The World Breastfeeding Trends Initiative (WBT*i*)

Name of the Country:	South Africa
Year:	November 2016

The Status of Infant and Young Child Feeding in South Africa

Policy, Programme and Practice

November 2016

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Acronyms

BFHI	Baby Friendly Hospital Initiative
FAO	Food and Agriculture Organization
GLOPAR	Global Participatory Action Research
GSIYCF	Global Strategy for Infant and Young Child Feeding
HIEC	Health, Information, Education and Communication Unit
IBFAN	International Baby Food Action Network
IFE	Infant and Young Child Feeding in Emergencies
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
MOH	Ministry of Health
MPC	Maternity Protection Convention
MSG	Mother Support Groups
NCD	Non Communicable Disease
WABA	World Alliance for Breastfeeding Action
WBT*i*	World Breastfeeding Trends Initiative
WHO	World Health Organization
IEC	Information, Education and Communication
UN	United Nations
NGO	Non-Governmental Organization
BMS	Breastmilk Substitute
HIV	Human-Immunodeficiency Virus
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
AIDS	Acquired Immunodefiency Disease
IMCI	Integrated Management of Childhood Ilnesses
ANC	Ante-Natal Care
PNC	Post-Natal Care

1. Introduction:

Breastfeeding contributes to infant nutrition and health through a number of important mechanisms. It provides a complete source of nutrients for the first six months of life, half of all requirements in the second six months of life, and one-third of requirements in the second year of life (1, 2, 3). Breastfeeding is also known for providing essential nutrients, protecting against specific illnesses, lengthening of post partum amenorrea in the absence of contraceptive use and lengthening of birth interval which is strongly related to infant and young child survival (4, 5).

Reports indicate that Infants under 2 months old who are not breastfed are six times more likely to die from diarrhea or acute respiratory infections than those who are breastfed. Approximately 1.3 million deaths could be prevented each year if exclusive breastfeeding rates increased to 90 percent (6) as promotion of breastfeeding is one of the least expensive and most cost effective interventions for saving children's lives (7).

Evidence based findings have disclosed the excellence of breastfeeding for its protection against malnutrition, diarrhea and respiratory infections which are the main killers of infants and young children in developing countries (8, 9 10, 11).

Studies carried out in Africa, Asia, and Caribbean countries and Latin America, have supported this fact showing that more than 66% of the deaths due to diarrhea and acute respiratory infections among infants 0-3 months and 32% of deaths among those aged 4-11 months could be prevented by exclusive and partial breastfeeding respectively (10,11,12).

1.1 Overview of IYCF in South Africa

According to recent national data (SANHANES 2012), 26% of boys and 25% of girls aged 1-3 years old are stunted, an increase from 2005. There is also a growing obesity problem in children aged 2-5 years, with 19% of girls overweight and 5% obese, and 17% of boys overweight and 4% obese.

Although breastfeeding initiated early post-delivery is a common practice, mixed feeding rather than exclusive breastfeeding is the norm.

The 2003 SA Demographic Health Survey (SADHS) found 61% mothers initiated breastfeeding within an hour of birth compared with 45% in 1998. The 2012 South African National Health and Nutrition Examination Survey (SANHANES)[1] found that more than 80% mothers initiated breastfeeding within one hour after birth suggesting that BFHI has been effective in increasing breastfeeding initiation rates. By establishing a pattern of exclusive breastfeeding during maternity stay, maternity facilities have taken an essential step towards improving the potential duration of exclusive breastfeeding postnatally.

The national household survey, the South African national HIV Prevalence, Incidence, Behaviour and Communication Survey[2] conducted by the HSRC (n= 13 6555, of which 1 630 were 0-2 year olds) indicated that only 25.7% of infants aged 0 to 6 months were exclusively breastfed and of these only 8% reached 6 months, furthermore 22.5% of infants 0 to 6 months were exclusively formula fed and 51.3% of the children in this age group were mixed-fed.

Findings from the 2012-2013 South African Prevention of Mother-to-Child Transmission of HIV Evaluation (SAPMTCTE)[3] revealed that infant feeding practices among HIV exposed infants by province indicated that exclusive breastfeeding at 4 to 8 weeks postpartum nationally increased from 20.4% in 2010 to 54.1% in 2012-2013 (8-day recall data).

The KwaZulu-Natal Initiative for Breastfeeding Support (KIBS) Baseline Survey 2016 found the rate of exclusive Breastfeeding in KwaZulu-Natal province is 45.1% at 14 weeks[4].

[1] Shisana, O, Labadarios, et.al, & SANHANES-1 Team 2013, 'South African National Health and Nutrition Examination Survey (SANHANES-1', Cape Town: HSRC Press.
[2] Shinsana et al. 2008. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, Cape Town, HSRC Press
[3] Goga AE, Jackson DJ, Singh M, Lombard C for the SAPMTCTE study group. Early (4-8 weeks postpartum) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2012-2013. South African Medical Research Council and National Department of Health of South Africa, 2015.
[4] KwaZulu-Natal Department of Health, KwaZulu-Natal Initiative for Breastfeeding Support (KIBS) Baseline Survey Report March 2006

In South Africa the current average duration of breastfeeding is reported as 5.9 months, with only 35.8% and 13.4% per cent of children still being breastfed at 12 – 15 months and 20-23 months, respectively; this is considerably lower than the 2003 SADHS where the median of breastfeeding was 16,6 months. This shows that continuation of breastfeeding should be promoted.

