and responsibilities.
  - b. Information is required to inform policies and programmes and to maintain ongoing progress and quality assessments.

## The objective, structure and methodology of the review

The DST-NRF Centre of Excellence in Human Development conducts research and disseminates information on issues that are key to human development, including breastfeeding. This policy review is one thread in this tapestry.

### Objective and structure

This review explores the adequacy of the current policy framework across the key three settings, as measured against the country's legal breastfeeding responsibilities. Specifically, it seeks to document the legal and developmental framework of responsibilities, assess South Africa's compliance with these as well as assess the country's effectiveness in realising the intended outcomes of governing international and regional commitments to improve early initiation of breastfeeding, exclusive breastfeeding to 6 months, introduction of appropriate complementary feeding, and continued breastfeeding until the age of 2 years.

The South African government has committed, in terms of a host of international, regional and national rights and development instruments, to systematise, and in so doing, universalise the protection, promotion and support of breastfeeding. As previously mentioned, these instruments and associated responsibilities are described in annexure A.

The government has developed and implemented a number of policies and programmes which translate its responsibilities into services and support for breastfeeding. This review focuses on three fundamental measures required by the Innocenti Declaration on the Protection, Promotion and Support for Breastfeeding (dating back to 1990), and which are particularly relevant to ensuring that breastfeeding is supported across the cross-sectional settings described in the Rollins et al (2016) framework.

These are:

- The Department of Health's Mother-Baby Friendly Initiative (MBFI);
- The Department of Health's Regulation of Marketing of Breastmilk Substitutes;
- Workplace protection for breastfeeding mothers.

This review undertook a rights- and evidence-based assessment of the extent to which these three policies / programmes have been fully systematised within the relevant public service delivery platforms to ensure effective and impactful realisation of the country's breastfeeding responsibilities.

This report provides an overview of the review findings, along with a number of recommendations for more effective compliance with the governing responsibilities through stringent systematisation of the various initiatives. The report is divided into three parts, each of which considers the three targeted programmes in turn. Each section provides an overview of the governing legal responsibilities and the associated duties to systematise solutions. This is followed by a composite visual overview, using the following colour-coded assessment key, of the levels of compliance with the stated responsibilities.

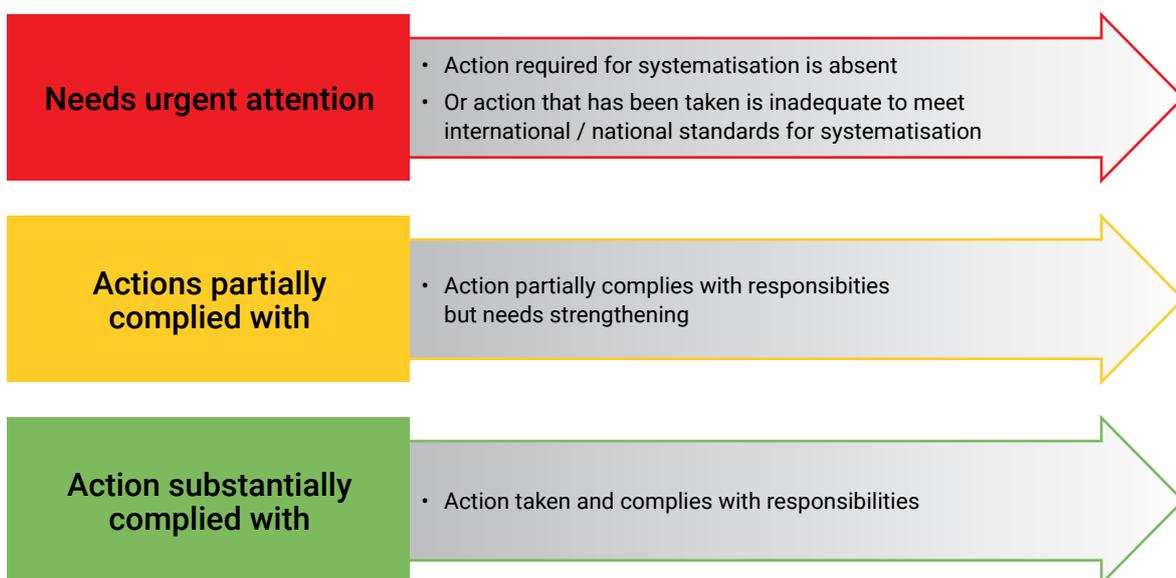


Figure 3: Assessment key

The initial overview (at a glance) is then followed by a more detailed **discussion** of the extent of compliance and the impact (or lack of impact) made by the relevant initiative explaining the assessment; an **analysis** of the underlying gaps and challenges driving the limitations observed; and concludes with a number of **recommendations** for improved systematisation, compliance and impact.

## Methodology

The information, observations and conclusions in this report were sourced through a mixed methodology which included:

- a. A review of documents and data (including legal instruments, policies, programme and evaluation and progress reports, journal articles and case studies) relevant to the country's responsibilities and the three targeted policy / programmatic responses.
- b. Semi-structured interviews were conducted with a cross-section of responsible and supporting role players. These included officials in the national Department of Health as well as in the Western Cape, Mpumalanga and KwaZulu-Natal departments; development partners such as UNICEF; partners in the DOH's Breastfeeding Technical Working Group; representatives from the corporate sector and the Infant Formula Association; and representatives from the labour sector.<sup>14</sup>
- c. A small-scale survey was conducted among diverse organisations, including private companies (large, medium-sized and small), government departments, development agencies, human rights institutions, academic institutions, and NGOs in South Africa to understand how and to what extent they comply with laws protecting, promoting and supporting breastfeeding in the workplace.

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<sup>14</sup> Engagements with the labour sector were limited to an interview with Michael Bagraim – an MP, labour expert and a member of Parliament's Portfolio Committee on Labour. Despite numerous attempts and requests, no interviews were secured with the Department of Labour.

# PART 1: MOTHER-BABY FRIENDLY INITIATIVE

## Legal framework of responsibilities to systematise the MBFI

Globally, the health sector has long recognised the value of breastfeeding for the growth, development and health of infants. The link between breastfeeding and children's survival and development is evidenced by the recognition of breastfeeding as central to the right to health, and its express protection by the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). It is also supported by science. Breastfeeding improves the survival, health and development of all children, as well as some aspects of adult health (Rollins et al, 2016). It has significant potential to improve the health and development of children and mothers, and these benefits have larger national developmental value. Breastfeeding is proven to protect children against child infections, to increase intelligence and reduce overweight and diabetes. The accumulative benefits of breastfeeding have the potential, if universalised, to prevent 823 000 annual deaths in children in under five years of age in lower and middle-income countries (Victora et al, 2016).

Given that breastfeeding is a right, promotes the healthy development of children, and as such, also the country's development, there is a duty on government to take concrete legislative, administrative, programmatic, and budgetary measures to protect, promote and support breastfeeding.

One of the longest-standing measures required is the adoption of the Baby Friendly Hospital Initiative (BFHI). The BFHI was launched by the WHO and UNICEF in 1991 following the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. It is a ten-step model which government is required to implement in all maternity settings to protect, promote and support breastfeeding. UNICEF and the WHO developed and adopted BFHI guidelines, tools and support materials in 1992, which were subsequently revised in 2004 and again in 2009. The revised 2009 Guidelines (World Health Organisation, 2009) stress that, whilst the BFHI is a proven intervention with the potential to make a significant difference to breastfeeding rates and practices, these benefits depend on the full systematisation to ensure scale and sustainability (United Nations Children's Fund / World Health Organisation, 2009).

### What does it take to fully systematise the MBFI?

The actions required to systematise the BFHI are described in the BFHI Background and Implementation Guidelines (2009). These, described in the next section, have been summarised and organised under the WHO health system's platforms.

### Leadership and governance

Government must:

1. Develop and adopt a written breastfeeding / Infant and Young Child Feeding (IYCF) policy and communicate it to all health care staff. The initiative must include HIV infant feeding.
2. Establish and convene a national coordinated authority to oversee the country's BFHI. It must include government, NGOs, development partners, academia, community representatives, communications and monitoring and evaluation specialists. It must be tasked with oversight of the WHO/UNICEF Global Strategy for Infant and Young Child Feeding (GSIYCF) which calls for supporting exclusive breastfeeding for the first 6 months, and continued breastfeeding with timely and appropriate complementary feeding for 2 years or longer.
3. Adapt the BFHI criteria for effective and universal expansion of the initiative into communities (beyond the clinic setting).

4. Integrate the BFHI goals into national policies and programmes.
5. Develop a system of standards, assessment and re-assessment, and compliance auditing of facilities.

### **Continuum of services**

Government must ensure that:

1. All pregnant women are informed about the benefits and management of breastfeeding.
2. Mothers are helped to initiate breastfeeding within an hour of birth and practise to skin-to-skin care.
3. Mothers are shown how to breastfeed and maintain lactation even if separated from infants.
4. New-born infants are given no food or drink other than breastmilk unless medically indicated.
5. Mothers and babies are allowed to room-in.
6. Breastfeeding on demand is encouraged.
7. No artificial teats or pacifiers are provided.
8. Breastfeeding support groups are established and mothers are referred to them on discharge from the hospital or clinic.
9. There is a national plan developed and implemented to create Baby-Friendly communities with the integral support of local community leadership and role players.

### **Health workforce**

Government must ensure that:

1. A national coordination structure is established to oversee, review and align training and curricula with BFHI.
2. The training of all health care staff is planned and provided to ensure the skills required to implement the BFHI at all levels of the health system (carry out the 20 hour course in all facilities plus specialised training in accredited facilities on lactation).

### **Information and research**

Government must ensure that:

1. The national health information system is designed to record feeding status of all contacts with children under 2 years of age.
2. Implementation and impact of the BFHI is monitored.
3. A BFHI Monitoring and Evaluation (M & E) plan is developed.

### **Public financing**

Government must ensure that:

A regular and adequate budget is identified and allocated to support the BFHI and the broader IYCF policy.

## The Mother Baby Friendly Initiative (MBFI): An assessment at a glance

### Leadership and governance

|   |   |  |  |   |
|---|---|--|--|---|
| <p>The MBFI goals have been integrated into national policies and programmes. The goals are included in, for example, the infant feeding policy and MNWCH policy.</p> | <p>South Africa has developed the required written breastfeeding / IYCF policies. However, they are inadequately communicated to all health care staff. However, these are not integrated into the DOH's Strategic and Annual Performance Plans, budgets and M &amp; E.</p> | <p>The NDOH has established the required national coordinating authority to oversee the country's MBFI. However, it does not function optimally.</p> | <p><b>The required adaptation of the BFHI criteria for expansion into communities has not taken place.</b></p> | <p>The required system of assessment, re-assessment and accreditation of facilities is well-developed, but is beset by design challenges that tend to demotivate staff.</p> |
|---|---|--|--|---|

### Continuum of services

|  |  |   |
|--|--|---|
| <p>Services are relatively well systematised and provided within maternity health care facilities.</p> | <p>A number of provinces have established the required groups providing breastfeeding support after discharge from facilities.</p> | <p><b>There has been no meaningful national systemic planning for, or roll out of baby-friendly communities to provide an ongoing continuum of support after discharge from maternity facilities.</b></p> |
|--|--|---|

### Health workforce

|   |   |
|---|---|
| <p>A national coordination structure has been established to oversee alignment of health care training and curricula with the MBFI.</p> | <p><b>There are significant deficits in the availability of qualified health care staff to implement the MBFI at all levels of the health system.</b></p> |
|---|---|

### Information, monitoring and research

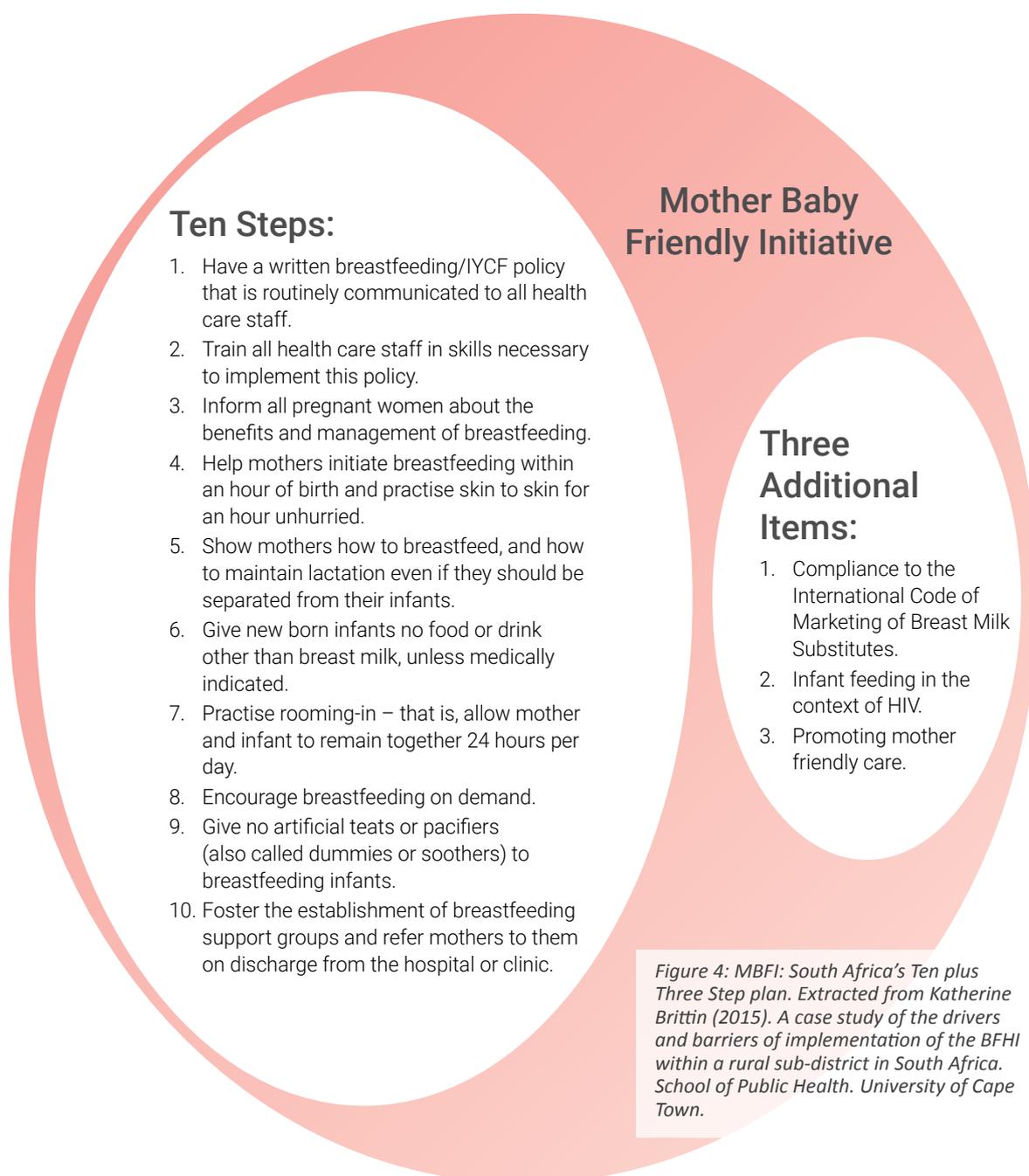
**The national health information system does not, as required, adequately monitor the feeding status of all contacts with children under 2 years of age.**

### Public financing

**The required budgets are not routinely available to support adequate implementation of the MBFI programmes, systems and structures.**

## Discussion

The South African health sector adopted the BFHI and its ten steps in 1994. It has, however, since 2011 implemented it under a different name – the “Mother-Baby Friendly Initiative (MBFI)” which has added three additional steps. The South African MBFI programme is depicted in the following diagram:



*Figure 4: MBFI: South Africa's Ten plus Three Step plan. Extracted from Katherine Brittin (2015). A case study of the drivers and barriers of implementation of the BFHI within a rural sub-district in South Africa. School of Public Health. University of Cape Town.*

As is evident from the preceding figure, the South African MBFI envisages its 13 steps as forming a continuum of care that starts antenatally in a facility, and continues after birth in a supportive home and community environment. The Government's responsibilities thus extend to ensuring an enabling and supportive legal and social environment across the full continuum of care. It has committed to the provision of quality counselling in the antenatal period, the establishment of breastfeeding support groups in communities, prevention of discrimination against breastfeeding in public, and the regulation of the marketing of breastmilk substitutes.

Subsequent to the adoption of the MBFI, the NDOH integrated responsibilities into the framework and operations of the health system. Integration measures have included the setting of national targets, the development and implementation of MBFI training materials, the development of an implementation strategy, the integration of MBFI responsibilities in provincial health managers' Key Performance Indicators (KPIs), and the establishment of an MBFI assessment and accreditation process.<sup>15</sup>

In 2012, South Africa committed to ensuring the MBFI accreditation of 65 percent of hospitals by 2013, and 90 percent by 2016.<sup>16</sup> A well-developed system of monitoring and accreditation has been established at facility level. Accreditation is awarded to hospitals with maternity facilities that comply with the stated MBFI criteria. Assessments are conducted at facility level by infant feeding coordinators, followed by a provincial assessment, and finally by external assessments coordinated by the NDOH. After successful assessments, facilities are expected to maintain the Ten Steps and to adhere to the principles of the International Code of Marketing of Breast-milk Substitutes. The initial assessments are followed up with re-evaluations of facilities every three years.<sup>17</sup>

Roll out of the initiative was initially sluggish. The ratio of accredited hospitals increased marginally between 1995 and 2002 from 0.4 to 12 percent. Roll out improved thereafter, increasing to 44 percent in 2011.<sup>18</sup> The MBFI acquired renewed impetus in 2011 after the adoption of the Tshwane Declaration of Support for Breastfeeding in South Africa, which resolved that all public hospitals would be MBFI accredited by 2015. This catalysed a rapid increase in the rate and number of accredited facilities to reach 75 percent by 2015 – as depicted in the table below.

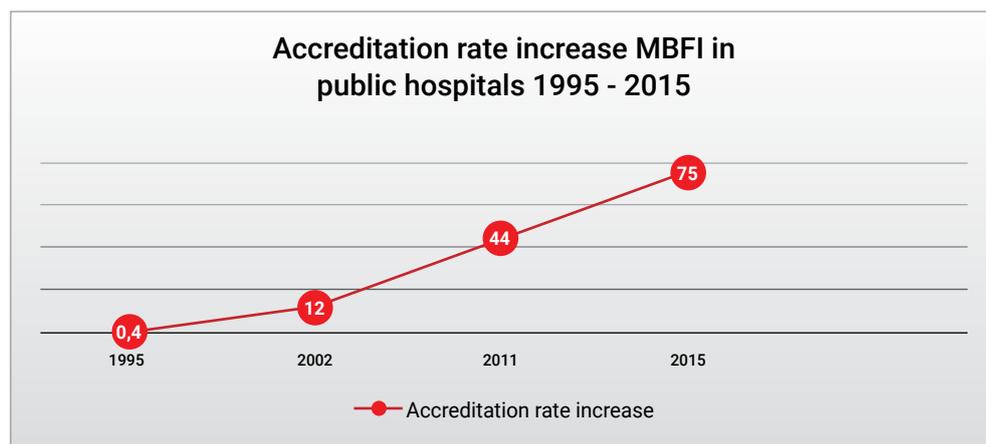


Table 2: Increase in accreditation in MBFI public hospitals 1995 – 2015<sup>19</sup>

<sup>15</sup> Kubeka (2016).