The South African breastfeeding agenda has been complicated by the HIV epidemic. Breastfeeding in the context of HIV and AIDS posed significant challenges due to the risk of transmission of the virus in breastmilk (WHO, 1998). The 2006 WHO guidelines recommended that breastfeeding in HIV-exposed infants should be avoided and recommended the use of replacement feeding i.e. infant formula. If breastfeeding of HIV-exposed infants could not be avoided, rapid cessation of breastfeeding after the infant reached six months of age, followed by appropriate complementary feeding, was recommended (WHO, 2006). The repercussions of these recommendations for the health and survival of the infants were despite reductions in HIV transmission rates, studies showed much higher mortality rates among HIV-exposed children compared to non-exposed children, due to diarrhoea, malnutrition and other diseases in non-breastfed children (Chetty et al., 2010; WHO, 2010a). The most recent WHO guidelines on infant feeding in the context of HIV are based on the evidence of positive health outcomes for HIV-free survival through provision of ARVs to mothers and the breastfed HIV-exposed infant (WHO, 2010).

Since the Tshwane Declaration in 2011, South Africa has introduced universal ARV treatment for all HIV-infected pregnant women and has a policy directive to support exclusive breastfeeding for all infants, regardless of their mother's HIV status (DoH, 2013). South Africa has made many strides in improving child health with high universal coverage of facility-based births, immunization coverage and the implementation of the Mother-Baby Friendly Initiative (MBFI). Despite this progress, South Africa has had limited improvement in exclusive breastfeeding rates. Research findings indicate that the biggest impact will be realized when multiple effective interventions are implemented across multiple sectors and at multiple levels, especially at the home, family and community level (Sinha et al., 2015)

1.2 The Global Strategy for Infant and Young Child Feeding (IYCF)

Global Strategy for Infant and Young Child Feeding was launched in 2003 and revised in 2007. The aim of the strategy was to revitalise efforts to promote, protect and support appropriate infant and young child feeding. It builds upon past initiatives, in particular the Innocenti Declaration and the Baby-friendly Hospital initiative and addresses the needs of all children including those living in difficult circumstances, such as infants of mothers living with

HIV, low-birth-weight infants and infants in emergency situations. It is within the context of the Global Strategy that South Africa seeks to implement national strategies to improve infant feeding.

The aim of the strategy is to improve through optimal feeding, the nutritional status, health, growth and development and thus the survival of infants and young children.

The Strategy has three specific objectives:

- Raise awareness of the main problems affecting infant and young child feeding, identify approaches to their solution, and provide a framework of essential interventions;
- Increase the commitment of governments, international organizations and other concerned parties for optimal feeding practices for infants and young children;
- Create an environment that will enable mothers, families and other caregivers in all circumstances to make – and implement – informed choices about optimal feeding practices for infants and young children.

The strategy is intended as a guide for action. It is based on accumulated evidence of the significance of optimal infant and young child feeding especially in the first two years of life for later growth and development. It identifies low cost interventions with a proven positive impact during this period.

World Breastfeeding Trends Initiative (WBT*i*)

Background

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative monitoring and evaluation tool, developed by IBFAN Asia, to assess the status and benchmark the progress of the implementation of the Global Strategy for Infant and Young Child Feeding at national level.The tool is based on two global initiatives, WABA's GLOPAR (Global Participatory Action Research) and the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBT*i* is designed to assist countries in assessing the strengths and weaknesses of their policies and programmes that protect, promote and support optimal infant and young child feeding practices. The WBT*i* has identified 15 indicators in two parts, each indicator having specific significance.

Part-I deals with policy and programmes (indicator 1-10)	Part –II deals with infant feeding practices (indicator 11-15)
1. National Policy, Programme and Coordination	11. Early Initiation of Breastfeeding

2. Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding) 3. Implementation of the International Code of Marketing of Breastmilk Substitutes 4. Maternity Protection 5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF) 6. Mother Support and Community Outreach 7. Information Support 8. Infant Feeding and HIV 9. Infant Feeding during Emergencies 10. Mechanisms of Monitoring and Evaluation System	12. Exclusive breastfeeding 13. Median duration of breastfeeding 14. Bottle feeding 15. Complementary feeding

Once assessment of gaps is carried out, the data on 15 indicators is fed into the questionnaire using the WBT*i* web based toolkit which is specifically designed to meet this need. The toolkit objectively quantifies the data to provide a colour- coded rating in Red, Yellow, Blue or Green. The toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international. lumbered

Each indicator used for assessment has following components;

- The key question that needs to be investigated.
- Background on why the practice, policy or programme component is important.