<sup>16</sup> NDOH. MNCWH Strategic Plan 2012 – 2016.

<sup>17</sup> Information provided by Ann Behr in November 2016.

<sup>18</sup> Kubeka (2016).

<sup>19</sup> Ann Behr, November 2016.

Whilst the country has, as a whole, made significant progress, increasing the national average by more than 70 percentage points since the implementation of the programme, progress has varied across the provinces. As is depicted in the next table, a number of provinces have achieved accreditation rates well above the national average, whereas others lag behind. For example, the Western Cape and Gauteng have rates in excess of 90 percent whilst provinces such as the Northern Cape, the Free State and the Eastern Cape have a considerable way to go with rates well below the national average.

| Province        | Facilities with maternity beds | Number of accredited facilities | % Accredited facilities |
|-----------------|--------------------------------|---------------------------------|-------------------------|
| Limpopo         | 62                             | 53                              | 85                      |
| North West      | 67                             | 48                              | 72                      |
| Gauteng         | 60                             | 55                              | 92                      |
| Free State      | 40                             | 18                              | 45                      |
| Northern Cape   | 46                             | 8                               | 17                      |
| KZN             | 58                             | 55                              | 95                      |
| WC              | 51                             | 50                              | 98                      |
| EC              | 92                             | 60                              | 65                      |
| Mpumalanga      | 64                             | 56                              | 88                      |
| <b>National</b> | 545                            | 403                             | 75                      |

Table 3: Number and proportion of MBFI accredited public health facilities 2015/16<sup>20</sup>

Progress has also been made in the accreditation of private hospitals. By 2015/16 there were six accredited private facilities and a further one in 2017/18. These are:

- In the Eastern Cape: 2 – Netcare Cuyler, McIntyre hospital (2017)
- In the Gauteng province: 2 – Genesis Hospital, Netcare Parklane
- In Cape Town: 3 – Cape Town Mediclinic, Vergelegen Mediclinic, Blaauberg Netcare hospital.<sup>21</sup>

### What difference has the MBFI made in South Africa?

The MBFI has supported a substantial increase in the proportion and number of women who start breastfeeding within an hour of their baby's birth. Data from the SA Demographic Health Survey (1998 and 2003) and the more recent SANHANES study suggests that the proportion has nearly doubled from 45 to more than 80 percent between 1998 and 2012 (Shisana et al, 2013).

The MBFI has also led to notable positive changes in accredited facilities, including the following:

- Breastfeeding initiation rates increased in facilities.<sup>22</sup>
- An increased number of accredited public health facilities has adopted appropriate practices supporting breastfeeding.
- Environments conducive to breastfeeding have been created in the wards (Henney, 2011).

<sup>20</sup> Ann Behr, November 2016.

<sup>21</sup> Data provided by the National Department of Health: Child, Youth and School Health Directorate in April 2017.

<sup>22</sup> Ann Behr, November 2016. Based on a 2008 evaluation of the BFHI conducted by the University of the Western Cape (commissioned by UNICEF and the DOH).

- There is protection of breastfeeding and no promotion of breastmilk substitutes in accredited facilities (Henney, 2011).
- Outdated maternal practices decreased, such as pre-lacteal feeding and the use of a nursery for well babies rather than rooming-in with mothers.<sup>23</sup>
- Positive and promotive maternity practices have been adopted, such as immediate skin-to-skin contact and encouraging feeding on demand (Henney, 2011).
- Where the facilities have active MBFI committees and non-rotating maternity staff, the initiative has secured better integration of breastfeeding support into child health programmes such as PMTCT.<sup>24</sup>
- There have been improvements in the health of mothers and infants. Respondents in a qualitative study in the Western Cape noted lower rates of common childhood illnesses such as diarrhoea and faster maternal recovery (Henney, 2011).
- The attitudes of maternity staff to breastfeeding improved (Henney, 2011). “Nurses, who previously left mothers to their own devices because they accepted that mothers knew how to breastfeed, are now more optimistic and are equipping mothers with knowledge and skills on breastfeeding. With the acquisition of greater knowledge and skill about breastfeeding, mothers experience less breastfeeding problems” (Henney, 2011, p. 24).
- Awareness of the benefits of breastfeeding has been created and this has contributed to greater uptake of breastfeeding among mothers using the maternity facilities (Henney, 2011).

### Significant limitations and challenges of the MBFI

Two significant limitations are evident in relation to the sustained impact of the initiative and equity in roll out.

The most significant limitation is that, whilst initial breastfeeding rates have increased, the benefit / impact does not last, and there has been, until recently, no comparable increase in exclusive breastfeeding rates up to the age of six months.<sup>25</sup> Whilst there was a massive 30 percent jump in facility accreditation rates between 2011 and 2015, the changes in the recorded 6 month breastfeeding rates in the same time period remained largely unchanged (Shisana et al, 2013).

Moreover, a substantial number of HIV-positive women continue to formula feed, even though the MBFI is implemented in accordance with South Africa’s updated breastfeeding policy which is aligned to both the updated 2013 Infant and Young Child Feeding Policy & Guidelines and 2010 WHO guidelines recommending that all HIV positive women on ARV drugs practise exclusive breastfeeding, A four-province study of breastfeeding trends and practices found that 25 percent of mothers who stopped breastfeeding did so because they were HIV positive, even though they were on ARV drugs (Siziba et al, 2015).

Whilst MBFI hospital accreditation rates have increased robustly in recent years, there is significant variation in progress across the provinces. The urbanised provinces of Gauteng and the Western Cape, as well as KwaZulu-Natal have achieved rates of over 90 percent, whereas rates are below the national average in provinces where nutritional status of children continues to be a problem and the need for

<sup>23</sup> Ann Behr, November 2016. Based on a 2008 evaluation of the BFHI conducted by the University of the Western Cape (commissioned by UNICEF and the DOH).

<sup>24</sup> Ann Behr, November 2016. Based on a 2008 evaluation of the BFHI conducted by the University of the Western Cape (commissioned by UNICEF and the DOH).

<sup>25</sup> Ann Behr, November 2016. This is confirmed by the national data on breastfeeding rates in South Africa.

effective interventions is most pronounced, such as the Eastern Cape, the Northern Cape, the Free State, and North West.

The following are some of the reasons given for the unequal implementation and limited impact of the MBFI:

- Facilities find it difficult to maintain their compliant practices after accreditation. Compliance and appropriate practices erode between initial accreditation and re-evaluations (Henney, 2011). The province of KZN has addressed this challenge through an effective and routine system of reassessments and internal monitoring during the three years between assessment periods.
- The difficulties of maintaining compliance are driven by staff issues, lack of organisational support and falling motivation after the accreditation process (Henney, 2011).
- Mothers are discharged before breastfeeding is established.<sup>26</sup>
- Maternity nurses revert to long-standing practices in the face of adversities, such as staff shortages, over-full wards or resistant mothers. Where the pressures are high, breastfeeding support is not one of the top priorities in the eyes of the staff (Henney, 2011).
- Staff is still influenced by the old messaging for feeding in the context of HIV. Even if staff members have been trained, many continue to counsel HIV-positive mothers not to breastfeed, but rather to formula feed (Henney, 2011). Also, staff may be trained, but many do not transfer their newly acquired knowledge to the mothers.<sup>27</sup>
- MBFI activities are seen as extra work, rather than an integral element of routine maternal care (Henney, 2011). Where the facilities have active BFHI committees and non-rotating maternity staff, the initiative secured better integration of breastfeeding support into child health programmes such as PMTCT.<sup>28</sup>
- The MBFI is primarily implemented in hospital facilities. Clinics are supposed to follow MBFI principles during ante- and post-natal care services, but in reality there is little commitment to MBFI at clinics by management and staff (Henney, 2011).
- Once mothers are out of the hospital, they are exposed to inconsistent and incorrect messaging and counselling from non-facility health staff, community and family members. A key barrier to sustained exclusive breastfeeding is the inaccurate and inconsistent information and advice mothers received at all levels of the delivery platform – within facilities, from facilities to post-natal clinics, and from community and family members.
- Left uncorrected, residual practices from the old 2001 PMTCT programme, including formula feeding and the provision of free formula (and their spill over effect), continue to influence feeding choices among both HIV positive and negative women, long-after the programme ceased (Du Plessis, 2013; Doherty et al, 2006).<sup>29</sup> There have been a number of changes in the country's feeding policies in the case of women who are HIV positive. The failure to provide clear messaging in the past, and then to correct practices in alignment with changing policies has resulted in confusion amongst health care workers and this has contributed to the persistently high levels of mixed feeding (Department of Health, Province of KwaZulu-Natal, 2015).

<sup>26</sup> Interview, Ann Behr, November 2016.

<sup>27</sup> Interview, Ann Behr, November 2016.

<sup>28</sup> Ann Behr, November 2016. Based on a 2008 evaluation of the BFHI conducted by the University of the Western Cape (commissioned by UNICEF and the DOH).

<sup>29</sup> This information was again shared at a Breastfeeding TWG meeting on 18 November 2016.

The confusion is understandable. Between 2001 and 2013 there have been five policy changes (following global policy changes) with regards to breastfeeding in the context of HIV. In 2001, women who were HIV-negative were encouraged to pursue exclusive breastfeeding for 6 months, followed by continued breastfeeding plus appropriate complementary feeding until the age of 24 months. The position was different for HIV-positive women. South Africa's first policy promoted formula feeding for women who were HIV-positive. Free formula milk was provided for mothers who opted not to breastfeed for 6 months.<sup>30</sup> In 2006 the policy changed for HIV-positive women. The country's first Infant and Young Child Feeding Policy<sup>31</sup> promoted exclusive breastfeeding for 6 months, followed by the weaning of the child and the provision of substitute milk or formula if it was acceptable, feasible, affordable, sustainable and safe (AFASS) for the mother and baby. In 2010, the policy was updated to provide daily nevirapine for breastfeeding infants. In 2011 the adoption of the Tshwane Declaration (see annexure A) catalysed changes to the Infant and Young Child Feeding Policy, which was revised to align with the WHO guidelines on HIV and Infant Feeding which recommended that countries choose one of two options:

1. Exclusive breastfeeding with ARV drugs; or
2. Avoid breastfeeding completely.

The Guidelines strongly recommend that countries with ready access to ARVs choose option 1, which South Africa has duly done. The 2013 Infant and Young Child Feeding Policy promotes exclusive breastfeeding for all women until the child is 6 months old, followed by continued breastfeeding and appropriate complementary feeding – the only difference for HIV-positive women is that they are provided with ARVs.

Whilst women in South Africa choose infant feeding options that are in the best interests of their infant, frequent policy changes, mixed messages and confused counselling often leave mothers unclear about what is best for their infants (Doherty et al, 2006). Within health facilities and in posters developed and still distributed by other sectors, such as DSD and DBE, messaging remains aligned to the 2001 PMTCT programme and is incorrect with respect to current policy. Pre-2007, no health worker – whether nurses or lay counsellors – 'was willing to take the risk of encouraging a mother to breastfeed in case the mother transmitted HIV to her baby. The difficult socio-economic conditions of many mothers at the time made it impossible to meet the AFASS criteria for formula feeding and receipt of free formula – thus creating a climate for very confused and uncertain counselling' (Department of Health Province of KwaZulu-Natal, 2015, p. 6).



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<sup>30</sup> National Department of Health (2001). Protocol for providing a comprehensive package of care for the prevention of mother to child transmission of HIV (PMTCT) in South Africa.

<sup>31</sup> National Department of Health (2007). Infant and young child feeding policy.

## Significant health system gaps and challenges driving implementation and impact challenges

Despite the roll out of the MBF initiative, breastfeeding rates have remained unacceptably low in South Africa. A number of researchers have interrogated the limited impact and identified underlying challenges that point to systemic challenges.<sup>32</sup> In short, the MBFI has not been adequately integrated into the public health system at all planning, operational, budgeting and monitoring levels. Insufficient resources and training, weak management and mentoring, and poor integration of the steps into all health initiatives undermine the effective implementation of the Ten Steps. In addition, the initiative operates in isolation. It is not part of a continuum of care. The quality of antenatal breastfeeding support is variable to weak and once mothers leave the hospital, they do not receive adequate support in homes, communities and the workplace (Du Plessis et al, 2016).

The following section of the report examines the levels of systematisation of the MBFI within the national health system within the combined WHO / GEAR systemic framework.

### Leadership and governance

#### Have the MBFI goals been integrated into national policies and programmes?

The integration of the country's breastfeeding responsibilities, such as the MBFI, into national policies is an essential foundational step towards effective systematisation of the initiatives. It is the essential pre-condition for universal coverage, sustained delivery, and attainment of intended outcomes and impacts envisaged by the many international and regional commitments made by the government.

To ensure implementation, high level political commitments to international and regional instruments and goals must be translated into administrative-level commitments to systematise the associated responsibilities. It requires administrative-level commitments to deliver, budget and monitor appropriate programmes designed to give effect to the relevant committed outcomes and impacts (African Child Policy Forum, 2016).

At a departmental level, the core documents that are key to this translation are strategic and annual performance plans (APPs). They bridge political commitments and sustained, universal delivery of programmes. The South African government follows a results-based planning framework and has instructed departments to develop their strategic and APPs and align their budgets and M & E frameworks to identify and advance the implementation of the country's and department's priorities (National Treasury, RSA, 2010). Thus it is clear to see that systematisation of programmes such as the MBFI depends in large measure on their integration into departmental strategic and APPs.

Whether or not departments identify a programme or issue as a priority (and systematise it) in turn depends, in large measure, on whether they have been identified as a national priority in the country's higher level national planning framework captured in the National Development Plan (NDP), the Medium Term Strategic Framework (MTSF), and associated 14 national priority outcomes and ministerial delivery agreements. South Africa's national results-based planning framework is designed to drive government-wide planning, resourcing and implementation of national priorities.

<sup>32</sup> For example, Nicolette Henney (2011) & Claire Bracher (2014).

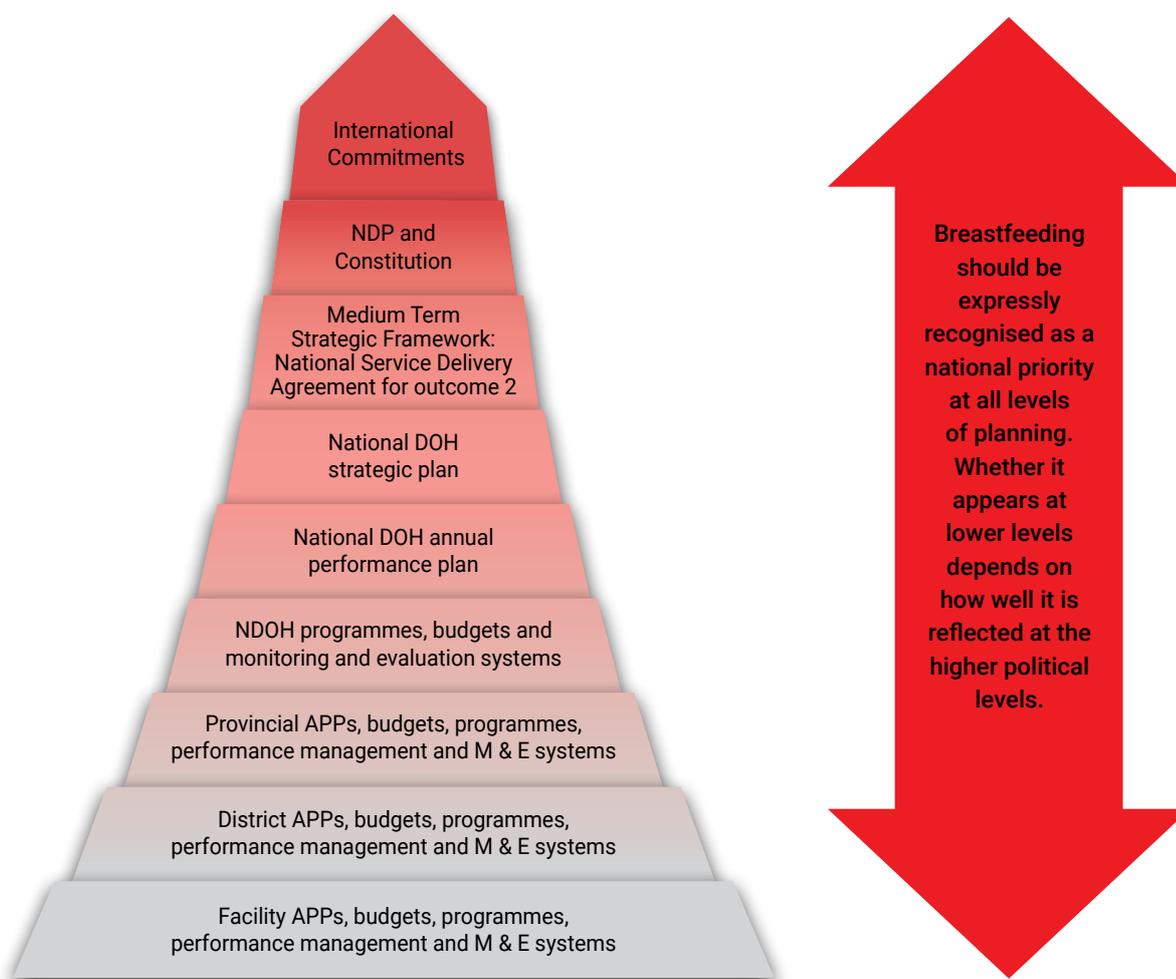


Figure 5: Interrelated and cascading levels of government planning within the national outcomes-based planning framework.

The framework is cyclical and planning cascades down the levels of government to give effect to the national priorities, as is depicted in the following diagram. To secure systematisation of programmes to promote, protect and support breastfeeding, such as the MBFI, breastfeeding and its supporting programmes, should thus be recognised and reflected as a priority at all levels of government planning – from the NDP down to departmental APPs, budgets and M & E frameworks.

### **Does the MBFI, and/or breastfeeding, and/or even the broader issue of young child nutrition feature in national development and departmental plans?**

No, not with sufficient visibility to lay the foundations for rigorous systematisation.

At the highest political level, we do well. Our international breastfeeding commitments are expressly referenced as a priority strategy in the *National Development Plan 2030: Our future – make it work* (NDP).<sup>33</sup> The NDP not only recognises the developmental importance of breastfeeding, it also

<sup>33</sup> National Planning Commission (2012), chapter 10, p. 335.

emphasises that attainment of targets, alongside other key health priorities, can only be achieved by strengthening our health systems. This commitment is reinforced through the Tshwane Declaration of Support for Breastfeeding in South Africa. It is a high-level political statement of support by the Minister and Deputy Minister of Health, members of executive councils (MECs), director generals (DGs), heads of departments (HODs), health managers and workers, experts, academics, traditional leaders and traditional health practitioners, non-governmental organisations (NGOs), civil society, and the United Nations Children’s Fund (UNICEF) and the World Health Organisation. The Declaration recognises breastfeeding as a national priority. It declares South Africa to be a country “that actively promotes, protects and supports exclusive breastfeeding, and [commits it to] take actions to demonstrate this commitment. This includes further mainstreaming of breastfeeding in all relevant policies, legislation, strategies and protocols” and commitment of public resources by government and other relevant bilaterals, partners and funders (but excluding the formula industry) to promote, protect and support breastfeeding.

However, these national commitments are not adequately reflected, or carried through in all subsequent national and departmental plans. The Negotiated Service Delivery Agreement (NSDA) 2010 – 2014 (updated in 2011) for Outcome 2: A Long and Healthy Life for All South Africans, the narrative of the national Department of Health’s Strategic Plan 2015 – 2020, its Annual Performance Plan 2017/18 – 2019/20, nor the Human Resources for Health Strategy for the Health Sector 2012/13 – 2016/17 do not expressly prioritise breastfeeding or the MBFI. Where nutrition is a priority, it does not extend to breastfeeding and the nutritional well-being of young children. For example, the Strategic Plan’s nutritional focus is the prevention of obesity, and whilst the NSDA calls for a 5 percent reduction in underweight and stunting rates in children under the age of five years, there is no apparent express priority given to breastfeeding, and the targets do not appear to be benchmarked against international and regional commitments. The APP narrative sets as a target the number of provincial departments with plans to reduce severe acute malnutrition, but makes no mention of stunting, increasing access to breastfeeding, or improvements in the MBFI as a strategic objective, indicator or target. The APP has no child-related nutrition strategic objective. The nutrition outcomes and activities fall under the strategic objective of reducing under-five mortality, rather than an objective linked to child nutrition or development.

The Strategic Plan for Maternal, Newborn, Children and Women’s Health (MNCWH) and Nutrition in South Africa 2012 – 2016 does recognise and promote breastfeeding as a key strategy and priority health intervention to secure new-born and child health. The APP sets as a target the development and implementation of a revised and updated Maternal, Newborn, Child, Adolescent, Women’s Health and Nutrition Strategy by 2017 /18 and 2019 respectively. However, without the express prioritisation of breastfeeding, young child nutrition, and breastfeeding support programmes in the systemic levers – that is to say – the Strategic and APP, there is a risk that the updated strategy will suffer the same high-level resourcing and implementation challenges as the current MNCWH and nutrition strategy and implementing programmes, such as the MBFI.

To secure the required levels of systematisation of the MBFI and other breastfeeding support programmes, breastfeeding and the supporting programmes should be expressly prioritised within both the NDOH’s Strategic and APP (aligned to the NDP and reflected in a revised NSDA) and accompanied by appropriate targets and indicators to measure their impact.

## Has the NDOH adopted a written breastfeeding / IYCF policy (that includes HIV and infant feeding) and communicated these to all health care staff?

This element has 2 requirements:

1. Written breastfeeding / IYCF policies must be adopted; and
2. They must be effectively communicated to health staff and the public.

South Africa has done well on the first requirement. There are a number of infant and young child feeding policies and strategies in place that commit South Africa to promoting, protecting and supporting breastfeeding.<sup>34</sup>

However, the second requirement has not been met. Whilst there are substantial policies on feeding, their content and associated rights and responsibilities are not effectively communicated to all health care workers, managers and communities. Ineffective communication of the policies leads to a lack of clarity on the current policy position, including for women who are HIV-positive. As a result mothers are provided with inconsistent messaging and advice across the service delivery continuum – within facilities by different staff, between facilities and communities, and families (Blacher, 2014; Brittin, 2015; Henney, 2011).

Moreover, the frequency and number of policy changes, the stigma and fear around HIV-transmission, and the length and strength of the previous policy messaging advocating the use of formula for HIV-positive women have resulted in policy uncertainty, and retention and use of incorrect and outdated information for HIV and non-HIV-positive women (Blacher, 2014).

In addition, different departments that have been involved in supporting HIV positive women, other than the DOH, such as DSD, still use outdated messaging, resulting in inconsistent messaging for mothers across sectors.

Consequences of outdated and inappropriate counselling is that women are still feeling pressure to use formula, but cannot afford to buy it, and then resort to using inappropriate substitutes such as rooibos tea and cornflour or oats. Thus not only is breastfeeding undermined, but so too is the provision of appropriate and safe alternatives and complementary food.<sup>35</sup>

The NDOH recognises these challenges and inadequacies. It has established a Breastfeeding Technical Working Group (this development is discussed further under the next leadership and governance requirement) which is in the process of developing a multi-media communications campaign (BF TWG, 2016). This positive development offers significant scope for remedying the policy uncertainty and consequences. However, this potential may not be realised given that the campaign plan does not expressly aim to correct the policy communications gaps and challenges which contribute to poor breastfeeding practices. The goals are very broadly framed around efforts to normalise breastfeeding, without reference to rectifying communications challenges such as inconsistent messaging, and without reference to the outcomes or communications and behaviour changes that the campaign seeks to achieve.

There is a list of activities, but no accompanying logical framework or theory of change indicating how the activities will drive the goals. Similarly, there is no accompanying monitoring and evaluation framework, targets and indicators aligned to the required changes in communication practices and

<sup>34</sup> PMTCT Guidelines and HIV Clinical Guidelines, 2010; Strategic Plan for Maternal, New Born, Child and Women's Health (MNCWH) and Nutrition in South Africa, 2012 – 2016; Roadmap for Nutrition in South Africa, 2013 – 2017; and the Infant and Young Child Feeding Policy & Guidelines, 2000, 2007 and 2013.

<sup>35</sup> Interview, Ann Behr, November 2016.

associated behaviours. The breadth of the communications campaign goals make them difficult to measure.

### **Has a national coordinating authority been established with the authority to oversee the MBFI within the broader framework of the global targets?**

Yes. The NDOH has established the MNCWH and N Think Tank which brings together experts from the MNCWH and N programmes, development and implementation partners, academia and civil society to leverage technical and experiential expertise to support the NDOH implement the MNCWH and N 2012 – 2016 Strategic Plan and the Road Map for Nutrition 2013 – 2017, and to provide a platform for review of data and available evidence and identification of gaps in programme data that need to be strengthened.

A number of sub-working groups are established under, and report to the Think Tank, one of which is the Breastfeeding Technical Working Group (BF TWG). The BF TWG is inclusive and is mandated to oversee and strengthen the multiple programmes supporting breastfeeding. It will be reviewing the MBFI methodology and ensuring that each province has a plan to implement MBFI with a focus on district and facility support (BF TWG NDOH, 2016a & 2016b).

The BF TWG Action plan is very wide in its scope (covering as it does the comprehensive suite of breastfeeding support initiatives) and has identified a number of high-level outcomes and associated indicators related to the MBFI. These are too general and too facility-focussed to serve as a coordinated planning and monitoring tool for strengthening the MBFI, especially with regards to the later community-based steps. There are few, if any, community-based targets and no service delivery or impact targets or timelines related to community and family support and breastfeeding rates / practices amongst women participating in MBFI.

*As such there is room for a more focussed and detailed coordinated plan for the MBFI specifically to be developed within the broader coordinated framework.*

There is also no mechanism in place, in terms of the plan, to coordinate and oversee the development of aligned provincial MBFI plans and strategies. The targets and indicators do not include the development of provincial plans and the TWG is not replicated at a provincial level to provide support and oversight, nor is there an alternative mechanism created for provinces to report on progress in developing plans and indicators.

Strong and focussed leadership and coordination of the MBFI (and other key breastfeeding initiatives) is limited by the organisational structure within the NDOH. Responsibility for not only nutrition, but indeed, the various breastfeeding initiatives, is split between different directorates. They are therefore subject to different planning, strategising, budgeting, implementation and monitoring processes and systems. Responsibility is split between the Nutrition Directorate and the Child, Youth and School Health Directorate. With the development of the national MCWH&N plan which deals holistically with child health and nutrition, all relevant nutrition services should have moved to the directorate leading the plan – the child and school health directorate. However, this was not possible, given the scope of the initiative and the resources within the child and school health directorate. Thus, some of the breastfeeding initiatives, such as the MBFI were moved from nutrition to child and school health, whereas others remained with the nutrition directorate – such as the regulation of marketing of breastmilk substitutes and human milk bank regulations. This creates coordination challenges. These are then further aggravated by the lack of alignment of the national and provincial organisational

structures. The provincial allocation of responsibilities or mandates for initiatives such as the MBFI is not the same. In the provinces, all nutritional responsibilities, including the MBFI are the mandate of the nutrition directorate (KZN) or nutrition sub-directorates within the child health directorates.<sup>36</sup>

## **Have criteria been adapted and adopted to expand the MBFI into communities?**

The criteria to secure continuity of the MBFI in the community and home-based setting must include:<sup>37</sup>

### **1. A defined MBFI community-based programme of services and support:**

A formal and defined community-based MBFI programme must be adopted which identifies the targeted group of beneficiaries (number, location, needs and barriers to breastfeeding), identifies the services and support that will be provided and by whom, as well as the targets and desired outcomes (and associated indicators) – including mother-to-mother or peer groups, organised support by lactation consultants, outreach by maternity and community health staff, referral to community-based health facilities with specialised training, and helplines. The programme should be an integral part of and further a national communications campaign.

### **2. Leadership and governance:**

The community-based MBFI programme and suite of services and support should be developed through an inclusive process which includes community political and social leadership as well as local health facilities and home-based carers, including midwives.

### **3. The human resource requirements:**

The programme must identify the key implementers and ensure that there is an adequate workforce in terms of numbers, spread of appropriately qualified and supported community, facility, and home-based personnel.

### **4. Financial resourcing:**

The plan or programme must be costed and adequately resourced.

### **5. Management, oversight and monitoring systems:**

The delivery of the programme must be integrated into the public health management and oversight, human resource management, quality control and monitoring, evaluation and reporting systems. This requires the identification and inclusion of community- and home-based services and outcomes in the key performance areas of provincial, district and facility-based managers, the mandates of Ward-based Outreach Teams, the scope of work and performance management systems of facility, community and home-based health personnel, the M, E & R framework of indicators at provincial, district, facility and home-based levels of the system.

Whilst there is recognition at the level of policy that the support provided through the MBFI should continue once the mother is discharged from hospital, the MBFI interventions are primarily facility-focused. There is little, if any, continuity of support, and mothers receive incorrect and inappropriate counselling on matters such as introduction of complementary foods and use of formula feeding from relatives, friends and even healthcare workers in clinics as well as home-based carers (Van der Merwe et al, 2015).

<sup>36</sup> Interview, Ann Behr.

<sup>37</sup> Adapted from World Health Organisation & UNICEF (2007), Planning guide for national implementation of the Global Strategy for Infant and Young Child Feeding. ([http://www.who.int/nutrition/publications/infantfeeding/gsiyycf\\_planning\\_guide.pdf](http://www.who.int/nutrition/publications/infantfeeding/gsiyycf_planning_guide.pdf)); and the BFHI Guidelines (updated) (2009)

In South Africa, as in many other countries, the failure to systematise, and thus universalise, an accessible, community- and family-based MBFI is a leading cause of the failure to sustain the impacts and benefits seen at facility level. The MBFI is not adequately integrated into primary and home-based health care platforms. The services are only systemically delivered through accredited facilities, which are limited to public health facilities with maternity wards. It does not extend (barring a few exceptions) to clinics or to the services provided by community health workers (Henney, 2011).<sup>38</sup> The one major exception to this is KwaZulu-Natal (KZN) where a deliberate decision was taken to systematise and universalise community-based support for breastfeeding using an appropriately capacitated network of public health care facilities, breastfeeding support groups at clinics, and the more than 10 000 community health workers (Department of Health, Province of KwaZulu-Natal, 2015).<sup>39</sup> As can be seen from the data in Figures 6 and 7 KZN has made substantial progress in improving feeding practices. It is in the process of research to establish a baseline for the measurement of breastfeeding rates at 6 months and this will enable tracking of the longer term outcomes of its systemic response.<sup>40</sup>

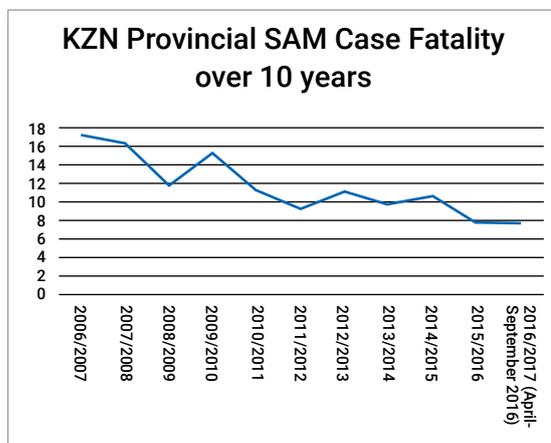


Figure 6: KZN SAM fatality case rates. Extracted from PowerPoint presentation by Z Mtshali, Deputy Director, Nutrition, KZN DOH. Presented at 2016 International Breastfeeding Conference, Johannesburg, December 2016.

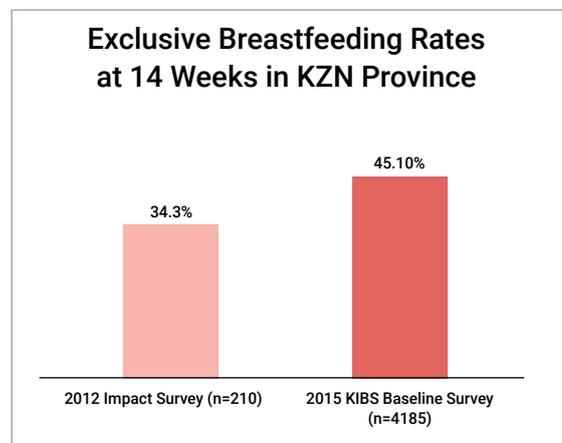


Figure 7 Exclusive breastfeeding rates at 14 weeks in KZN. Extracted from PowerPoint presentation by Z Mtshali, Deputy Director, Nutrition, KZN DOH. Presented at 2016 International Breastfeeding Conference, Johannesburg, December 2016.

This gap in community- and family-based support is recognised and the Tshwane Declaration commits to:

1. Ensure that all communities are supported to be Baby-Friendly; and
2. Implement community-based interventions and support as part of the continuum of care with facility-based services to promote, protect and support breastfeeding.

The NDOH's Action Plan to Protect, Promote and Support Breastfeeding (2016) seeks to remedy this gap. However, the plan does not lay the required planning, resourcing and monitoring foundations to drive the systematisation of community-based support. The national action plan should, based

<sup>38</sup> Information provided by Ann Behr, November 2016.

<sup>39</sup> Interview, Lenore Spies, Chief Director of the Nutrition Directorate, KwaZulu-Natal DOH, Dec 2016.

<sup>40</sup> Interview, Lenore Spies.

on the requirements of the Ten Steps and supporting guidelines, develop a set of adapted criteria aligned to the Ten Steps, and guidelines for provinces, districts and communities for the development, resourcing, implementation and monitoring of appropriate community-based MBFI programmes. The plan proposes a desktop review of “promising models for community-based support” and identifies the associated target as the scaling up of identified good practices.

The plan does not provide guidance on how to achieve the stated target of “scaling up good practices”, or include targets and indicators that are reflective of the systematisation of good practices that would be required for scaling up. For example, it does not have as a stated outcome the development of a national programmatic framework for community-based roll out of the MBFI based on best practices and adaptation of the MBFI requirements; or the development of guidelines for implementation of the national framework; or a review of financial and human resources and development of appropriate funding and human resourcing strategies to implement a community-based MBFI. Nor does it provide targets and/or indicators against which to plan and monitor progress in delivery and impact of community-based MBFI programmes.

### **Has a system been developed to audit facility compliance?**

Yes, a system of assessment, re-assessment and accreditation of facilities has been developed. However, the accreditation process has been shown to demotivate facilities and staff and undermine sustained implementation of the MBFI (Henney, 2011).

Measurement focusses on facility accreditation – which is only one of 10 steps and the accreditation process can, where implemented within a negative framework, undermine the success of the MBFI (Henney, 2011). Also the assessment system has not been integrated into the routine facility / district / provincial routine quality control cycle. KZN is one province that differs in this regard. The assessment system was integrated into an ongoing internal monitoring process, between external national assessments and re-assessments. The province has developed and formalised a system of internal reassessment and monitoring and does not, as in the case of other provinces, have the same problem of lapsing practices.<sup>41</sup>

Underlying all of these issues is the lack of political will and leadership necessary to integrate MBFI implementation into all systems – monitoring, budgets, quality assurance and human resource management systems. If provincial, district and facility-level managers do not buy in to the MBFI completely, then there is little chance of quality and sustained implementation (Brittin, 2015) (Henney, 2011).<sup>42</sup> “When the BFHI is not included as a key performance and quality of care indicator of the district, practices were not sustained.”<sup>43</sup>

KZN is one province that differs in this regard. In addition to its integration of the assessment system into its routine quality improvement cycle, the province has secured the translation of its political commitments into action at all levels of management – at provincial, district, and facility level – by fully integrating its MBFI outcomes and indicators into the performance management agreements and systems across the planning and delivery value chain – including provincial, district and facility-level managers (Mtshali, 2016).

<sup>41</sup> Interview, Ann Behr.

<sup>42</sup> Interviews with representatives from 3 provincial departments of health (WC, KZN and Mpumalanga) confirmed the critical importance of management buy-in to successful and sustained implementation of the MBFI.

<sup>43</sup> Information provided by Ann Behr.

## Continuum of services

The BFHI guidelines require the provision of a continuum of services (described in detail at the start of this section) over the life cycle of a woman's pregnancy and whilst her child is an infant. Support, including communication, education and counselling must be provided at facility, support group, and community level.

As seen from the discussion under the previous sub-heading, whilst there has been substantial compliance with these responsibilities at facility-level, there is a significant gap in the systemic – and hence universal and sustained – provision of breastfeeding support groups and community-based MBFI programmes. It is difficult to assess progress in terms of coverage, access or impact of the breastfeeding support groups and other community-based initiatives because there is not data collected or relevant indicators embedded within current monitoring, evaluation and reporting systems.

KZN is again an exception, where breastfeeding support groups are required to be established at clinics<sup>44</sup> and community-based support has been integrated into the existing community health worker programme, thus securing sustained universal coverage. In the Western Cape breastfeeding counsellors or mentors have been established in midwife operational units in community health clinics to provide maternal education and community support.<sup>45</sup> However, this initiative has not been fully systematised and is hampered by resource challenges and coverage in areas of great need, such as rural areas. In addition, unlike the KZN province, the programme is not supported through universal community-based initiatives already systematised within public health such as community health workers. As such, in the provinces, the "community-based support arena remains a challenge."<sup>46</sup>

## Health workforce

The BFHI guidelines require that the DOH plan for and train all health care staff to implement the BFHI at all levels of the health system (using the 20-hour course in facilities, plus specialised training in accredited facilities on lactation). In addition, a national coordination structure should be established to oversee, review, and align training and curricula with the BFHI.