A list of key criteria as subset of questions to be considered in identifying achievements and areas needing improvement, with guidelines for scoring, colour-rating, and ranking how well the country is doing.

Part I: A set of criteria has been developed for each target, based on the Global Strategy for Infant and Young Child Feeding (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005). For each indicator, there is a subset of questions. Answers to these as mentioned above, can lead to identify achievements and gaps in policies and programmes to implement the Global Strategy for Infant and Young Child Feeding. This shows how a country is doing in a particular area of action on Infant and Young Child Feeding.

Part II: Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random household survey or other surveys that are national in scope.

Once the information about the indicators is gathered and analyzed, it is then entered into the web-based toolkit through the ' WBT*i* Questionnaire'. Further, the toolkit scores and colour- rates each individual indicator as per **IBFAN Asia's Guidelines for WBT*i*.**

Country Process

South Africa was trained on how to conduct the WBTi assessment in 2009. However due to other commitments, it was not possible to carry out the actual assessment until November 2016. This is a very welcome achievement. The Department of Health represented by the Infant and Young Child Feeding Coordinator, Ms Ann Behr and Ms Zandile Kubeka participated and guided the assessment with the technical support of IBFAN Africa. WBTi is based on secondary data and in this respect, Ms Behr compiled all the relevant documents.

Validation.

Upon completion of the report, Ms Behr will guide its validation in order for it to be approved as a national report.

Part I: IYCF Policies and Programmes

In Part I, each question has a possible score of 0-3 and each indicator has a maximum score of 10. Once information about the indicators is entered, the achievement on the particular target indicator is then rated i.e. Red, Yellow, Blue and Green based on the guidelines as shown in Table 1.

Table 1: IBFAN Asia Guidelines for WBTi

Scores	Colour- rating
0 – 3.5	Red
4 – 6.5	Yellow
7 – 9	Blue
> 9	Green

Indicator 1: National Policy, Programme and Coordination

Key question: Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National infant and young child feeding committee and a coordinator for the committee ?

Background:

The "Innocenti Declaration was adopted in 1990. It recommended all governments to have nationalbreastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country. World Summit for Children (2000) recommended all governments to develop national breastfeeding policies. The Global Strategy for Infant and Young Child Feeding (2002) calls for an urgent action from all member states to develop, implement, monitor and evaluate a comprehensive policy on IYCF. The Innocenti Declaration on Infant and Young Child Feeding (2005) captures the renewed commitments made at this historic anniversary meeting and records the additional five operational targets that were identified as part of the ongoing global strategy on Infant and Young Child feeding including the WHA resolutions regarding IYCF.
The Planning Guide for national implementation of the Global Strategy for Infant and Young Child Feeding (2007) calls for implementation of the Global Strategy for Infant and Young Child Feeding into concrete focused national strategy, policy and action plans.

Guidelines for scoring		
Criteria	√ *Check all that apply*	
1.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	1	1
1.2) The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	1	1
1.3) A national plan of action developed based on the policy	2	2
1.4) The plan is adequately funded	2	0
1.5) There is a National Breastfeeding Committee/ IYCF Committee	1	1
1.6) The national breastfeeding (infant and young child feeding) committee meets , monitors and reviews on a regular basis	2	2
1.7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.	0.5	0.5
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level.	0.5	0.5
Total Score		**8/10**

Information Sources Used:

1. Infant and Young Child Feeding Policy (2013): Department of Health, South Africa
2. Roadmap for Nutrition in South Africa – 2013 – 2017: Dept of Health, South Africa
3. Action Plan to protect, promote and support breastfeeding in South Africa. 2016
4. National Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition (2012–2016 – Mid-term Review. (2014)
5. Tshwane Declaration of support for Breastfeeding in South Africa. 2011

Conclusion*:*

The dept of Health has a national infant and young child feeding policy which was officially adopted in 2007 and revised in 2013. The aim of the policy is to standardize and harmonise infant and young child feeding practices in line with global and national policies. The policy recognises and acknowledge the countriy's Constitution article 28(2) which states, " A child's best interests are of paramount importance in every matter concerning the child." The policy further recognises government's obligations under Article 24 of the Converntion on the Rights of the Child to ensure that parents and children are informed and supported with knowledge of child health and nutrition.

Following the release of the WHO Guidelines on HIV and infant feeding (2010) the Government of South Africa then held a national Breastfeeding Consultative meeting in 2011 in which South Africa declared itself as a country that actively protects, promotes and supports exclusive breastfeeding, as a public health inervention to optimise child survival. This demonstrates a strong political will and commitment to upholding optimal infant and young child feeding and maternal health.

A number of other policy documents, including the National Department of Health - Roadmap for Nutrition in South Africa 2013–2017; the National Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition 2012–2016; and the National Health Promotion Policy and Strategy 2015–2019 have also prioritised the promotion, protection and support of breastfeeding and are in line with the infant and young child policy. There was a review of the National Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition (2012–2016) in 2014 with very strong recommendations for strengthening breastfeeding support and promotion.