The knowledge of the health care workforce is critical. Their knowledge is the main source of information for women and a key determinant of mothers' feeding practices (Van der Merwe et al, 2015; Brittin, 2015; Du Plessis, 2013). Women are, however, also influenced by the advice given by their family members, such as mothers and sisters – and where that advice is incorrect, it drives poor feeding patterns such as mixed feeding, use of salt and starch water. Therefore, it is important that the "workforce" at community and home levels is adequate in number and has sufficient knowledge to provide appropriate and consistent community-based support.

Securing an adequate work-force – in terms of numbers, coverage, knowledge and quality counselling – requires:

1. The provision of appropriate training to enable accurate and appropriate counselling;
2. The development of differentiated training packages suited to the specific cadres of health workers who provide counselling;
3. The allocation of sufficient personnel / counsellors at the required levels of the system, in the required areas and localities;

<sup>44</sup> However, oversight of this and reporting are within the Primary Health Care Directorate, rather than the Nutrition Directorate.

<sup>45</sup> Interview, Nicolette Henney, Western Cape DOH, May 2017. The interviewer was advised that the Western Cape does track progress in appointment of counsellors. A request was made for the data, but it had not been provided by the time of writing up this review.

<sup>46</sup> Interview, Nicolette Henney.

4. Consistency in knowledge and counselling / messaging across the workforce; and
5. The integration of workforce requirements and expectations into the human resource management and quality control systems and procedures at all levels of the health system (Fallon et al, 2005 in Henney, 2011; (World Health Organisation and UNICEF, 2007).

The current workforce at both facility and community level is deficient in key respects.

The workforce is not adequately trained to ensure universal coverage of feeding counselling aligned to current policies. The content of the training, in terms of consistency of messaging, alignment with policy and responsibilities, and the skills and attitudes it imparts, is not adequate to capacitate health care workers to provide quality and consistent counselling. The training leaves knowledge gaps, does not correct past knowledge and practices based on outdated policies, leaving space for health care workers, community and family members to provide incorrect information based on outdated policies and their personal view points and experiences (Blacher, 2014; Henney, 2011; Brittin, 2015). A small study conducted in 2016 in Mpumalanga (not yet published) confirms that health workers are scared of promoting breastfeeding in the context of HIV before receiving formal training.<sup>47</sup>

The inconsistencies and inadequacies in training leads to contradictory counselling which leaves mothers, especially those who are HIV positive, uncertain about appropriate feeding choices. In-service training, whilst provided, is not accessible because of staff shortages and is aggravated by high staff turnover (Henney, 2011).<sup>48</sup> Training is also not provided to all health care workers across all levels of the health system, such as clinic staff, paediatricians and community health workers (except in KZN). Only accredited facility staff tend to be trained and this creates inconsistent knowledge, counselling and support practices which undermine the MBFI and its continuity across the health system (Henney, 2011; Blacher, 2014)

There is also currently no systematic breastfeeding-specific curriculum or training (pre- or in-service) provided to health care workers generally, or in accredited facilities, other than for dieticians whose tertiary studies include training on breastfeeding. A few years ago, FHI 360 assisted the NDOH to train nursing tutors in nursing colleges and to train doctors and professional nurses. However this was never integrated into the NDOH's routine training programme and systems, and this training no longer takes place. With regard to provincial departments, the NDOH does not really know what training is provided to support the MBFI. All that is provided is an hour or two of breastfeeding training through IMCI training; there is no breastfeeding training programme per se.<sup>49</sup> A draft breastfeeding training package was developed some years ago, but was never finalised, signed off and approved for use by the NDOH.

It is not just the content of the messaging that impacts on breastfeeding practices, but also the manner in which the message is delivered (Brittin, 2015). Health care workers suggest that conveying information in a positive, affirming manner, rather than a judgemental and negative manner is more likely to lead to appropriate and sustained practices and a positive attitude to breastfeeding. However, health care workers find it a challenge to convey messages in an appropriately supportive manner because their training does not cover this element of communication (Brittin, 2015). Training on MBFI has not succeeded in changing historical attitudes of staff and does not, on its own, guarantee that trained staff will indeed convey knowledge and confidence to mothers. Often this does not happen,

<sup>47</sup> Correspondence with Maria van der Merwe, Nutrition Sub-directorate, Department of Health, Mpumalanga Provincial Government, January 2017.

<sup>48</sup> High staff turnover undermines effective and lasting impact of training according to Maria van der Merwe, Mpumalanga Health Department, November 2016.

<sup>49</sup> Interview, Ann Behr.

in part, because of work pressures brought about by staffing limitations and workloads, and personal experiences and attitudes of staff.

The number and availability of trained staff is also key to effective implementation. Staff shortages are a key barrier – they impact on the time and consideration given to MBFI practices and impact on the possibility of training. Staff shortages mean nurses cannot take time off to attend in-service training and where contract or agency staff are brought in to fill the gaps, they are reluctant to use their own time to attend the 20-hour training (Henney, 2011). A significant issue is the turnover or rotation of staff that have been trained. “We train them today and tomorrow they are gone.”<sup>50</sup> A critical opportunity for remedying the dislocation / continuity of the MBFI between facility, the community and the family is through the Ward-based Outreach Teams and community health workers. However, whilst the CHWs should play a nutritional role, it is one area that is sorely lacking.” CHWs have not, other than in KZN, received training on breastfeeding.<sup>51</sup>

There is also little evidence (except in KZN) of the integration of key MBFI outcomes and responsibilities within the human resource performance management system and tools, such as KPAs and performance agreements (Henney, 2011).

The NDOH is aware of this major human resourcing gap and the BF TWG’s Action Plan (2016) does seek to address it, in part. However, the plan does not go far enough to ensure the integration of MBFI requirements into the full human resources for health framework. It focuses almost exclusively on the development of appropriate training package/s for different cadres of workers. The Plan provides a coordinated framework for actioning a review, revision and publication of training, curricula and training tools aligned to the MBFI and related breastfeeding programmes. The plan aims to update and finalise the breastfeeding training package which was developed in previous years, but has not been signed off and implemented across the system.

The target is to have:

- By 2016/17 – a breastfeeding training package finalised and approved
- By 2017/18 – an online course available.

Whilst critically important, this is not enough to secure an adequate workforce for universal and effective implementation of all ten steps. In effect this requires a systematic review and understanding of the human resource requirements, in terms of numbers and qualifications at all levels of the health system across all cadres of health care workers, as well as the current status of the workforce and training provided as measured against these requirements, and the development of a costed and resourced human resource (including training) development strategy to support the MBFI.

There has not been any such assessment and the Plan does not envisage this assessment taking place. Moreover, the training-focussed interventions / plan is not costed, and thus budgeting for it will prove difficult, if not impossible.

In sum, the training components of the plan are not located within, or supported by a comprehensive human resources strategy for breastfeeding which spells out the number and competencies of the health care workforces required to implement the MBFI. Furthermore, it is not supported by a costed implementation plan and M & E framework for rolling out the training, measuring training coverage, and measuring the impact of the training and for securing adequate numbers of personnel at the different levels of the health system, including CHWs.

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<sup>50</sup> Interview, Ann Behr.

<sup>51</sup> Interview, Ann Behr.

## Information and research

The two core requirements here are the development of a national health information system that includes a record of feeding status of all contacts with children under 2 years of age, and the development of a BFHI M & E plan.

Neither of the 2 requirements has been met adequately.

The national health data collection and management system does not measure and record feedings status at all contacts with children under 2 years. This contributes to the lack of reliable data on progress in breastfeeding rates aligned to the WHO recommendations.

There are two key sources of data:

1. The District Health Information System (DHIS) which measures breastfeeding rates at 14 weeks. The collection of data is linked to the immunisation system. The immunisation schedule was changed and nurses were not updated, and as a result many nurses stopped collecting data on breastfeeding at 14 weeks. As a result, the recorded rate of breastfeeding at 14 weeks dropped. Also, there has been a poor supply of the vaccine (which is the denominator) and so the quality of the vaccine programme is impacting negatively on the data.
2. Survey data through the SANHANES study. However, there are no plans to repeat the study.

Whilst there is a broad monitoring and evaluation framework for the MBFI, the targets, outcomes and indicators remain facility-focused. The mid-term review of the MNCWH&N strategy found that systems were not in place to track MBFI results at district and facility levels for each programmatic area. Districts and facilities are not working towards improving results, and are often not aware of the results they need to achieve. Thus districts and facilities are not identifying and addressing bottlenecks (Department of Health, 2016).

The only published data that was accessible for the purpose of this review was the accreditation rates of facilities. The lack of data appears to be driven by the absence of appropriate outcomes and associated indicators in the Action Plan to Protect, Promote and Support Breastfeeding (and indeed for the MNCWH & N plan).

## Allocation of sufficient public funds

A fundamental requirement for effective systematisation of the MBFI is that a routine and adequate budget be made available by government to support the implementation of the IYCF policies, as well as the MBFI.

A recent child nutrition diagnostic study identified the lack of identifiable nutrition-specific budgets, including a budget for the MBFI, as a major systemic weakness undermining the effectiveness of child nutrition programmes (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014). The researchers were also asked to, but could not, evaluate the adequacy of child nutrition budgets. They noted that it was not possible because there were no discernible and discrete budgets aligned to specific plans. The only observation they were able to make was that there had been a reduction in the amount spent on formula foods by provinces since the adoption of the Tshwane Declaration.<sup>52</sup>

Budgeting is starting to improve, but is still not adequate: for example, there is a media / communications campaign in development to support breastfeeding (discussed under the next section of this review).

<sup>52</sup> Interview, Ann Behr.

It has an allocated R 500 000 budget – which is not much, “but for the 1st time we have a dedicated budget aligned to a breastfeeding communications plan which is supported by political profiling of breastfeeding.”<sup>53</sup>

The BF TWG’s National Action Plan has not been costed, and therefore there is a risk that the activities listed, including those targeting the strengthening of the MBFI, will not be adequately funded. Work items in the plan are currently allocated to members of the TWG, including civil society organisations, thus creating a risk to sustainability should the relevant organisation not have adequate resources, or should it exit the TWG.

The Action Plan does not require provinces to develop costed plans and allocate and report against designated budgets to support their MBFI strategies / strengthening initiatives. Given that implementation budgets are allocated at provincial level where delivery takes place, this is a significant systemic gap. The budgets at provincial level are generally quite limited for nutrition – and cover inputs as well as support.<sup>54</sup>

## Recommendations

The preceding gaps and challenges point to fundamental weaknesses in a number of the health system building blocks supporting the MBFI. The following recommendations centre on a number of steps that would strengthen the systemic building blocks of the MBFI within the public health system.

### Leadership and coordination

#### 1. Develop, as part of the national breastfeeding action plan, a strategic advocacy plan.

Build advocacy objectives, outcomes, targets, activities and indicators into the national BF plan of action.

Advocacy and high-level political and administrative leadership are key to ensure that breastfeeding, child nutrition and supporting implementing programmes, such as the MBFI are adequately profiled within the national outcomes-based planning framework. It is essential to ensure effective translation of international commitments into meaningful delivery and lasting change for young children from the highest political level, down to the departmental levels (national and provincial).

South Africa has a tremendous advantage in that breastfeeding enjoys high-level advocacy and leadership. The Minister of Health is a breastfeeding champion, and has on numerous occasions spoken publicly of the need for stronger policies, programmes and budgets. For example, in July 2016, he commemorated World Breastfeeding Week with the following words:

*Our exclusive breastfeeding rates are amongst the lowest in the world. We must all work harder to ensure that we support mothers to exclusively breastfeed for at least six months and rapidly reach a target of at least 50% of mothers’ breastfeeding for at least 6 months after the infant in born. This will require an extra mile by all of us to encourage and support breastfeeding mothers by improving their workplace and social environment.*<sup>55</sup>

<sup>53</sup> Interview, Ann Behr.

<sup>54</sup> Interview, Ann Behr.

<sup>55</sup> Namugwe, E. (2016). <http://unicpretoria.org.za/2016/07/29/south-africas-health-minister-urges-employers-to-support-breastfeeding-mothers-in-the-workplace/>.

However, it is not enough to have advocacy and champions at the highest political levels only; it must cut across the planning value-chain. In KZN, champions were active at varying levels, from the Premier, to the Health MEC, to the HOD, and the Director of the Nutrition Directorate. As noted by the Director of the Nutrition Directorate, advocacy and leadership is key, particularly when faced with the fractured organisational structure and budgeting practices of the health departments. Whilst the guidelines require a dedicated and identified breastfeeding support budget within the health budget, in reality, “health budgets do not work this way. The budget for various initiatives will be [potentially] part of, and integrated into the programme budgets of the various directorates and sub-directorates [as will the reporting requirements] and it is up to the administrative breastfeeding champions to motivate the various directorates, through consistent advocacy, to prioritise within their planning and budgeting, breastfeeding support initiatives.”<sup>56</sup>

**2. Within the framework of the BF Action plan, develop a costed comprehensive and detailed national MBFI strengthening strategy with appropriate outcomes, indicators and targets aligned to identified implementation and sustainability gaps and challenges, with a focus on strengthening the underlying health systems supporting the MBFI.**

Notably, the plan should provide clear direction on goals, objectives, outcomes, targets, activities and indicators for strengthening the systemic platforms which are especially weak:

- a. Leadership and coordination – advocacy, identification of leadership location, integration into planning, delivery, budgets, HR management and M & E systems;
- b. Communications campaign to change behaviours, attitudes and practices at all levels – including health planners, health workers, communities, families, mothers;
- c. Human resources development;
- d. Community- and family-level platforms for delivery of support.

**3. Cost and budget for the implementation of the national BF TWG Action Plan and the strategy for the strengthening the MBFI.**

The Action Plan, and specifically the MBFI strengthening strategy, should be costed. Ideally the implementation of the plan should be reflected in the DOH’s APP and identified as a budget line item in the annual budget supporting the APP.

**4. Strengthen provincial action, alignment and standardisation of strategies to drive equitable and nation-wide strengthening of the MBFI.**

The plan should require all provinces to develop aligned and costed provincial MBFI strengthening strategies supported by replicated provincial TWGs. In addition, an oversight / reporting pathway must be established to ensure provinces report against progress on development, implementation and impact of their plans using the same outcomes, targets and indicators set in the national M, E & Reporting framework.

The NDOH should develop standardised guidelines for use by provinces in developing effective MBFI strengthening plans based on evidence and lessons learned from successful provincial initiatives.

<sup>56</sup> Interview, Lenore Spies.

**5. Ensure that policies are clearly and consistently communicated to health care workers and then in turn to communities, families and mothers through simple and effective core messaging.**

This requires the development of a comprehensive and integrated communications campaign that:

- a. Addresses and corrects past messages and practices simply and clearly;
- b. Addresses the rights and challenges of women who are HIV-positive directly;
- c. Promotes key practices in all settings based on the current policy in simple terms;
- d. Is replicated and integrated at all relevant levels of the MBFI – from facility through to community through to the family; and
- e. Is positive and empowering in its approach and the manner in which messaging is conveyed to communities, families and mothers.

**6. Review the current training and communications content and implementation plan to ensure:**

- a. They advance core simple messages that correct past inaccuracies;
- b. Are replicated at all relevant levels of the health system;
- c. They promote and support positive attitudes and encourage the use of positive practices, rather than judge and forbid practices.

### Continuum of services

1. Develop and implement a clearly defined strategy for universal roll out of community-based and family-centred support for breastfeeding mothers. The plan should focus on using and integrating services within existing platforms within the public health system such as community health workers.
2. The log frame and monitoring and evaluation framework developed at national level should include key indicators against which provinces and national should report to show progress in expanding community-based support and the impact made by these measures.

### Health workforce

1. Develop a costed and comprehensive human resources development strategy to support breastfeeding, including the implementation of the BFHI. It should include recruitment, training and integration of responsibilities across all human resources management systems.
2. The plan should recognise and address documented challenges such as training content, staff attitudes, staff rotation and the historical legacy of past policies regarding feeding in the context of HIV.
3. The human resources development strategy should be preceded by and based on the results of a needs assessment of required staff (numbers, location and competencies and skills) for breastfeeding support against the targeted population, across the service delivery continuum.
4. A training implementation plan should be developed, costed and budgeted for. It should identify the cadres of health care workers that should be trained, what training they should receive, the deficits of the current training curriculum and packages, the training curriculum and packages required to meet the needs at different levels, as well as the modalities for rolling out training and monitoring quality and impact of the training provided.
5. The MBFI responsibilities of different cadres of staff – from management through to community health workers – should be integrated into all human resource and performance management systems and tools.

## Information, monitoring and research

1. Develop a comprehensive M, E & R framework for the MBFI to measure (and drive) systematisation and impact of the MBFI, focussing on areas that are particularly relevant to the successful implementation and impact of the initiative.
2. This requires expanding the outcomes, indicators and targets in plans such as the National Action Plan, to measure, not only facility accreditation rates, but more importantly, the implementation and impact of system's strengthening steps that are key to effective and sustained implementation of the MBFI to achieve lasting changes in feeding practices, including:
  - a. Development of costed provincial and district-level MBFI-strengthening plans;
  - b. Allocation of budgets, nationally and provincially;
  - c. Coverage and impact of updated training at CHW and facility-level on the quality of counselling;
  - d. Service provision / support of MBFI activities in communities and homes by CHWs and support groups;
  - e. Changes in / quality of counselling provided in communities and homes by CHWs, support groups and family members;
  - f. Breastfeeding rates / feeding practices among mothers provided with MBFI services and support.
3. Ensure that directorates and sub-directorates report against budgets allocated, implementation of activities and expenditure of budgets on breastfeeding supporting initiatives through the national coordinated plan and supporting monitoring and evaluation framework. This should be achieved through advocacy aimed at ensuring that the indicators in the National Action Plan are reflected in the national health information management, evaluation and reporting framework and system.

## Public financing of the MBFI

1. Ensure that all strategic and action plans are accompanied by costed implementation plans.
2. Advocate for budget allocations to fund the plans and that plans and budgets are reflected in national and provincial annual plans.
3. Advocate for the allocation of appropriate budgets within programme / directorate / sub-directorate budgets.

# PART 2: REGULATION OF MARKETING OF BREASTMILK SUBSTITUTES

## Legal framework of responsibilities

In addition to the adoption of the BFHI, the Innocenti Declaration also required the adoption, by governments, of a Code regulating the marketing of breastmilk substitutes. The WHO recommends that infants be exclusively breastfed for the first 6 months, and that thereafter mothers continue to breastfeed until children are 2 years old, supplemented with safe and appropriate complementary foods to meet their evolving nutritional needs (World Health Organisation & UNICEF, 2003). It further recommends that after 6 months, local, nutritious foods should be introduced to complement breastfeeding. Not only does the WHO consider infant formula undesirable as a source of food for children in the first six months, it has also determined that follow-up formula is unnecessary and an unsuitable substitute for breastmilk because of its content. In the case of children who are not breastfed, or for whom breastfeeding stops before the age of 2, the provision of “specially formulated milks (so-called ‘follow-up milks’) is not necessary” (World Health Assembly, 1982). The WHO maintains that not only are they unnecessary, but that they are especially unsuitable when used as a breastmilk replacement from the age of 6 months onwards. The formulations tend to provide too much protein and too few nutrients such as essential fatty acids, iron, zinc and B vitamins than recommended by the WHO for adequate growth and development of young children (World Health Organisation, 2013).

In order to ensure country-wide promotion and protection of breastfeeding practices, the WHO formulated the **International Code of Marketing of Breast-milk Substitutes (“the Code”) and subsequent WHO Resolutions** (World Health Organisation, UNICEF, IBFAN, 2016). The Code seeks to do so by regulating and limiting the “the harmful effects of marketing of breastmilk substitutes, feeding bottles and teats on a global scale” (Hawkins et al, 2006).

There are 4 broad requirements that must be met by government to fulfil its responsibilities in terms of the Code. Governments should:

1. Domesticate the code through a legislative instrument which prohibits advertising and other forms of marketing of breastmilk substitutes and regulates the labelling of products.
2. Ensure the availability of objective and consistent information on infant and young child feeding which guards against the use of formula and related products, addresses the main barriers to breastfeeding, promotes the value of breastfeeding, and provides promotional information on appropriate complementary feeding practices.
3. Establish a formal monitoring and enforcement mechanism and body that is (1) able to perform its duties and tasks without external pressure or influence (2) has the authority and sufficient resources to investigate Code violations (3) empowered to take remedial action (4) makes information regarding monitoring activities, final results and remedial actions publicly available and accessible and (5) has safeguards to detect and exclude persons with conflict of interest to preserve its independence and integrity.
4. Report to the WHO every 2 years on measures taken to implement and systematise the Code and make the reports publicly available.

## What does it take to fully systematise the Code?

These requirements, viewed within the preceding systemic framework, translate into the following responsibilities which are based on the legal responsibilities created by Code.

### Leadership and governance

Government must:

1. Adopt national legislation, regulations, or other suitable measures to ensure adherence to the Code. This is a 'minimum requirement' for all countries, including regulation of follow-up formula (World Health Organisation, 2013). The national law must:
  - a. Regulate information on infant and young child feeding for families and those involved in the field of infant and young child nutrition.
  - b. Prohibit provision of samples to pregnant women, mothers and families, point of sale advertising, distribution of samples, or any other promotion device to induce sales directly to the customer at retail level, such as special displays, discount coupons, sales, etc. Legal measures must:
    - i. Explicitly prohibit the full range of promotion and marketing activities of all products within the scope of the Code;
    - ii. Ensure that breastmilk substitutes are not promoted in health facilities and to health workers as per Resolution WHA47.5 (1994), such as donations of free, low-cost or subsidised products in any part of the health system. Article 7.3 of the Code prohibits financial or material inducements to promote products within the scope of the Code to health workers or their family members;
    - iii. Regulate labelling: Article 9.1 of the Code requires that labels provide the necessary information about the appropriate use of the product, and should not discourage breastfeeding, and requires information set out in Article 9.2 must be made compulsory. Article 9.2 requires information to be included on all formula labels which confirms the superiority of breastfeeding, that the product should be used on medical advice only, and includes instructions for appropriate and safe preparation.
2. Establish a formal monitoring and enforcement mechanism and body that (1) is able to perform its duties and tasks without external pressure or influence; (2) has the authority and sufficient resources to investigate Code violations; (3) is empowered to take remedial action (4) makes information regarding monitoring activities, final results and remedial actions publicly available and accessible and (5) has safeguards to detect and exclude persons with a conflict of interest to preserve its independence and integrity (Resolution WHA 49.15 in (World Health Organisation, UNICEF, IBFAN, 2016).

## Continuum of services

Government must:

1. In terms of Article 4.1 of the Code, ensure the availability of objective and consistent information on infant and young child feeding for families and those involved in the field of infant and young child nutrition, including those involved in the planning, provision, design and dissemination of information. Information should include the following:
  - a. Benefits and superiority of breastfeeding;
  - b. Maternal nutrition and preparation for and maintenance of breastfeeding;
  - c. Negative effects on breastfeeding of introducing partial bottle-feeding;
  - d. Difficulty of reversing the decision not to breastfeed;
  - e. Where necessary, the proper use of infant formula, whether manufactured industrially or home-prepared (Article 4.2). When materials contain information on formula, the publication must (1) describe the social and financial implications of its use; (2) the health hazards of inappropriate foods or feeding methods; and (3) the health hazards of improper or unnecessary use of infant formula and other breastmilk substitutes.
2. Design the regulatory framework and supporting systems to ensure the prohibition of the provision of samples to pregnant women, mothers and families, point of sale advertising, giving of samples, or any other promotion device to induce sales directly to the customer at retail level, such as special displays, discount coupons, sales etc. Legal measures must:
  - a. Explicitly prohibit the full range of promotion and marketing activities of all products within the scope of the Code; and
  - b. Ensure that breastmilk substitutes are not promoted in health facilities and to health workers as per Resolution WHA47.5 (1994) such as donations of free, low-cost or subsidised products in any part of the health system. Article 7.3 of the Code prohibits financial or material inducements to promote products within the scope of the Code to health workers or their family members.

## Information and research

Government must:

1. Make information generated through its monitoring activities, including the results and remedial actions taken, publicly available and accessible;
2. In terms of Article 11 of the Code, report every two years to the WHO on action it has taken to give effect to the Code.

## Public financing

Government must:

Ensure that the national agencies established to oversee the Code are not only legally but also financially empowered through adequate budgets to monitor compliance with national legal measures, identify Code violations, and take corrective action when violations are identified.

## The regulation of the marketing of breastmilk substitutes: An assessment at a glance

| Leadership and governance   |  |
|---|--|
| South Africa has adopted a comprehensive law (Regulation 991) which substantively aligns with the Code. It could be strengthened by making the provision of positive information on breastfeeding available.                              | South Africa has not established the required monitoring and enforcement structures, mechanisms or systems.                      |
| Continuum of services   |  |
| Regulation 991 is comprehensive and prohibits all outlawed forms of marketing of all prohibited substances.   | Regulation 991 does not adequately actively promote the provision of all required information on infant and young child feeding. |
| Workforce   |  |
| Training on Regulation 991 has been integrated into the MBFI processes which contributes to a knowledgeable workforce in MBFI health facilities. However, knowledge is not universal across the health - and supporting social workforce. |  |
| Information and research  |  |
| There is no national monitoring, reporting and evaluation system and publication of data on marketing baselines or progress.  | The NDOH has submitted reports to the WHO on action taken to give effect to the Code.  |
| Public financing  |  |
| There is no evidence of a costed plan or allocated resources as required to establish and sustain an effective national coordination, oversight and remedial mechanism.   |  |

## Discussion

### Progress in relation to the Code

Since its adoption by the World Health Assembly, the International Code of Marketing of Breastmilk Substitutes has been applied on a voluntary basis in South Africa. It had no legal standing until 2011. In 2011, the country formalised the Code with the adoption of Regulation 991 – The Regulations Relating to Foodstuffs for Infants and Young Children.<sup>57</sup> The NDOH has taken the further step of developing and publishing “Guidelines to Industry and Health Care Personnel: The Regulations Relating to Foodstuffs for Infants and Young Children”. The guidelines provide the Department’s interpretation of the Regulations and provide advice on the legal requirements and measures that should be taken to fulfil these.

The 2016 global report on country compliance found South Africa’s regulations, compared to other countries, to be comprehensive and in near-full compliance with the prescribed requirements (World

<sup>57</sup> Minister of Health (2012, December 6). Retrieved from <http://extwprlegs1.fao.org/docs/pdf/saf122685.pdf>.

Health Organisation, UNICEF, IBFAN, 2016). The annexures to the 2016 report suggest that South Africa's regulations are of a high quality with high levels of compliance. More specifically, the regulations are acknowledged as:

1. Covering the full scope of products contemplated by the Code including infant formula, follow-up formula, complementary foods, feeding bottles, teats, and/or pacifiers and other designated products, and cover the products up to the age of 36 months; and
2. Regulating the required informational/educational materials.

UNICEF South Africa recognises the regulations as providing a sound legal foundation for the promotion and support of breastfeeding as the best infant feeding option, and protection of "parents and health professionals from aggressive or inappropriate marketing of breast milk substitutes such as formula milk, milk-like drinks and teas specifically marketed as a suitable product for infants and young children" (Delvigne-Jean, 2012).

### **What positive differences has Regulation 991 made to marketing and breastfeeding practices?**

It is difficult to ascertain what differences Regulation 991 has made to the marketing, sale of, purchasing and use of infant formula, and to breastfeeding and complementary feeding practices. This is because no relevant data is routinely and systematically collected and/or made publicly available.

There is no baseline data on the situation when the Regulation was introduced, or any subsequent information or data on changes over the past six years. The researcher made a number of requests to the NDOH for information and data, as well as for an opportunity to interview the responsible role players on current national systems supporting the implementation and monitoring of the Regulations.

These requests were met with silence, which strongly suggests an absence of accessible administrative information. This observation was further supported by the outcomes of dialogues with the BF TWG members and a review of the NDOH's website and publications. There is no evidence of any national system of monitoring, recording and reporting on transgressions, thus making it impossible to know the extent of compliance with, or transgressions of, the Regulations.

Based on inputs made by a number of respondents and other anecdotal sources, a number of positive developments were observed which may, in part, be attributed to the adoption of the Regulations.

### **More vigorous corporate compliance**

The adoption of the Regulation has encouraged corporates involved in the manufacture and sale of formula to strengthen and align their compliance and regulatory mechanisms and practices with the dictates of the Code. For example, Nestle South Africa, which is a global corporate, has historically sought to comply with the International Code. However, before the adoption, the interpretations and applications were aligned to generic international principles. Subsequently, the South African Nestle group aligned their internal regulatory processes and practices with the specific South African context. In addition, it appointed a dedicated compliance officer to oversee and guide the company's compliance with Regulation 991. It has developed extensive guidelines governing its business practices for the manufacture, marketing and sale of alternative feeding products which are aligned to the specific provisions in the Guideline.<sup>58</sup>

A further example of the corporate sector strengthening the regulation of business practices – as a result of the Regulation – is evident from the approach adopted by the Infant Feeding Association

<sup>58</sup> Interview, Anne-Marie De Beer, Nestle South Africa, October 2017.

(IFA) in South Africa. It is a voluntary forum with 14 members involved in the manufacture, marketing and/or sale of infant formula and complementary foods. Its website identifies its purpose as providing “a platform where the concerns of the infant and young child food industry can be voiced and lateral debate can be pursued with key stakeholders such as the Department of Health and healthcare professionals amongst others with the ultimate goal of aligning the interests of all.” It further states that it is committed to:

1. Assisting government, wherever possible, in its quest to support the health of infants and young children through the provision of education and science-based information to healthcare professionals.
2. Ensuring compliance of its members to the South African Regulatory Framework and the Rules for Responsible Conduct. The IFA encourages other industry players to embrace the implementation of the Regulatory Framework and the Rules.
3. Making best use of the expertise of the infant nutrition industry and cooperating with government and other relevant stakeholders to develop laws and regulations based on science, as well as rigorous food quality and safety standards that contribute to the nutritional well-being of babies and young children.<sup>59</sup>

The IFA has developed its own supportive interpretive document to guide its members in applying the Regulation to their business practices to ensure compliance; it provides training and support to its members on the Regulation; and monitors and follows up on reported cases of transgressions among its members, with the objective of preventing business practices that do not comply with the Regulation.<sup>60</sup>

Both corporate structures interviewed indicated that the integration of Regulation 991 into their operations and ongoing monitoring and support has borne fruit as they have witnessed very few cases of transgressions of the Code. Neither parties record all cases of transgressions, and were not able to provide consolidated data in this regard. They both indicated that transgressions are few and far between and can be described as isolated incidents at the hands of uninformed store managers who, for example, may place formula that has a limited remaining shelf-life on sale. Both respondents indicated that where cases are identified, they immediately step in and ensure the situation is corrected.

### **Improved knowledge and compliance among health workers**

The provisions of the Regulation are integrated into the MBFI orientation and accreditation process. This has, according to a NDOH spokesperson, served to raise awareness and improve compliance with the Regulation among health care providers and workers in MBFI facilities.<sup>61</sup>

### **A decline in government expenditure on formula**

The NDOH reports that there has been a decline in provincial spending on the purchase of infant feeding formula (but no figures were provided showing the scale of the drop).<sup>62</sup> It would however appear that this reduction is largely attributable to the change in feeding policy pursuant to the Tshwane Declaration to discontinue the provision of formula to HIV-positive mothers, rather than the adoption of the Regulation.

<sup>59</sup> Infant Feeding Association of South Africa (n.d.). <http://ifa-sa.co.za/>.

<sup>60</sup> Interview, Julia O’ Grady, Infant Formula Association, October 2017

<sup>61</sup> Information provided by Ann Behr, NDOH, and Nicolette Henney, Western Cape DOH.

<sup>62</sup> Information provided by Ann Behr.

## Significant implementation and impact limits of Regulation 991

### No discernible reduction in the sale of infant formula

Thirty-four years after the adoption of the Code, global sales of breastmilk substitutes total US\$44.8 billion, and are expected to rise to US\$70.6 billion by 2019 (World Health Organisation, UNICEF, IBFAN, 2016).

The adoption of the Regulation in South Africa does not appear to have led to a significant decline in the total formula market. No government agency appears to collect data or have a system in place to measure the size and changes in the formula market or in the rate of use of formula or other breastmilk substitutes. However, based on figures provided by Nestle South Africa, there has been little, if any significant drop in the rate of production or sales of formula since the adoption of the Regulation. The total infant formula market in South Africa is approximately 28 985 tonnes and this has remained constant for the past few years. There has been a nominal 0, 4 percent decline in the total formula market.<sup>63</sup>

### Limited changes in breastfeeding rates and appropriate complementary feeding practices

There is little if any evidence to suggest that the introduction of the Regulation has impacted significantly on the country's exclusive breastfeeding rates, reductions in the rate of formula feeding, or improvements in the provision of appropriate complementary foods after six months. As illustrated earlier in this Review's Introduction, a significant proportion of women continue to adopt feeding practices that the Regulation specifically seeks to limit. To summarise, the recent DHS showed that one quarter of infants under 6 months are not breastfed at all; nearly half are fed using a bottle with a nipple, and less than one quarter of children aged 6 – 23 months receive a minimum acceptable diet of milk and an adequate mix of complementary food from the required food groups (Statistics SA, National Department of Health, SAMRC & the DHS programme, 2017).

Whilst the recent PMTCT study by Gogo et al (2015) shows an increase in exclusive breastfeeding rates at 8 week post-partum among HIV-exposed infants, this data speaks to the positive impact of the change in the HIV-infant feeding policy and practice, rather than the effectiveness of the prohibition on marketing of breastmilk substitutes.

The data on the continued high prevalence of bottle feeding and poor complementary feeding practices, alongside the limited increase in breastfeeding, raises questions about perverse incentivisation of feeding practices. The formula industry is concerned that the data suggests that the clamp-down on formula, in the absence of quality nutritional counselling, has simply resulted in large numbers of women continuing to bottle-feed, but using different (and even unsafe) sources of alternative food (such as condensed, or cow's milk).<sup>64</sup> Industry representatives noted with concern that the Regulation has closed the door on formula feeding, but not allowed or enabled corporates to provide education on appropriate or safe alternatives or even on appropriate complementary feeding. They believe this has contributed to the persistently high rates of the use of inappropriate complementary feeds as alternatives to breastfeeding or formula feeding. Based on calculations provided by Nestle South Africa, approximately 27 percent of infants 0-36 months are fed only with formula. Using the upper bound estimates at 6 weeks, where 43 percent of infants are exclusively breastfed, this leaves 30 percent of infants who are fed some formula, some breastmilk and potentially also inappropriate,

<sup>63</sup> Correspondence received from Anne-Marie De Beer, Nestle South Africa, December 2016.

<sup>64</sup> Correspondence received from Anne-Marie De Beer.

and perhaps even harmful, substitutes.<sup>65</sup> In the absence of consistent and clear information, these practices are likely to continue to contribute to poor nutritional outcomes.

### **Continued non-compliance with Regulation 991**

Information provided during interviews and observations made by both government and civil society organisations points to ongoing practices in contravention of the Regulation. However, given the lack of published reports or information from the NDOH regarding transgressions, it is difficult to ascertain the prevalence or nature of the transgressions in South Africa. The corporates interviewed noted that it is often the case that NDOH representatives maintain, in public, that marketing of breastmilk substitutes remains rife. However, these statements are not backed up with national – but rather cite global – data and case studies. They cautioned against making assumptions about marketing practices in South Africa based on the experiences in other, less regulated lower- and middle-income countries.

There is an abundance of evidence of transgressions of the Code across the globe, in lower-, middle-, and high-income countries. However, the evidence does suggest that marketing transgressions in developed countries has become more subtle and more difficult to identify and remedy (Brady, 2012). Transgressions occur in contexts that include, for example:

- In 2003, 80 percent of health workers in Togo and Burkina Faso had never heard of the Code;
- In 2004, 125 health care workers cited Code violations in Uganda;
- In 2008, 70 percent of 427 health professionals in Pakistan were unaware of the Code and their own breastfeeding laws and 12 percent had received sponsorship from pharmaceuticals for training sessions.

Current data and literature on the situation in South Africa does not provide a comprehensive, updated picture. Nonetheless, there is ongoing evidence of transgressions.

For example, the evaluation of the country's under-five nutrition strategies (2014) suggests that government departments in the Eastern Cape have a working relationship with companies that produce formula. Because the relationship is forged around products that are non-formula related, the government officials deem this to be acceptable. In the same province, formula companies have been reported to run continuing professional development courses for health care workers such as dietitians and nutritionists, which the health department also deemed appropriate. It is not only the health department, but also the Department of Social Development that works with nutrition companies. Nutrition training for departmental social workers has been sponsored by a formula company (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014). In KZN, pamphlets and booklets about child feeding with Purity branding were found at one clinic (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).

It must, however, be noted that these cited cases are already quite old, and likely to pre-date the formal adoption and roll out of the regulations. Given the growing momentum in the roll out of the MBFI and the various corporate compliance and education initiatives, it is likely that many of these are historical rather than current practices.

<sup>65</sup> Correspondence received from Anne-Marie De Beer. The total infant formula market for 0 – 36 months in South Africa produces 28 958 tonnes. If one transposes this onto the approximately 1.2 million babies born each year in South Africa, this equates to enough food to feed approximately 27 percent of children. If a maximum of 43 percent are breastfed, then this leaves 30 percent being fed something other than breastmilk or formula.



Figure 9: Advertisement by EDCON, South Africa, June 2017

Despite the previous caution, there is need for vigilance, effective monitoring and follow-up given the continuing marketing violations which have been, and continue to be, identified on an ad hoc basis. For example, the South African Civil Society Coalition on Women's, Adolescents' and Children's Health (SACSoWACH) identified and reported two significant violations of the code during breastfeeding week in 2017. The first was the adjacent Father's Day advertisement by EDCON, South Africa:

SACSoWACH addressed a constructive letter of concern to EDCON alerting it to the fact that the advert contravened Regulation 991. Its concerns were that, whilst the advert promotes a positive image of a caring father, it contravenes the prohibition against the promotion and advertising of infant feeding bottles and teats.