Gap:

These important government efforts in improving infant and young child health in South Africa need to be supported by an increased budgetary allocation to nutrition including breastfeeding interventions. Priority nutrition interventions are not necessarily receiving dedicated budget.

Recommendations:

South African policies create a favourable environment for implementation of priority interventions. Although there is a favourable political environment, there are key facilitators, barriers and lessons that can be used to strengthen efforts around IYCF interventions. The need for reprioritization of resources including strengthening human resource capacity cannot be over emphasised.

Indicator 2: Baby Friendly Care and Baby-Friendly Hospital Initiative

Key questions:

- *What percentage of hospitals and maternity facilities that provide maternity services have been designated as "Baby Friendly" based on the global or national criteria?*
- *What is the quality of BFHI program implementation?*

Background:

The Joint WHO/UNICEF Statement: Protecting, promoting and supporting breastfeeding: the special role of maternity services, in 1989 called on the leadership of those working in maternity services to sustain or if necessary to re-establish a " breastfeeding culture". The Innocenti Declaration of 1990 calls on governements to ensure that all maternity services fully practice all ten of the Ten Steps to Successful Breastfeeding.

The ten steps to successful breastfeeding established there, became the cornerstone of the global Baby-friendly Hospital Initiave launched in 1992 by both agencies. Several countries initiated action on BFHI and progress made so far has been in numbers mostly and reports suggest that fall back happens if the skills of health workers are not sufficiently enhanced. The Global Strategy for Infant and Young Child Feeding indicates the need for implementation of BFHI, monitoring and reassment of already designated facilities (materials developed in 1998) and expanding the Initiative to include clinics, health centers and paediatric hospitals. The Global Criteria continue to be the minimum requirement for all baby-friendly facilities. The Global Criteria were revised in 2005, both to update them to take account of new evidence regarding best practices and to insure that the needs of non-breastfeeding mothers were fully met, as well as to provide new criteria for HIV and infant feeding and mother-friendly care, which could be included at the discretion of the national authority for BFHI.
The revised, updated and expanded for integrated care material published in 2009 is the comprehensive document to guide the implementation, monitoring and reassessment. It contains a training course of 20 hours for all health workers and a special programme for countries with a prevalence of 20% of HIV positive mothers and/or a Prevention of Mother-to-Child Transmission (PMTCT) programme. The 2009 BFHI material includes specific new modules for the support of non-breastfeeding mothers and for mother-friendly care and recommendation for baby-friendly expansion up to complementary feeding. The focus on compliance with the International Code is reinforced. The questionnaire will focus on quantitative and qualitative aspects both. It looks at the percentages of hospitals and maternity facilities designated as BFHI; how it is monitored and evaluated and the expansion of the programme. Below is the ten steps to successful breastfeeding

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

Guidelines – Quantitative Criteria

2.1) 403 out of a total 545 public health facilities and 5 private hospitals (both public & private)and maternity facilities offering maternity services have been designated or reassessed as "Baby Friendly" in the last 5 years. :74 %

Criteria	√ **Check only one which is applicable**	
0	**0**	
0.1 - 20%	1	
20.1 - 49%	2	
49.1 - 69%	3	
69.1-89 %	4	4
89.1 - 100%	5	
Total rating for 2.1		**4**

Guidelines – Qualitative Criteria

Quality of BFHI programme implementation:

Guidelines for scoring		
Criteria	√ **Check that apply**	
2.2) BFHI programme relies on training of health workers using at least 20 hours training programme[5]	1.0	1
2.3) A standard monitoring[6] system is in place	0.5	0.5
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities	0.5	0.5
2.5) An assessment system relies on interviews of mothers.	0.5	0.5
2.6) Reassessment[7] systems have been incorporated in national plans with a time bound implementation	1.0	0
2.7) There is a time-bound program to increase the number of BFHI institutions in the country	0.5	0.5
2.8) HIV is integrated in to BFHI programme	0.5	0.5
2.9) National criteria are fully implementing Global BFHI criteria (See Annex 3)	0.5	0.5
Total Rating 2.2 – 2.9)		**4.0**

[5] IYCF training programmes such as IBFAN Asia's '4 in1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc; breastfeeding Promotion and Support in a Baby Friendly Hospital – A 20 hour course for maternity staff may be used.

[6] ***Monitoring*** is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps* to assist with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an ongoing basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

[7] ***Reassessment*** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *Ten Steps* and other babyfriendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the *Global Criteria* and includes a reassessment visit by an outside team.Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

Total Rating (2.1 – 2.9)		8.0

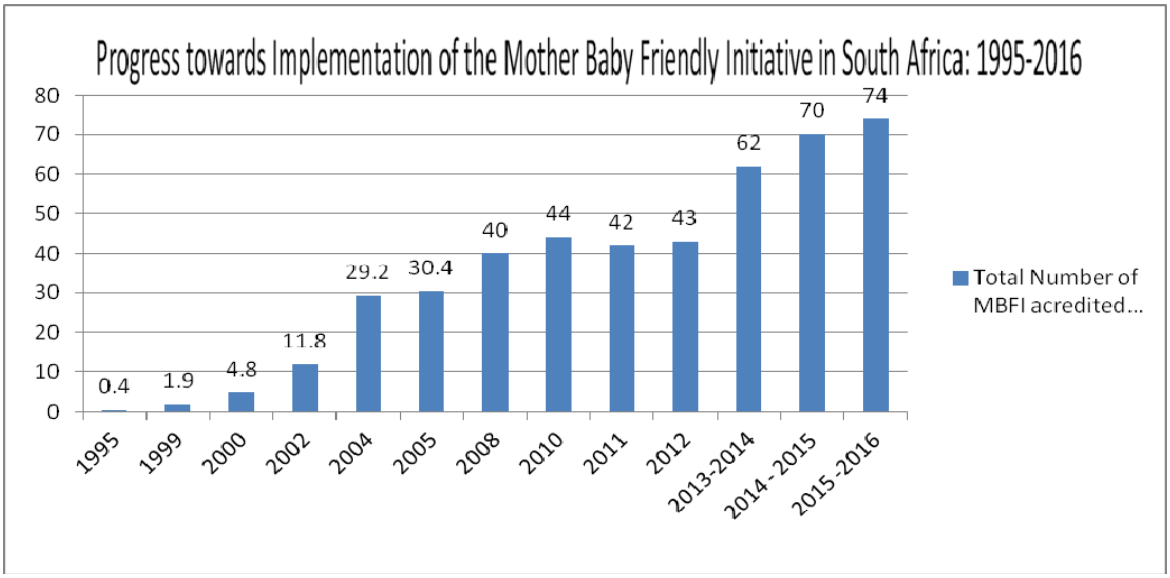
Information Sources Used:

1. Review of the implementation of the Baby Friendly Hospital Initiative in Public Maternity Units in South Africa 2008
2. Department of Health, South Africa. Strategic plan for maternal, newborn, child and women's health (MNCWH) and nutrition in South Africa, 2012-2016. Pretoria: 2012
3. UNICEF/WHO MBFI Section 5: Hospital External Assessment/ Reassessement and self Appraisal Tools revised & adapted - SA context
4. The BFHI Strategy, not revised.

Conclusion:

South Africa has made significant progress since 1994 in the implementation of BFHI strategy now known as the mother-baby-friendly initiative (MBFI). To date South Africa has accreditated 74 percent of its public health facilities as mother and baby friendly. A number of documents have been revised to align with the policy change following the Tshwane Declaration (2011). The following documents have been revised but not yet published: The Breastfeeding course Tool Kit consisiting of the Health Care provider course to protect, promote and support exclusive breastfeeding. This replaces the WHO 20hour intergrated training. The tool kit includes the participants manual and facilitators manual. South Africa also adapted the UNICEF/WHO BFHI Section 5: Hospital External Assessment/ Reassessement and self Appraisal Tools to align with a South African context.

Table1: MBFI Progress:



Gaps:

Although there has been significant progress in the implementation of the MBFI, in 2012 a decision was taken that external reassessments become a Provincial responsibility in order to increase the number of MBFI facilities with the aim to reach a target of accrediting 100% facilities by 2015.

There is a weak link in breastfeeding support beyond facility level to community in order to improve breastfeeding rates.

Recommendations:
A continuous monitoring system should be sustained in order to ensure optimal implementation of the MBFI.There is need to strengthen post natal support through estrablishing a mother/ care giver tracking system that will link the mother to a community health worker or caregiver throughout the critical stages of the infant and young child development / first 1000days.

Indicator 3: Implementation of the International Code of Marketing of Breastmilk Substitutes

Key question: *Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolution are in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*

Background:

The "Innocenti Declaration" calls for all governments to take action to implement all the articles of the International Code of Marketing of Breastmilk Substitutes and the subsequent World Health Assembly resolutions. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The "State of the Code by Country" by the ICDC on countries' progress in implementing the Code provides sufficient information on the action taken.

Nations are supposed to enact legislations as a follow-up to the International Code. Several relevant subsequent World Health Assembly resolutions, which strengthen the International Code have been adopted since then and have the same status as the Code and should also be considered. The Global Strategy for infant and young child feeding calls for heightened action on this target. According to WHO 162 out of 191 Member States have taken action to give effect to it but the ICDC's report brings out the fact that only 32 countries have so far brought national legislations that fully covers the Code.

A report by WHO (2013) "Country implementation of the international code of marketing of breastmilk substitutes: status report 2011' has also highlighted dismal status of the global implementation of the International Code.
http://apps.who.int/iris/bitstream/10665/85621/1/9789241505987_eng.pdf

The Code has been reaffirmed by the World Health Assembly several times while undertaking resolutions regarding various issues related with infant and young child nutrition.