A further transgression was observed during an SABC 2 Health Talk show hosted during World Breastfeeding Week in which SACSoWACH and the NDoH participated. A video clip of the show may be viewed at <https://youtu.be/MvwTJS49jko>. The introductory messages at the start of the show did not promote exclusive breastfeeding. Instead, in direct contravention of the regulations, they promoted the use of supplementary feeding and the use of bottles for infants that appear not to be receiving adequate feeding after being breastfed; in addition, the segment states that failure to supplement under these circumstances is detrimental to the child's health and brain development.

Transgressions such as the above by the national television broadcaster are cause for concern. A study of television adverts for food in 2011 in South Africa identified television as the "most powerful medium" for shaping feeding and public consumption practices (Mchiza et al, 2013). It further recorded at least five TV adverts for infant formula, all of which claimed health benefits in direct contravention of the Code.

## Significant health system gaps and challenges

Whilst South Africa has a comparatively laudable set of marketing regulations, there is a significant gap between the regulations and their implementation, with few, if any robust systems in place supporting their full integration and application through the health system. The following discernible systemic gaps undermine the implementation and impact of Regulation 991.

### Leadership and governance

In terms of its leadership and governance responsibilities, the government must:

1. Adopt national legislation, regulations, or other suitable measures to ensure adherence to the Code; and
2. Establish a formal monitoring and enforcement mechanism and body to oversee and monitor implementation of the Code.

**1. With regards to the first responsibility, South Africa has done well in adopting Regulation 991. However, the national regulations exhibit a number of deficiencies and limits.**

The regulations cover the full scope of products contemplated by the Code including infant formula, follow-up formula, complementary foods, feeding bottles, teats, and/or pacifiers and other designated products and cover the products up to the age of 36 months, and all required informational/educational materials. However, the regulations do not, as required, regulate or require the development and delivery of positive and promotive information on:

- The benefits and advantaged of breastfeeding;
- Maternal nutrition and preparation for, and maintenance of, breastfeeding;
- The negative effects of bottle feeding on breastfeeding;
- The difficulty of reversing a decision not to breastfeed;
- Proper use of infant formula;
- The social and financial implications of breastmilk substitutes; and
- The health hazards of inappropriate feeding and use of formula and other alternatives.

Moreover, the regulations place a universal ban on corporates involved in infant nutrition from providing any form of education or awareness-raising on issues such as appropriate complementary feeding and safe alternatives to breastfeeding. Corporates, such as Nestle and the IFA, are of the view that this is an unreasonable curtailment of a positive contribution they can make to improving nutrition of children in South Africa. In the absence of an effective and universal government campaign providing education and raising awareness, mothers are at risk of resorting to use of inappropriate alternatives when they can't access formula. The corporates interviewed indicated that, through their significant education budgets and reach they could, acting within the parameters of the regulatory intent fill – as they have in the past – this communications vacuum.<sup>66</sup> However the regulations, as currently worded, prevent this from happening.

**2. The government has, however, not complied with its second responsibility.**

The government has not established a formal, effective, and adequately empowered and resourced monitoring and enforcement mechanism to oversee and monitor implementation of the Code. This is confirmed in both the national under-five nutrition evaluation (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014) and the recent global report on country compliance with the International Code (World Health Organisation, UNICEF, IBFAN, 2016).

The latter report notes that, whilst South Africa's regulations comply with the duty to legislate the Code, it has not put in place the necessary monitoring and enforcement mechanisms without which the Code is rendered no more than a piece of paper (World Health Organisation, UNICEF, IBFAN, 2016).

In South Africa, there is no formal and transparent national mechanism for monitoring transgressions or impact of the Code. There is further, no publicly available record of transgressions of the Code, as required. At national level, "there is no monitoring or compliance structure – there are no staff and no supporting institutional framework."<sup>67</sup> At provincial levels, the degree of monitoring varies. In the Western Cape, for example, the health department has developed and distributed a circular for all health facilities and practitioners supported by monitoring tools. The system in

<sup>66</sup> Interviews, Anne-Marie De Beer & Julia O'Grady, October 2017.

<sup>67</sup> Interview, Nicolette Henney.

place allows for identification of violations, reporting on violations on a standard form, checking the violation within the department, and then onward transmission to the national office. The Western Cape, however, does not have a register of all transgressions reported. And even where provinces such as the Western Cape implement formal systems, the lack of monitoring and compliance structures at national level makes the collection of provincial information redundant. In Mpumalanga there is no formal monitoring mechanism, system or tools, but rather ad hoc monitoring by staff members of the department as they go about their rounds.<sup>68</sup> In the Free State, it has been reported that even at health facility level, there is inadequate monitoring of enforcement of the regulations. Monitoring only takes place during supervisory visits which are hampered by staff shortages and transport constraints (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).

### Continuum of services

In terms of its service delivery responsibilities, the government has both a prohibitory and promotional responsibility. It must, in the first instance, provide services that effectively prohibit, prevent and sanction all prescribed marketing activities. In addition, it must ensure the availability of objective and consistent information on infant and young child feeding for families and those involved in the field of infant and young child nutrition.

1. With regards to the first requirement, the Regulation is comprehensive in the range of activities prohibited and regulated. However, systems to ensure compliance are absent, as discussed before.
2. However, the government does not adequately meet its second set of responsibilities related to the provision of prescribed information.

Current communications and education provided in support of, or in accordance, with Regulation 991 are deficient in key respects:

- a. The messaging and communications aligned to the regulations tend to focus on the dangers of formula feeding, and neglect the dangers of harmful breastmilk substitutes such as cow's milk, sweetened condensed milks, tea and other fluids. In the absence of consistent and clear information, and based on current data, it appears that the wide-spread use of unsafe or inappropriate alternatives is driven by this communication gap which contributes to poor nutritional outcomes such as stunting.<sup>69</sup>
- b. Information as required by the Code on the value of breastfeeding, dangers of mixed feeding, etc., is not consistently available across the country, particularly outside of the health facility setting. Information gaps include the failure to provide clear and accessible information setting straight misconceptions on breastfeeding in the context of HIV and to correct historically outdated understandings (Doherty et al, 2006).
- c. The current national breastfeeding communications plan does not expressly seek to secure (in terms of planning or budgeting) the provision of consistently available information covering the information prescribed by the Code using multiple media platforms and integrated messaging through the health system (community, family and facility-based).
- d. Historical and residual practices linked to the old 2001 PMTCT programme, communications, advocacy for formula feeding and the provision of free formula (and their spill-over effects) continue to influence feeding choices among both HIV-positive and -negative women, long after

<sup>68</sup> Interview, Maria van der Merwe.

<sup>69</sup> Correspondence received from Anne-Marie De Beer.

the programme was done away with (DuPlessis, 2013; Doherty et al, 2006). Mixed messaging continues to drive poor knowledge and inappropriate feeding practices (Department of Health Province of Kwazulu-Natal, 2015).

### Health workforce

As previously noted, the lack of adequate training of the health workforce, especially in the “muddied” context of HIV-messaging, has contributed to the failure to provide effective education and support to mothers (both HIV-negative and -positive). In addition, there is evidence to suggest that the supportive workforces in the social development and education sectors are not adequately trained and educated on the regulations. This contributes to transgression and inconsistent messaging (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).

### Information and research

Government is required to collect and disseminate information regarding monitoring activities, document results and take remedial action taken to ensure regulatory compliance, and it is further required to make this information publicly available and to report to the WHO every 2 years on action it has taken to give effect to the Code.

Whilst South Africa appears to have submitted a report to the WHO which informed the WHO’s global 2016 assessment report (World Health Organisation; UNICEF; IBFAN, 2016), it does not have a system in place, and does not routinely collect, analyse and use information as required by the WHO to assess its progress, inform planning, and keep the public and health sector informed.

### Allocation of sufficient public resources

Government must allocate adequate financial and human resources to establish an effective monitoring and reporting structure and systems.

Given the absence of dedicated coordination and oversight mechanisms and systems, it seems reasonable to conclude that appropriate budgets have not been allocated.

## Recommendations

The preceding analysis points to a significant failure to systematise the implementation, and monitoring and reporting of the impact of Regulation 991. The following recommendations are suggested to improve the systemic and sustained implementation and impact of Regulation 991.

### Leadership and coordination

1. Strengthen leadership and coordination to ensure that all role players within and beyond the health system fulfill their responsibilities and contribute to the effective implementation of Regulation 991. This includes:
  - a. Ensuring that all role players are aware of the Regulations, their respective responsibilities and reporting channels;
  - b. Strengthening monitoring, reporting and enforcement mechanisms to ensure a reduction in violations of R991;
  - c. Increasing positive information, behaviours and practices to promote and support breastfeeding, and discourage breastmilk substitutes. If exclusive breastfeeding is not possible, health workers must advise on safe preparation and use of alternatives.

2. Establish a national and provincially-aligned coordination and monitoring body to oversee the planning, implementation, resourcing and monitoring of Regulation 991, including the development of a standard system of reporting, together with tools and training on the regulations and code.

### Continuum of services

Women in South Africa choose infant feeding options based on their understanding of what is best for their infant and what best protects their infants (Doherty et al, 2006). This presents a unique opportunity to shift behaviours through an effective communications campaign that complies with the International Code and guidelines, and which is delivered in partnership by government and business entities.

1. Develop national standardised messaging and a national, publicly funded, communications campaign using multiple mass and targeted media and health system platforms covering information prescribed by the Code. Particular attention should be paid to addressing incorrect, competing and residual messaging dating back to the older PMTCT programmes, and to the use of appropriate and safe alternative and complementary foods.
2. The communications campaign should provide information, not only on the fact that breastmilk is best, but also on what constitutes nutritionally supportive and appropriate complementary or supplementary feeding, and what forms of substitutes to avoid because of the harm that can be done to the infant's growth and development.

### Information and research

1. Develop a national and standardised Monitoring, Evaluation and Reporting framework aligned to the Code. It should make provision for documenting all transgressions as well as follow-up actions taken in the case of transgression, the consequences and outcomes. Information should be provincially disaggregated, as well as by nature of transgression to enable trends to be traced and weak areas identified, as well as the impact of the Code in terms of number of reported transgressions, decreases in formula marketing and sales, and increases in breastfeeding rates.
2. Data collection should be strengthened to include measurement of use and impact of:
  - a. Exclusive breastfeeding;
  - b. Use of infant formula at different ages;
  - c. Use of substitutes other than infant formula at different ages;
  - d. Production and sales of infant formula.
3. Research should be conducted on the impact of the regulations, including the establishment of baselines on marketing practices, sale of formula, number and nature of transgressions, etc.
4. The country should develop reports every 2 years using the reporting framework. Critically, the information collected and reported should be used to strengthen the system. It should be used for planning for quality improvement and reports should be made publicly available on the NDOH's website.

### Allocation of sufficient public resources

Develop a costed implementation plan for the establishment of the coordinated oversight, monitoring and reporting mechanisms and allocate budgets to support the plan.

# PART 3: PROTECTING, PROMOTING AND SUPPORTING BREASTFEEDING IN THE WORKPLACE

## The Legal Framework of Responsibilities to Systematise Workplace Support

One of the primary factors that prevent exclusive and continued breastfeeding of infants under the age of 6 months is that women have to **return to work**. Therefore, one of the key duties in terms of the Innocenti Declaration is that governments ensure that breastfeeding is protected, promoted and supported in the workplace.

There is an abundance of evidence showing the link between breastfeeding cessation and a woman's return to work. Delaying the return to work, or allowing for part- or flexi-time return to work extends the duration of exclusive breastfeeding (Rollins et al, 2016). Mothers who had to return to work for financial reasons or used informal day care arrangements, rather than care by themselves or partners, are less likely to breastfeed for 4 months or more (Hawkins et al, 2006). Women who return to work at or before 4 months are less likely to breastfeed for 4 months compared to those who return later, after 6 months (Hawkins et al, 2006). Babies in day care, especially when in informal day care (day mothers or other family members), are breastfed for a shorter period of time (Hawkins et al, 2006).

However, returning to work does not have to mean the cessation of breastfeeding. A mother's return to work and continued breastfeeding is influenced by her employment environment, day care arrangements, and type of maternity leave pay (Hawkins et al, 2006 ).

*Working does not necessarily have to lead to lower rates of breastfeeding. The quantity and nutritional quality of breast milk are not undermined by maternal work or activity, including vigorous exercise, and there is no indication that working women are less interested in breastfeeding than non-working women. Rather, it is the difficulty of continuing to breastfeed under the conditions experienced when they return to work that women most often cite as the reasons for supplementary feeding or for weaning infants. A woman's ability to breastfeed is markedly reduced when she returns to work if breastfeeding breaks are not available, if quality infant care near her workplace is inaccessible or unaffordable, and if no amenable facilities are available for pumping or storing milk (Heymann et al, 2013, p. 398).*

The evidence is compelling. Where the workplace environment is supportive of breastfeeding and creates an enabling environment, women can and do continue breastfeeding. Where they do this in sufficient numbers, it contributes to improved national breastfeeding rates. There is also a growing body of evidence of what forms of workplace support are most likely to protect and promote breastfeeding at the required scale. These include:

1. Employers offering family-friendly or flexible working arrangements (Hawkins et al, 2006). Family-friendly arrangements include, for example, day care vouchers or assistance with day care, and flexible arrangements include, for example, part-time work, job sharing, and flexible working hours.
2. Statutory paid maternity leave for 6 months, plus additional pay during maternity leave, has been shown to delay the return to work and extend the period of breastfeeding, independent of confounding factors such as socio-economic status and maternal education (Hawkins et al, 2006).

3. National policies guaranteeing breastfeeding breaks in the workplace until the infant is at least 6 months old are associated with significantly higher rates of exclusive breastfeeding in countries where the share of females in the labour force is high. This is true, even when controlling for Gross Domestic Product, female literacy and the percentage of the population living in urban areas. Where the share of the female workforce averages at around 40 percent, a national policy guaranteeing breastfeeding breaks was associated with an 8 percentage point increase in the rate of exclusive breastfeeding in infants younger than 6 months (Heymann et al, 2013). The association was seen in low, middle and high-income countries.

### What are the requirements for systematising workplace support?

The evidence and, indeed, South Africa's international treaty and development commitments compel us to adopt a number of policies and laws, as well as support their implementation, to ensure that all women can delay their return to work for as long as possible without having to forego all income. Further, the regulatory environment must ensure that once they return to work, their employers provide an enabling and supportive workplace that protects and promotes their and their babies' right to breastfeed.

### The legal obligations

The legal duties on government are regulated by a number of international instruments.

**The International Labour Organisation's (ILO) Maternity Protection Convention 2000 (No. 183)**<sup>70</sup> sets standards for protecting and supporting breastfeeding among working mothers. It is augmented by the Maternity Protection Recommendation, 2000 (No. 191) and applies to all employed women, including those in informal and atypical forms of dependent work and requires:

1. The adoption of measures to ensure that pregnant or breastfeeding women are not obliged to perform work that is detrimental to their or their child's health.
2. A guaranteed minimum of 14 weeks maternity leave which is either accompanied by payment of salary or cash benefits at a level which ensures that the woman can maintain a suitable standard of living for her and her child. Recommendation 191 urges 18 weeks of paid maternity leave.
3. If cash benefits are paid, this should not be less than two thirds of the woman's previous earnings. Recommendation 191 urges that benefits should equal a woman's previous earnings.
4. Job protection and non-discrimination for breastfeeding workers.
5. Legislative protection of one or more paid breastfeeding breaks or reduced work hours without reduced pay to allow for breastfeeding.
6. Recommendation 191 requires that measures be put in place requiring assessments of workplace risks to the safety and health of the pregnant or nursing woman and her child, and where such risks are identified, that they are addressed.
7. Recommendation 191 recommends that where practicable, provisions should be made for the establishment of facilities for nursing under adequate hygienic conditions at/or near the workplace such as nursing or childcare facilities.

<sup>70</sup> General Conference of the International Labour Organisation (2000, June 15). Convention C183 - Maternity Protection Convention, 2000 (No. 183). [http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_ILO\\_CODE:C183](http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C183).

***Additional international and regional rights instruments require the protection and promotion of breastfeeding in the workplace. These include:***

1. The International Covenant on Economic, Social and Cultural Rights (ICESCR) includes special protection for mothers before and after childbirth including paid leave or leave with adequate social security benefits.
2. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires special measures to guarantee maternity protection.
3. UN General Comment No.15 (2013): The right of the child to the enjoyment of the highest attainable standard of health (Article 24 of the CRC) requires, inter alia, that States take measures to protect and promote breastfeeding practices (paragraph 35). States must, in fulfilment of their responsibilities to protect, promote and support the right of children to health and nutrition, take special measures to promote community and workplace support for mothers in relation to breastfeeding and feasible and affordable childcare services.

**Evidentiary imperatives**

A growing body of evidence provides guidance on measures that should be to extend the duration and prevalence of exclusive and extended breastfeeding among working mothers. These include:

1. Statutory paid maternity leave for 6 months (Hawkins et al, 2006).
2. Promoting part or flexi-time work for returning mothers (Hawkins et al, 2006)
3. Legislative universal guarantee of breastfeeding breaks up to 6 months supplemented with appropriately supportive workplace environment and conditions (Heymann et al, 2013)
4. Women who place their children in formal child-care, as opposed to care by relatives or day mothers, are more likely to continue breastfeeding, making a strong case for employers to provide day care on-site or close to mother's employment (Heymann et al, 2013).

**In summary, the policies and laws that should be adopted include:**

1. Paid maternity leave for a minimum period of 14 weeks (however, an extended period of 18 weeks is recommended) accompanied by payment of a salary or cash benefits which should be no less than 2/3rds of the woman's earnings.
2. Job protection and protection from discrimination.
3. Incentives for employers to create supportive work arrangements such as the provision of day care, nursing and child-care facilities.
4. Guaranteed breastfeeding breaks in the workplace until the infant is at least 6 months old which should cover the formal and informal economy. The breastfeeding break policy should secure universal coverage (it should not only cover a fraction of the workforce) and must allow for breaks that are long enough to enable women to pump milk or breastfeed, and should compel facilities to provide safe storage of pumped milk (Heymann et al, 2013). In addition, the laws should require all employers to conduct a workplace risk-assessment for women who are returning from work and remedy these.

Critically, the adoption of policies must be supported by systems to ensure implementation, monitoring and enforcement.

## Workplace support for breastfeeding: An assessment at a glance

### Leadership and governance

South Africa has a number of clear laws in place to secure an enabling and supportive workplace. However, there are a number of gaps in the law, as measured against the legal requirements. There is a law requiring breastfeeding breaks, but it is poorly implemented. In addition, no laws incentivise the provision of a supportive breastfeeding workplace which, therefore, limits the positive creation of an enabling workplace culture.