Guidelines for scoring		
Criteria (*Legal Measures that are in Place in the Country***)**	**√ Check that apply**	
3a: Status of the International Code of Marketing √ (*Check that apply.If more than one is applicable, record the highest score.)*		
3.1 No action taken	0	
3.2 The best approach is being considered	0.5	
3.3 National Measures awaiting approval (for not more than three years)	1	
3.4 Few Code provisions as voluntary measure	1.5	
3.5 All Code provisions as a voluntary measure	2	
3.6 Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	3	
3.7 Some articles of the Code as law	4	
3.8 All articles of the Code as law	5	

3.9 Relevant provisions of WHA resolutions subsequent to the Code are included in the national legislation[8] a) Provisions based on at least 2 of the WHA resolutions as listed below are included b) Provisions based on all 4 of the WHA resolutions as listed below are included	 5.5 6	 **6**
3b: Implementation of the Code/National legislation		
3.10 The measure/law provides for a monitoring system	1	0
3.11 The measure provides for penalties and fines to be imposed to violators	1	1
3.12The compliance with the measure is monitored and violations reported to concerned agencies	1	0
3.13 Violators of the law have been sanctioned during the last three years	1	0
Total Score (3a + 3b)	**_7_/10**	

Information Sources Used (please list):

1. Guidelines to industry and health care personnel: the regulations relating to foodstuffs for infants and young children, R. *991 of 6 december 2012 ("regulations")*
2. Regulations relating to Food stuffs for infatns and young Children.. *R. 991 of 6 december 2012 gazetted on 6th December 2012.*
3. *National Policy on Infant Feeding Practices (2013)*

Conclusions:

Regulation 991, which governs the Code of Marketing of Breastmilk Substitutes and other foodstuffs for infants and young children, was legislated in December 2012. Phased implementation of these Regulations over a three-year period, culminated in their full implementation in 2015.

Gaps:

The impact of this legislation on infant food manufactures' compliance and on breastfeeding practices in South Africa is not regularly assessed. There is no monitoring system in place, however the Department receives complaints from members of the public and from companies but no sanctions have been implemented.

Recommendations:

There is need to set up a database for tracking and reporting industry compliance. The impact of the legistation on breastfeeding practices need to be assessed.

[8] Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.
1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32)
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

Indicator 4: Maternity Protection

Key question: Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?

Background:

The Innocenti Declarations (1999, 2005) and WHO Global Strategy for IYCF (2002) call for

provision of imaginative legislation to protect the breastfeeding rights of working women and further monitoring of its application consistent with ILO Maternity Protection Convention No 183, 2000 and Recommendation 191. The ILO's Maternity Protection Convention (MPC) 183 specifies that women workers should receive:

- Health protection, job protection and non-discrimination for pregnant and breastfeeding workers
- At least 14 weeks of paid maternity leave
- One or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed

Furthermore, Recommendation 191 encourages facilities for breastfeeding to be set up at or near the workplace.

The concept of maternity protection involves 7 aspects: 1) the scope (in terms of who is covered); 2) leave (length; when it is taken, before or after giving birth; compulsory leave); the amount of paid leave and by whom it is paid – employer or government; 3) cash and medical benefits; 4) breastfeeding breaks; 5) breastfeeding facilities; 6) health protection for the pregnant and lactating woman and her baby; 7) employment protection and non-discrimination.

Only a limited number of countries have ratified C183, but quite a few countries have ratified C103 and/or have national legislation and practices which are stronger than the provisions of any of the ILO Conventions. Maternity protection for all women implies that women working in the informal economy should also be protected. Innocenti Declaration 2005 calls for urgent attention to the special needs of women in the non-formal sector. Adequate maternity protection also recognizes the father's role in nurturing and thus the need for paternity leave.

Guidelines for scoring		
Criteria	**√ Tick one which is applicable**	
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave a) Any leave less than 14 weeks b) 14 to 17weeks c) 18 to 25 weeks d) 26 weeks or more	0.5 1 1.5 2	1
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. a) Unpaid break b) Paid break	0.5 1	1
4.3) Legislation obliges private sector employers of women in the country to	1	0

give at least 14 weeks paid maternity leave and paid nursing breaks.		
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. *(more than one may be applicable)* a) Space for Breastfeeding/Breastmilk expression b) Crèche	1 0.5	1 0
4.5) Women in informal/unorganized and agriculture sector are: a) accorded some protective measures b) accorded the same protection as women working in the formal sector	0.5 1	0 0
4.6) . *(more than one may be applicable)* a) Information about maternity protection laws, regulations, or policies is made available to workers. b) There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	0.5 0.5	0 0
4.7) Paternity leave is granted in public sector for at least 3 days.	0.5	0.5
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5	0
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5	0.5
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	1	1
Total Score:	**5_/10**	

Information Sources Used (please list):

1. Employment Rights Act 2008 as amended 2013;
2. National Remuneration Board; and
3. Pay Research Bureau report 2008.
4. The Basic Conditions of Employment Act 1997 under the Code of Good Practice on the Protection of Employees during pregnancy and after the birth of a child..

Conclusion :

The legislation on maternity leave covers public sectors employees. Some private sector employers offer maternity benefits for their workers although they are not required by law to remunerate them.

Gaps:

South Africa has a high rate of teenage pregnancies and the basic conditions of employment Act does not cover these young mothers. The ILO Convention 183 (2000) and the recommendations 191 (2000) cover all women workers as well as those in the informal sector. The current legistation does not cover women in the private sector and those in the informal sector.

Recommendations:

There is need to establish partnerships with relevant actors to strengthen advocacy around maternity protection to cover workers in the informal and the private sectors. There is also need to strengthen awareness within the formal sector on relevant information that should be promoted within the formal sector to empower women on their maternity rights. The informal[i]

Indicator 5: Health and Nutrition Care Systems

Key question: *Do care providers in these systems undergo* skills training, *and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place*? (*See Annex 5*)

Background:

It has been documented that many of the health and nutrition workers lack adequate skills in counseling for infant and young child feeding which is essential for the success of breastfeeding.

Ideally, new graduates of health provider programmes should be able to support optimal infant and young child feeding practices from the outset of their careers. All providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate breastfeeding counseling, lactation management, and infant and young child feeding into their care. The topics can be integrated at various levels during education and employment.

Guidelines for scoring			
	Scoring (√*Check that apply)*		
Criteria	Adequate	Inadequate	No Reference
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country[9] indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1	0
		1	
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. *(See Annex 6 Example of criteria for mother-friendly care)*	2	1	0
	2		
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.[10]	2	1	0
	2		
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
		0.5	
5.5) Infant feeding and young feeding information and skills are integrated, as appropriate, into training programmes	1	0.5	0

9 Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

10 The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)		**0.5**	
5.6) In-service training programmes referenced in 7 are being provided throughout the country.[11]	1	0.5	0
		0.5	
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	0.5	0
	1		
Total Score:	**7.5/10**		

Information Sources Used:

1. Mother Baby Friendly Intitiative reports: (annual reports)
2. CARRMA stratergy encourages Mother lodger facilities (2012)
3. The draft Breastfeeding Training Package for South Africa, replacing the WHO/UNICEF 20 hour manual- training package still for formal approval, training package included the participants manual, facilitators manual and the health care provider manual and training slides. (2014)

Conclusions:

A lot of effort has been put into capacity building through in- service training. Training materials have been adapted into the South African context in order to align them with current national policies and global intiatives. These training materials were developed to facilitate ownership by provinces to conduct their own training and move away from dependency on development partners. Trainers of-trainers were trained in order to facilite in-house trainings to best suit the facilitys' particular circumstances..eg modules, self-study and online studies for future consideration.

Gaps:

Incoperating training into pre-service is still a gap. Although a number of provinces are incorporating IYCF into pre-service training for health workers, eg doctors, this is not nation wide and advocacy efforts are required in order to strengthen this component.

Recommendations:

There is need to advocate and negotiate for the inclusion of IYCF training package into pre-service curriculum of nursing colleges, school of health sciences and public health.

11 Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

Indicator 6: Mother Support and Community Outreach

Key question: Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding (See Annex 8)

Background:

Community-based support for women is essential for succeeding in optimal breastfeeding practices.

Step 10 of BFHI as well as the Global Strategy for IYCF, which includes mother support and peer support, recognizes this need. Mother Support, as defined by the Global Initiative for Mother Support (GIMS) is "any support provided to mothers for the purpose of improving breastfeeding practices for both mother and infant & young child".

Women need the support of evidence-based public health policies, health providers, employers, friends, family, the community, and particularly of other women and mothers in regards to preparation for breastfeeding which can come during the pregnancy and postpartum and after delivery. Reaching community level to give appropriate support, community volunteers or health workers under the health systems can offer and ensure sustained support to mothers. Their knowledge and skills have to be at the highest quality and they must have required training for giving support. It is necessary to have appropriate counseling in the community for motivation and increasing confidence in breastfeeding and home based complementary feeding. The support to mothers can be provided at the door steps by the women's groups sometimes they are the mother support group (MSG) who are composed of some successful mothers and others of the same community. Mother support group is a core component of empowerment of the women. With correct knowledge at community and outreach level, mothers can help themselves by giving exclusive breastfeeding up to six months and continue for two years or beyond and start home base appropriate complementary food by themselves when services and counselling are available by mother support groups and or health worker serving under the health services. Community centers run by women and children ministry can help in caring babies when mothers are at work.

Other important area is to consider the people living in remote areas where services are difficult to provide and receive. Support by peers in community and mothers support groups have shown raising Exclusive breastfeeding rates and appropriate Complementary feeding rates even in large scale intervention. The quality of interaction and counseling are critical issues. Community counselling and services on IYCF are to be focused to new mothers, and various vulnerable groups.