**Education, support and monitoring and enforcement of a number of the key laws, especially the Code (see p.55) supporting breastfeeding breaks are essentially non-existent.**

### Continuum of services

Employers are compelled by law to provide a minimum package of services supporting breastfeeding. However, they are not universally applied as required by law and for achieving impact on national breastfeeding rates.

### Workforce

Government departments, such as the Departments of Labour and Public Service and Administration do not appear to have an adequate workforce to support implementation, monitoring and reporting against compliance with the laws. In addition, the general workforce in companies and organisations are not educated or trained on the laws, the importance of adherence to the laws and creating an enabling workplace for breastfeeding mothers, and how to create an enabling workplace.

### Public financing

**There is no discernible public financing of systems to support the central law supporting breastfeeding – the Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child.**

### Information and research

**There is limited knowledge of the laws, or their impact on corporate and organisational practices, or the impact these have on organisational workplace practices and policies, or the impact on breastfeeding rates in the country.**

**In addition, given the apparent lack of systematisation of monitoring and support of the laws within the DOL or DPSA, there is no data or information available on the levels of compliance across the country.**

## Discussion

### Progress in securing a supportive workplace

South Africa has adopted a number of laws to protect, promote and support breastfeeding in the workplace, including:

***The Basic Conditions of Employment Act*** No. 75 of 1997 guarantees women 4 months' (unpaid) maternity leave, six weeks of which must be taken after the birth of the baby. Paid maternity leave is not obligatory.

***Unemployment Insurance*** in the form of a maternity benefit can be claimed if contributions have been made by the mother to the Unemployment Insurance Fund (UIF) in the months preceding her pregnancy. The benefit can be claimed for a maximum of 121 days of up to an amount of 60 percent of the contributor's salary. However, a sliding scale is adopted, and women earning at the higher end of the scale may claim significantly less than 60 percent. The highest earning women may claim a maximum of only 38 percent of their salary.

**Protection from discrimination through the Basic Conditions of Employment Act, the Labour Relations Act No. 66 of 1995, and the Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 of 2000.** These three acts protect women against dismissal during their maternity leave; deem dismissals for pregnancy or reasons related to pregnancy as automatically unfair; and expressly prohibit any form of discrimination on the grounds of pregnancy.

**Guaranteed breastfeeding breaks are secured through the Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child (“the Code”).**<sup>71</sup> South Africa has adopted the Code which provides that arrangements should be made to enable women who are returning to work to have two breaks every day for up to 30 minutes for breastfeeding purposes until their child is six months old. The Code was developed and adopted in terms of section 87(1)(b) of the Basic Conditions of Employment Act, with the objective of providing “guidelines for employers and employees concerning the protection of the health of women against potential hazards in their work environment during pregnancy, after the birth of a child and while breast-feeding”.

The focus of the Code is on the prevention of harm to mothers who are breastfeeding rather than the promotion of their right to breastfeed. Paragraphs 5.12 and 5.13 do, however, make limited provision for promotion of women’s right to breastfeed. Para 5.13 provides that “Arrangements should be made for employees who are breastfeeding to have breaks of 30 minutes twice per day for breast-feeding or expressing milk each working day for the first six months of the child’s life.” Paragraph 5.12 provides that “arrangements should be made for pregnant and breastfeeding employees to be able to attend antenatal and postnatal clinics as required during pregnancy and after birth.”

The Code creates a legally enforceable right.

*The Code of Good Practice, which is issued in terms of the Basic Conditions of Employment Act, provides a right to breastfeeding breaks in the work place that the courts, arbitrators and CCMA will enforce, if approached to do so.*<sup>72</sup>

### **What positive difference have the various protective laws made to securing supportive workplaces?**

As in the case of the Code against the marketing of breastmilk substitutes, it is difficult to determine, with any accuracy, the impact that these laws have made on securing a more supportive working environment, delaying the return of women to work after giving birth, and improving breastfeeding rates. The impact of the laws on breastfeeding rates do not appear to be measured, and studies similar to those cited at the start of this section of the report examining the link and statistical impact of maternity laws on breastfeeding do not appear to have been conducted in South Africa.<sup>73</sup>

### **Survey of workplace policies and practices supporting breastfeeding women in South Africa**

For the purpose of this review, a small-scale survey was conducted among diverse organisations, including private companies (large, medium-sized and small), government departments, development agencies, Chapter Nine human rights institutions, academic institutions, and NGOs in South Africa

<sup>71</sup> Minister of Labour (1998, November 13). <http://www.labour.gov.za/DOL/legislation/codes-of-good-practice/Basic%20Conditions%20of%20Employment/code-of-good-practice-on-pregnancy>.

<sup>72</sup> Interview, Michael Bagraim, Attorney (labour law), Member of Parliament, Portfolio Committee on Labour, Cape Town, March 2017.

<sup>73</sup> Small-scale, informal case studies have been conducted, but provide little insight into national trends and practices in the workplace or the impact on population-level changes in breastfeeding rates. See, for example, Reimers (2009).

to understand how, and to what extent they comply with key maternity laws, notably the Code and maternity leave legislation.

The survey was sent to approximately 100 respondents, and after numerous follow-ups, replies (of varying quality and comprehensiveness) were received from 32 respondents. Generally there seemed to be high levels of anxiety and, therefore, reluctance about participating in the survey. The survey process started with calls to potential respondents to determine if they would be willing to participate, and if so, to whom the questionnaire should be addressed. The first point of inquiry was sent to the relevant organisation's Human Resources manager. However, in most cases, the Human Resources managers indicated that they were not familiar with the issue and were not prepared to engage on behalf of the organisation. Inevitably, the researcher was then referred to a more senior management level, including to Chief Operations Officers or Directors. This suggests high levels of ignorance and wide-spread failure to systemically integrate breastfeeding promotive practices and responsibilities into the human resources framework of employers in the sample.

As a result, the survey does not reflect a comprehensive picture, especially with regards to the number of contacted organisations that do not comply with the Code to provide a supportive environment, as a substantial number indicated, during the initial contact, that they did not know about the issue and did not have policies and practices in place. During these initial conversations it became clear that many organisations do not have breastfeeding policies in place, are not aware of their responsibilities, nor are they fulfilling them. This included a number of rights-based NGOs and human rights institutions in the country. The researcher was informed of a comparable small survey being conducted by North West University where similar results were found. As part of a 4th year Nutrition Students' assignment, in 2016, students contacted 10 tertiary institutions that train Nutrition and Dietetics students and enquired of their Human Resources managers if they had a Workplace Breastfeeding Policy in place. None of the institutions (including the university which was home to the students) had a policy in place.

### Survey respondents and replies

Replies were received from across the range of the sample as follows:

|  |    |
|--|----|
| <b>Companies</b>                           | 11 |
| <b>NGOs</b>                                | 9  |
| <b>Development agencies</b>                | 3  |
| <b>Parastatal / government departments</b> | 5  |
| <b>Academic institutions</b>               | 2  |
| <b>Other</b>                               | 2  |

The respondents employed between 1 and 1 200 women per institution.

Based on the results received, it is evident that there are a number of organisations that are taking extraordinary measures to create an enabling and supportive workplace, and are complying with the governing laws. However, it is not clear to what extent they are doing so because of their recognition and understanding of the legal responsibilities in terms of the governing national laws, or to what extent it is occurring on a voluntary basis because the companies recognise these practices as features of good corporate governance, or because they are required to do so by global developments or their own corporate policies.

### Organisations with a breastfeeding policy

Eleven of the 32 organisations that replied indicated that they had a workplace breastfeeding support policy and 14 that they did not. Of the 11 that answered positively, only 5 have a written policy. The remainder have ad hoc informal arrangements in place. The balance of respondents did not answer this question.

The respondents were asked why they had adopted a breastfeeding policy. Only one replied that this was to ensure compliance with national laws. Others indicated that it was because it was required as part of their global or international governance framework. This was particularly so for multinational companies and international development agencies. One organisation indicated that it adopted its workplace policy because of a clear understanding of the value of breastfeeding.

For those who did not have a policy in place, the reasons were varied and included:

- Lack of demand and possible ignorance on the part of employee representatives;
- Unsuitable buildings that would make the policies impossible to apply;
- One organisation did indicate that it is in the process of reviewing its policies and recognised the need for a breastfeeding policy (possibly promoted by the survey);
- Some were not sure why they did not have policies in place.

### Organisations providing paid breastfeeding breaks

Of the 32 organisations that replied:

- 19 (60%) indicated that they provided paid breastfeeding breaks;
- 5 indicated that they provided unpaid breastfeeding breaks;
- 4 said they did not provide breastfeeding breaks.

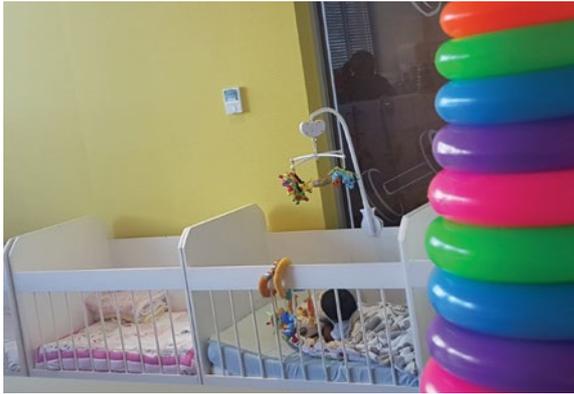
The majority (11) provide breaks for 6 months, but a number were more progressive; 3 provided breaks up to 12 months, and one for 24 months.

### Additional measures taken by surveyed organisations to support breastfeeding

In addition to provided breastfeeding breaks, a number of organisations provided additional support in the form of:

- Providing breastfeeding rooms as well as, in the case of one company, providing express pumps, comfortable couches, baby wipes and a microwave to warm milk, as depicted in the following pictures.





- Providing safe and clean storage facilities for expressed milk;
- Providing cups to feed babies;
- Flexible working hours;
- Allowing parents to bring their baby to work;
- One organisation in particular provided on-site day care facilities – as depicted in the adjacent pictures, so that women could bring their children to work, know they are cared for, and have access to them for breastfeeding purposes – in addition to the provision of lactation rooms and supportive equipment.



### **Training / sensitisation of the workforce**

12 organisations indicated that, as required by the Code, they provided education or sensitisation to the general workforce on the rights of women and infants to breastfeed. This is to create an accepting culture in the workplace. 11 said they did not.

### **Maternity leave**

All surveyed organisations provided maternity leave (4 unpaid) of between 4 and 6 months. Thus there was significantly higher compliance with the maternity leave laws than the breastfeeding support laws.

### **Significant implementation and impact limits**

#### **Not all women benefit from maternity leave protection because of ad hoc compliance with the law**

Based on existing literature, it is evident that, whilst some women are benefitting from maternity leave protection, a substantial number of women, especially those living in vulnerable circumstances and in the informal sectors, do not. They have to return to work early and be separated from their infants, either because maternity leave is not paid, or because they do not qualify for it.

The experience of Anele as recorded by the organisation My Wage, is typical of many young women in South Africa:

*I did not breastfeed because I had to return to work after 2 weeks as I am the only breadwinner in my household. I worked odd hours, and did not know much*

*about expressing. I tried expressing during the day but I could only fill half a cup as I did not know about a breast pump. It was also difficult to me to get a quiet space to sit and express freely without interruption. I had to express in the toilet. My mother had to take my baby because I could not cope with working and taking care of him as I was also recovering from giving birth.<sup>74</sup>*

For many, employment is in the informal or domestic work sector and for them, one option is to send their children away to live with their grandparents when mothers return to work. For example, Dr Sindisiwe Van Zyl who works with HIV patients in Orange Farm near Johannesburg observed, in a *Mail and Guardian* report, that exclusive breastfeeding is impractical for some HIV-infected women. “Many of the mothers I see are domestic workers who often only get 2 months maternity leave. They are not allowed to take their babies to work and send them home to their grandmothers. How on earth will they be able to only breastfeed?” (Malan, 2011)

### **Low levels of compliance with breastfeeding laws**

In the case of breastfeeding support specifically, as seen from the survey results, there are low levels of compliance with the law, and a great degree of variation in measures adopted. This means that only a few women, often in more prosperous large companies and organisations, enjoy the rights to which they are entitled.

### **Legal compliance alone is not enough to promote breastfeeding in the workplace**

What was observed in a company that provided extensive workplace support and spaces was the low take-up of the breastfeeding facilities. Only one mother – of the many (approximately 30) mothers with young children using the day care facilities – chose to breastfeed and use the breastfeeding facilities. The other mothers all chose formula. An enabling workplace is not just about spaces, it must include a broader suite of education and support.

### **Poor use of the law to enforce rights to breastfeeding breaks, and poor knowledge of the breastfeeding law within the Department of Labour**

Whilst the Code is a legally enforceable instrument that bestows a justiciable right to breastfeeding breaks and a supportive work environment, the Code is infrequently, if ever, used to assert women’s rights in the workplace. Very few, if any, cases come before the courts, and very few employers, unions and/or employees use it to enforce women’s rights in this regard. Michael Bagraim – a labour law specialist with 25 years’ experience in facilitating collective bargaining agreements, representation of unions, employers and employees in labour litigation, and in supporting the development of complaint workplace policies – observed that he has never seen the issue of breastfeeding breaks feature in these proceedings.<sup>75</sup> In his view, this is because people, across the board, do not know about the Code and the associated rights and responsibilities.

His analysis of the underlying cause was reinforced through the engagements the researcher had with the Department of Labour. Despite sending at least 6 emails and numerous follow-up calls to a variety of officials in the Department, the researcher was unable to identify who, if anyone, was responsible for oversight and support of implementation of the Code, or indeed, if there was anyone with a working knowledge of the Code.

<sup>74</sup> My Wage (n.d.). Breastfeeding, p. 4. [http://lrs.org.za/docs/DFL\\_Breastfeeding.pdf](http://lrs.org.za/docs/DFL_Breastfeeding.pdf)

<sup>75</sup> Interview, Michael Bagraim.

Formal requests for information about the Department of Labour's systems that are in place to support implementation of the Code of Good Practice on the Protection of Employees Labour, monitoring the implementation of the code, and supporting employers to implement the code to support breastfeeding were addressed to, inter alia:

- The Director-General's office;
- The offices of the Deputy Director-Generals of Corporate Services and Inspection and Enforcement Services;
- The OHS Chief Inspector's office;
- The Employment Standards team;
- The office of the Compensation Commissioner.

After protracted attempts, no information was made available to the researcher from the Department in response to these requests.

Indeed, knowledge of South Africa's Code is poor even at international levels. Despite the fact that the Code has been in place in South Africa since 1998, a publication by the ILO in 2013 notes incorrectly that South Africa is one of only ten countries in Africa that does not guarantee women breastfeeding breaks in the workplace (International Labour Organisation, 2014).

## Significant health system gaps and challenges

Whilst South Africa appears to have a good set of laws in place protecting the rights of breastfeeding women and their young children, these – and notably the legislative protection of breastfeeding breaks – are poorly implemented in the workplace and by government departments responsible for implementation and monitoring. There is widespread ignorance of the law, rights, and associated responsibilities by key government departments, by employers and by women in the workplace. These challenges point to the near wholesale failure to systematise the laws protecting breastfeeding by government and by employers alike. This means that, whilst there are a few institutions that apply the breastfeeding protection laws and procedures, the manner in which this is done is not consistent with breastfeeding protection as a right. There is often inequality, inconsistency and unlawful discretionary implementation of the Code. It depends largely on the willingness or motivation of a particular organisation or individual. As a right, it requires universal application in all workplaces, as well as monitoring, follow up of transgressions and support for implementation. Moreover, the inconsistencies in application undermine the potential impact of this measure. The evidence has shown that breastfeeding support in the workplace is a key intervention that can improve a country's breastfeeding rates, but only if it is universally practised.

### Leadership and governance

In terms of its leadership and governance responsibilities, the government must:

1. Adopt a suite of laws protecting breastfeeding in the workplace by compelling universal compliance, including paid maternity leave for 6 months and paid breastfeeding breaks for up to 6 months;
2. Incentivise the adoption of breastfeeding-promoting workplace policies and practices;
3. Establish and resource a system of education, monitoring and compliance.

Legal gaps include:

1. The Basic Conditions of Employment Act does not guarantee paid maternity leave for 6 months;
2. Women in the informal sector remain unprotected;
3. The suite of national employment equity laws and laws and procedures governing human resourcing policies, good governance and auditing requirements for private companies, government departments and development organisations do not incentivise the creation of breastfeeding supportive workplaces or require reporting on measures taken. The laws seek to only create obligations. They provide little in the way of motivation or increased awareness of the intrinsic value of breastfeeding support in the workplace as a matter of good governance or as a matter of employer well-being, both key elements of sustainable productivity and socio-economic development of corporates and the country.

In addition to reviewing the direct workplace protection laws, this review also examined a number of employment equity, preferential procurement and ethical governance instruments which are, in part, intended to engender not only socially responsible practices but also practices promotive of equality and socio-economic development.

Instruments reviewed include the:

- Employment Equity Act and targets set by the Commission for Employment Equity which is not only mandated to oversee compliance, but indeed take measures to incentivise compliance, such as giving awards recognising achievement in promoting the intent of the Act;
- B-BBEE Codes of Good Practice;
- Preferential Procurement Policy Framework Act 2000 and accompanying Regulations as well as Treasury's General Procurement Guidelines which aim to advance, through affirmative procurement practices, the social and economic advancement of women and disabled people.

None of these instruments makes any reference to the promotion of breastfeeding, or recognises compliant companies as preferred providers. Thus there is no evidence, within this legal framework, of a system of incentivising the development of supportive workplaces, or engendering recognition among employers of the intrinsic governance, and social and economic developmental value of supporting breastfeeding in the workplace.

### **Continuum of services and the workforce**

As is evident from this survey and other small-scale surveys, the suite of laws South Africa has in place does not translate into universally-available enabling and supportive workplaces. This is in part because of lack of compliance, but also the lack of knowledge, monitoring of the laws, and recognition by organisations of the intrinsic value of complying. There is also limited application of the laws to provide spaces for women, as well as of sustained corporate or organisational education to create awareness and support amongst returning mothers and their co-workers.

There have been some attempts within government to secure wider changes in corporate ethics and attitudes through training and support. However, these have been ad hoc and not sustained, monitored and improved upon. A respondent from the NDOH noted that "we tried to develop, with the support of FHI360, guidelines for the Department of Public Service and Administration (DPSA), for circulation to other departments on how to create a workplace environment that is supportive of breastfeeding.

However, we don't know if this has been circulated or if any or how many departments are using it."<sup>76</sup> In a subsequent meeting with a former representative from the DPSA, it became apparent that this initiative has not been taken any further and has not been implemented in any meaningful way.<sup>77</sup>

### Information and research

There is limited knowledge of the laws, or their impact on corporate and organisational practices, or the impact these have on organisational workplace practices and policies, or the impact on breastfeeding rates in the country.

In addition, given the apparent lack of systematisation of monitoring and support of the laws within the DOL or DPSA, there is no data or information available on the levels of compliance across the country.

### Allocation of sufficient public resources

Given the absence of systems, support and monitoring of the laws, it seems reasonable to conclude that appropriate budgets have not been allocated.

## Recommendations

The preceding analysis points to a significant failure to systematise the implementation, monitoring and reporting of compliance and progress in application of the workplace protection laws. The following recommendations are suggested as possible means to strengthening the systematisation of workplace support for breastfeeding.

### Leadership and coordination

1. Amend the Basic Conditions of Employment Act to guarantee paid maternity leave for 6 months.
2. The laws should be strengthened to guarantee paid breastfeeding breaks as well as the provision of supplementary support in the way of flexible working hours or day care services. The Minister of Health has called for the adoption of a law compelling employers to make it possible for women to breastfeed by, for example, establishing crèches and breastfeeding rooms (Malan, 2011).
3. Strengthen the legal visibility of the Code and develop a clear and costed plan of action to ensure that it is well publicised and that all affected institutions are supported in implementation of it by the DPSA, and that it is monitored by the Department of Labour.
4. **Leadership is required, not just at policy level, but within organisations.** There must be recognition that breastfeeding support is a form of good governance and in the interests of the company and country, and that simply complying with the law is not enough. Leadership is required by companies and organisations which should, through their practices, advocate for enabling and supportive workplaces. They should not just comply with the letter of the law, but should also provide education and, indeed, promote breastfeeding. Structures like the Infant Feeding Association (IFA) are well placed to play a stronger advocacy role in this regard, as could the development of incentives by government through laws and awards.
5. Incentivise companies, parastatals, government departments and NGOs and development organisations to develop and implement supportive breastfeeding workplace policies and practices

<sup>76</sup> Interview, Ann Behr.

<sup>77</sup> Interview, Dr Sinabe, former employee of the DPSA, December 2017.

through the inclusion of the issue in the Employment Equity and Black Economic Empowerment laws and regulations, as well as the reporting, regulatory and auditing requirements of the various governing structures such as the Public Service and Administration, government's preferential procurement policies, the Employment Equity Act, the Johannesburg Stock Exchange, NGO funding frameworks, etc.

6. The Employment Equity Commission should create an annual award for companies and organisations that lead by example.
7. Human rights institutions such as the Human Rights Commission and leading rights-based NGOs should lead by example in the adoption of policies and practices, as well as engage in active oversight of the issue.
8. The NDOH, in collaboration with DOL, DPSA and human rights institutions should engage in systematic education and sensitisation of companies and organisations so that they recognise breastfeeding as a matter of good governance, staff well-being policies and essential to a healthy and sustainable workforce. In other words, that it is in their benefit to have an active breastfeeding workplace support policy that supports mothers and educates and sensitises the whole workforce of co-workers and managers.

### **Continuum of services**

1. It is critical that the laws be publicised and monitored for compliance to ensure universal availability of the service in all workplaces.
2. In addition, it is not enough just to comply with the laws and make spaces available for women to breastfeed. It is essential that these measures be accompanied and supported by organisational and national communications and education efforts that educate women on the value of breastfeeding and encourage them to make use of the available services.

### **Information and research**

1. Academic institutions as well as the National Department of Planning, Monitoring and Evaluation (DPME) should engage in focussed research to build an evidence base on the adequacy of our laws and practices, and their impact on promoting breastfeeding in the country. The evidence should then be used to strengthen the country's regulatory and supportive framework.
2. Systems should be established to monitor compliance and best practices, and regular reports developed and published to enable not only monitoring of progress but also sharing of knowledge and best practices.

### **Allocation of sufficient public resources**

A comprehensive costed plan of action to strengthen the enabling legal and regulatory framework and its application in the workplace should be developed by the DOH, in collaboration with the DOL, DPSA and DPME.

# CONCLUSION AND THE WAY FORWARD

It is apparent that there are significant systemic challenges in the current policy framework supporting breastfeeding and that these inhibit the translation of our bold national commitments into effective and impactful changes in breastfeeding practices, rates, and the nutritional status of young children in South Africa.

Notably, there is a deep-seated failure to systematise the various laws and programmes across government operations, thus making sustained universalisation of the benefits difficult. In addition, it is clear that it is not enough to focus on one set of interventions alone; it is critical that all interventions be integrated and delivered in a coordinated and synergistic manner to support and reinforce their intent and impact. There is insufficient coordination of the various measures which undermines the effectiveness of the individual programmes.

South Africa has good policy foundations in place, but unlocking their full potential requires the integrated and synergistic implementation of the three core programmes and associated responsibilities or commitments, which if systematised and implemented at scale, could provide a universal continuum of support that could make a real difference to the nutritional well-being of young children in the country.

This requires a multifaceted response to be implemented at scale through simultaneous and mutually reinforcing programmes and interventions designed to respond to legal and development responsibilities and local needs and barriers to breastfeeding, including the:

1. **Baby-friendly hospital initiative**
  - a. At community level
  - b. Through trained facility, community and home-based workers.
2. **Marketing of breastmilk substitute regulations and the communications responsibilities** should serve to augment and continue the support provided through the MBFI in the hospital and then post-hospital in the community and family;
  - a. Supported by an effective and responsive national communications strategy.
3. **Workplace legislation protecting women and promoting breastfeeding** that is supported so as to be an integral part of our corporate and organisational ethos in the country.

Coordination is key to securing a successful life-cycle oriented, holistic and integrated approach. Comparative case studies (Brazil and Malawi) reveal that countries which have made progress in advancing the nutritional status of children have an effective, appropriately placed coordination mechanism (in the Office of the President with aligned political authority and institutional support for consolidated planning, budgeting and oversight of roles and responsibilities) to coordinate the implementation of nutrition interventions by line ministries. Brazil's structure is supported by a multi-sectoral advisory council which includes civil society representation. South Africa's overall nutrition coordination mechanism is located in the Department of Agriculture, and currently lacks political authority, is institutionally weak, and does not bring an adequate child-sensitive focus to its strategic vision for the country (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).

Effective leadership and coordination of the various breastfeeding initiatives, such as the MBFI have, on the one hand, been strengthened in the NDOH with the move that located core nutrition programmes under the political and administrative leadership of the child and school health directorate. This has led to better alignment of all health policies with the policy positions on breastfeeding.<sup>78</sup>

However, coordination remains weak and to some extent ad hoc because the move to centralise child nutrition within the child health directorate has not been complete. With the development of the national comprehensive MCWH&N plan which deals holistically with child health and nutrition, all relevant

<sup>78</sup> Interview, Ann Behr.

nutrition services should have moved to the directorate leading the plan, the Child and School Health Directorate. However, this was not possible, given the scope of the initiative and the limited resources within the Directorate. Thus, some nutrition / breastfeeding initiatives, such as the MBFI were moved from nutrition to child and school health, whereas others remained with the nutrition directorate, such as the regulation of marketing of breastmilk substitutes and human milk bank regulations.<sup>79</sup> This creates coordination challenges and these are aggravated given the non-alignment of the national and provincial organisational structures. The provincial allocation of responsibilities or mandates for initiatives such as the MBFI are not the same; in the provinces, all nutritional responsibilities, including the MBFI are the mandate of the nutrition directorate (KZN) or nutrition sub-directorates within the child health directorates.<sup>80</sup>

To overcome some of these challenges, the NDOH has established its breastfeeding technical working group (BF TWG) to coordinate breastfeeding initiatives. Whilst this includes civil society organisations, it is limited in its focus on breastfeeding; there is no linkage with broader nutritional coordination mechanisms. The TWG and its plan are located alongside – rather than as an integral and contributing part of – the national integrated nutrition strategy for children.

There is no common operational plan for consolidating nutrition activities and targets across the sectors and at all levels of implementation for children under five years. Such a plan would operationalise national priorities and investments in child nutrition, including those related to breastfeeding, and be supported by national goals, objectives, activities, targets or budget. Notably, in Brazil and Mozambique these plans exist and they have an explicit target – the reduction of stunting in children under 5 years. (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014). There is no common and consolidated M & E Framework for nutritional support services for children under the age of five years (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).

Indeed, this gap is highlighted by the recently adopted National Integrated Early Childhood Development Policy. This policy requires and, indeed, elevates as a programmatic priority, the development by 2017 of **a national multi-sectoral comprehensive food and nutrition strategy for children under five**. It obligates the DOH to initiate and lead an inclusive process which brings on board other departments and civil society, to review and strengthen a national multi-sectoral comprehensive food and nutrition strategy for children under five. This must include a comprehensive statement of responsible role players and their roles for food and nutritional support for young children, including breastfeeding support, and develop mechanisms for accountability of role players.<sup>81</sup>

Therefore, as a concluding recommendation, this review urges the NDOH to take the lead and strengthen its strategic visioning and coordination of a national nutritional programme for young children and embed breastfeeding within the broader strategic framework by, inter alia:

- Establishing an effective under-five nutrition coordination mechanism;
- Initiating and driving an inclusive process for the review and development of a national multi-sectoral comprehensive food and nutrition strategy for children under five which includes national goals, objectives, activities, targets and budget as well as role players, responsibilities and accountability mechanisms for all components, including breastfeeding support and promotion; and
- Developing a common and consolidated M & E nutrition framework aligned to the strategy / holistic implementation plan.

<sup>79</sup> Interview, Ann Behr.

<sup>80</sup> Interview, Ann Behr.

<sup>81</sup> Republic of South Africa (2015), para 5.3.2.

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# ANNEXURE A:

## International, regional and national legal and development responsibilities and duties to promote respect, protect and promote breastfeeding

| International and regional responsibilities  |   |
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| <p>United Nations Convention on the Rights of the Child</p> <p>General Comment No. 15 (2013)</p> <p>CRC Concluding observations (2016)</p> | <p>The CRC guarantees all children the right to enjoy the highest attainable standard of health (article 24). State parties are required to take all measures to respect, protect and promote this right, including to combat disease and malnutrition through access to adequate nutritious food, and to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition and the advantages of breastfeeding (articles 24(2) c and e).</p> <p>The scope of responsibilities of the State with regards to supporting breastfeeding in furtherance of children's rights to health and nutrition are spelt out in more detail in General Comment No. 15 (2013).<sup>82</sup> State Parties must:</p> <ol style="list-style-type: none"> <li>1. Ensure the full protection and promotion of breastfeeding practices in line with the WHO guidelines</li> <li>2. They must introduce into domestic law, implement, and enforce internationally agreed standards concerning children's right to health</li> <li>3. Special measures must be taken to promote community and workplace support for breastfeeding mothers and must comply with the ILO convention No.183 (2000)</li> <li>4. Adopt measures across the life-cycle of the child, such as the baby-friendly hospital initiative, training health workers, etc.</li> <li>5. Provide health-related information and support the use of information which should be accessible, understandable and appropriate to the age of the audience. It should include information on the obligations of Government and should be provided through the school curriculum and health setting. Information should be provided to all parents, individually or in groups, the extended family, caregivers and others through clinics, parenting classes, public information platforms, professional bodies, community organisation and the media.</li> </ol> <p>The CRC Committee recently (in 2016) reflected on South Africa's progress and compliance and expressed concern at the persistently low rates of breastfeeding for children under the age of 6 months. It directed the Government, in the next reporting period, to prioritise and report in its next report, on measures taken to promote exclusive breastfeeding for at least 6 months, with appropriate guidance and support for breastfeeding by HIV-infected mothers, and to regulate the promotion of breast milk substitutes.<sup>83</sup></p> |
| <p>African Charter on the Rights and Welfare of the Child</p>  | <p>The ACRWC guarantees all children the right to the best attainable state of health and obligates the government to take all necessary measures (not only policy, but budgetary, capacity-building, advocacy and awareness-raising measures) to:</p>  |

<sup>82</sup> UN Committee on the Rights of the Child (2013). General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24).

<sup>83</sup> UN Committee on the Rights of the Child. (2016, October 27). Concluding observations on the second periodic report of South Africa.

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| <p>Concluding Observations of the African Committee of Experts on the Rights and Welfare of the Child (2016)</p>  | <ol style="list-style-type: none"> <li>1. Ensure the provision of adequate nutrition</li> <li>2. Combat malnutrition within the framework of primary healthcare</li> <li>3. Ensure appropriate health care for expectant and nursing mothers</li> <li>4. Develop preventive health care and family life education and provision of service</li> <li>5. Ensure that all sectors of society, in particular parents, children, community leaders and community workers, are informed and supported in the use of basic knowledge of child health and nutrition, and the advantages of breastfeeding</li> <li>6. Support, through technical and financial means, the mobilisation of local community resources in the development of primary health care for children (Article 14).</li> </ol>  |
| <p>ILO Maternity Protection Convention, 2000 (No. 183)<sup>84</sup> <b>sets standards for protecting and supporting breastfeeding among working mothers and recommends and is augmented by R 191 – Maternity Protection Recommendation, 2000 (No. 191).</b></p> | <p>Requires the adoption of the following measures for all employed women:</p> <ol style="list-style-type: none"> <li>1. Ensure that pregnant or breastfeeding women are not obliged to perform work that is detrimental to their or their child's health</li> <li>2. Guarantee a minimum of 14 weeks maternity leave which is either accompanied by payment of salary or cash benefits. Recommendation 191 urges 18 weeks pf paid maternity leave</li> <li>3. Job protection and non-discrimination for breastfeeding workers</li> <li>4. Legislative protection of one or more paid breastfeeding breaks or reduced work hours without reduced pay to allow for breastfeeding.</li> <li>5. Compulsory assessments of workplace risks to the safety and health of the pregnant or nursing woman and her child and remediation of identified risks</li> <li>6. Where practicable, establishment of facilities for nursing under adequate hygienic conditions at or near the workplace such as nursing of childcare facilities.</li> </ol> |
| <p>1990 and 2005 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding Call for Action</p>  | <p>The Innocenti declarations obligate the government to take systemic measures to protect promote and support breastfeeding. Specifically to:</p> <ol style="list-style-type: none"> <li>1. Ensure all mothers are aware of their rights and have access to support, information and counselling</li> <li>2. Establish sustainable systems for monitoring and using information on feeding practices to inform advocacy and programming</li> <li>3. Identify and allocate sufficient resources to implement the required programmes</li> <li>4. Monitor and report on progress</li> <li>5. Appoint a national breastfeeding coordinator with appropriate authority and establish a multisectoral national breastfeeding committee</li> <li>6. Adopt the Baby-Friendly Hospital Initiative (BFHI)</li> <li>7. Adopt the Code on the Regulation of Marketing of Breastmilk Substitutes</li> <li>8. Enact legislation protection the breastfeeding rights of women and children in the workplace.</li> </ol>                                |

<sup>84</sup> General Conference of the International Labour Organisation (2000, June 15); and International Labour Organisation. (n.d.). International Labour Standards on Maternity protection. <http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/maternity-protection/lang-en/index.htm>.

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| The International Covenant on Economic, Social and Cultural Rights (ICESCR)  | Requires special protection for mothers before and after childbirth including paid leave or leave with adequate social security benefits.  |
| The Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)  | Requires special measures to guarantee maternity protection.   |
| International Code of Marketing of Breastmilk Substitutes ( <b>the Code</b> ) adopted by the WHO (1981)  | In sum: requires the adoption of three key measures / steps: <ol style="list-style-type: none"> <li>1. Baby-friendly hospital initiative (BFHI)</li> <li>2. National legislation regulating the marketing of breastmilk substitutes</li> <li>3. Workplace protection and support for women who are breastfeeding</li> </ol>    |
| WHO/UNICEF Global Strategy for Infant and Young Child Feeding (GSIYCF) 2009 Rapid Advice Guidelines and the New Who Recommendations: Preventing Mother-to-Child Transmission | Calls for supporting exclusive breastfeeding for the first 6 months, and continued breastfeeding with timely and appropriate complementary feeding for 2 years or longer (2002)<br><br><b>Recommended that HIV-positive mothers, or their infants, take ARVs for the duration of breastfeeding to prevent HIV transmission</b> |
| WHO guidelines on HIV and Infant Feeding: recommends countries choose one of two options (2010)  | All HIV positive women on ARV drugs, practise exclusive breastfeeding.   |

## National legal and development responsibilities to respect, protect and promote breastfeeding

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| The Constitution of the Republic of South Africa | <p>Section 28 (1) (c) of the Bill of Rights guarantees for every child, the right to basic nutrition.</p> <p>Children's rights to food and nutrition are not, as in the case of the generic S27 right to sufficient food and water, subject to progressive realisation. Moreover, it is not limited to the right of access to the service as in the case of S27 rights.</p> <p>This means that, whilst parents are the primary duty bearers vis-à-vis their children's rights to nutrition (including breastfeeding), where they are unable to fulfil their duty, the State is duty-bound to immediately provide support programmes, including educational and material support, to enable parents to meet their responsibilities. (Liebenberg, 2006) (Stewart, 2008) (Government of the Republic of South Africa and Others V Grootboom and Others , 2000) (Minister of Health and Others v Treatment Action Campaign and Others , 2002)</p> |
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| <p>The National Development Plan 2030</p>   | <p>The NDP recognises optimal early childhood health and development as a foundation for sustainable development. It expressly recognises and encourages breastfeeding as a core strategy to secure optimal early development.</p> <p>The NDP specifically calls for strengthening systems to increase access to all health promotive services. It requires the development of human capacity and sets as a goal, that every household has access to a well-trained Community Health Worker (CHW).</p>  |
| <p>Integrated Food Security Strategy for South Africa, 2002</p> <p>Integrated Food Security and Nutrition Programme, 2006</p> <p>Baby Friendly Hospital Initiative, 2009 (now known as the Mother Baby Friendly Initiative)</p> <p>National Development Plan 2030, 2011</p> <p>National Integrated Nutrition Programme, 2010</p> <p>Tshwane Declaration, 2011</p> <p>South Africa's National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA), 2012</p> <p>PMTCT Guidelines and HIV Clinical Guidelines, 2010</p> <p>Strategic Plan for Maternal, New Born, Child and Women's Health (MNCWH) and Nutrition in South Africa, 2012 – 2016</p> <p>Roadmap for Nutrition in South Africa, 2013 – 2017</p> <p>Infant and Young Child Feeding Policy &amp; Guidelines, 2000, 2007 and 2013</p> <p>National Integrated Early Childhood Development Policy, 2015</p> <p>Regulations Relating to Foodstuffs for Infants and Young Children. Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972 (updated 2012/12/06)</p> | <p>The South African government has taken a number of policy and legislative measures to give effect to the right of children to nutrition, including breastfeeding.</p> <p>Policies and strategies adopted are listed in the left-hand column. The national framework is an inter-sectoral one which aims for a holistic response that addresses the immediate, underlying and basic causes of malnutrition (Departments of Health, Social Development and Performance Monitoring and Evaluation, 2014).</p> <p>The many policies, strategies and laws in place commit South Africa:</p> <ol style="list-style-type: none"> <li>1. To actively promote, protect and support exclusive breastfeeding for 6 months, including among HIV positive women with access to ARV treatment</li> <li>2. To promote appropriate alternative feeding where breastfeeding is not possible, and nutritious and appropriate complementary feeding from 6 months</li> <li>3. To provide nutritional support and counselling, as well as public education to ensure appropriate breastfeeding, alternative and/or complementary feeding practices</li> <li>4. To provide a supportive workplace through appropriate legislation and support for workplace practices.</li> </ol> |



**Further information:**

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