There is also need to provide adequate information to improve maternal nutrition without which IYCF action by mothers may be suboptimal as the mother is incapable to produce good quality milk and prepare and feed CF appropriately. Mother support is often seen as woman to woman (or more commonly known as mother-to-mother) but generally covers providing accurate and timely information to help a woman to build confidence; providing sound recommendations based on up-to-date research; providing compassionate care before, during and after childbirth; practicing empathy and active listening, providing hands-on assistance and practical guidance. It also includes support and counseling by health professionals and health care workers. Various community outreach services can also support women in optimal IYCF.

The activities in these contexts include woman-to-woman support, individual or group counseling, home visits or other locally relevant support measures and activities that ensure woman have access to adequate, supportive and respectful information, assistance and counseling services on infant and young child feeding. Mother support enhanced by community outreach or community-based support has been found to be useful in all settings to ensure exclusive breastfeeding for the first six months and continued breastfeeding with appropriate and local complementary foods for 2 years or more.

There needs to be a review and evaluation of existing community support systems, especially for the provision of counseling in infant and young child feeding. Women who deliver in a hospital need continued support in the home and in the community, with support for all members of the family, including the father and grandmother of the baby.

Guidelines for scoring			
Criteria	**Scoring** (√ *Check that apply)*		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based ante-natal and post -natal support systems with counseling services on infant and young child feeding.	2	1	0
		1	
6.2) All women recieve support for infant and young child feeding at birth for breastfeeding initiation.	2	1	0
		1	
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	2	1	0
		1	
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.	2	1	0
	2		
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	2	1	0
		1	
Total Score:	**_6_/10**		

Information Sources Used:

Infant and Young Child Feeding Policy (2013)

Breastfeeing training package(2014)

Conclusion: On-going support counseling for breastfeeding mothers and pregmanbt women is an area that still requires strenghtening. Some areas have achieved strong support for mothers through Mothers-to-mothers support and community health workers who were paid a stipend with assistance from development partners. This has proved to be unsustainable when the external support was no longer there.

Gap: Breastfeeding support at community level is still a gap in many provinces. Some of the established support groups are no longer functional.

Recommendations:

There is a need to strengthen support to community health workers by investing in a proper model that will attract and retain them with sufficient funding including compensation for their time and necessary resources to enable them to function e.g job aids, continuous capacity building and formalized reporting structures for accountability.

The model should allow community health workers to support the breastfeeding mothers/pregnant women throughout the continuum of care.

Indicator 7: Information Support

Key question: Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?(See: Annex 9)

Background:

Women and carers having the right to appropriate and objective support and information, education and communication (IEC) strategies are important aspects of a comprehensive programme to improve infant and young child feeding practices.

However, because such programmes are expensive and often take place within a commercial context, they tend to attract inappropriate funding, for example, from the baby feeding industry. This can undermine the effectiveness of any campaign and lead to unwise decision making.

The first crucial step in an information strategy should be to ensure that baby feeding industry influence of such messaging is kept to an absolute minimum. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counseling cards, flip charts, manuals, newspapers, magazines), interpersonal (counseling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community.

Information strategies are more likely to lead to positive behavior change if they are supported by counseling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. IEC strategies are comprehensive when they ensure that all information channels convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels.

Guidelines for scoring			
Criteria	**Scoring (√*Check that apply)***		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts or interest are avoided.	2	0	0
		0	
7.2a) National health/nutrition systems include individual counseling on infant and young child feeding	1	.5	0
	1		
7.2b) National health/nutrition systems include group education and counseling services on infant and young child feeding	1	.5	0
	1		
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
	2		
7.4. IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	2	1	0
	2		
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF).[12]	2	0	0
	2		√
Total Score:	**8/10**		

Information Sources Used:

1. The Mother and child health and nutrition booklet (2013), pamphlets for breastfeeding support for working mothers, pamphlets on feeding beyond six months and many more are developed at provincial and district and facility levels.
2. Breastfeeding Question and Answer Booklet.(2012)
3. MomConnect Programme (2014)

Conclusion:

MBFI requires that materilals are developed and handed out to pregnant women, and mothers following ante-natal and post-natal education and support where possible. A few of materials were developed at national level due to funding constraints. Various materials (pamphlets, posters, dramas, public service announcements for radio) are also developed at provincial and district and facility levels.

[12] to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;

Materials are evaluated for content and compliance to the Code of marketing of breastmilk substitutes and the regulations R991.

Gaps:

While substantial packages of materials are available for breastfeeding mothers and pregnant women, South Africa does not have a formal IEC strategy on IYCF. IEC materials are not standardized at national level.

Recommendations :

South Africa needs to develop a formal IEC strategy that will guide the development of all IEC materials on IYCF/nutrition. This need has been recognized in the in the draft plan for breastfeeding promotion protection and support.

Indicator 8: Infant Feeding and HIV

Key question: Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice? *(See Annex 10)*

Background:

The HIV and infant feeding 2010: an updated framework for priority action12 has suggested following activities to achieve HIV free survival for children.

- Develop or revise (as appropriate) a comprehensive evidence-based national infant and young child feeding policy which includes HIV and infant feeding
- Promote and support appropriate infant and young child feeding practices, taking advantage of the opportunity of implementing the revised guidelines on HIV and infant feeding
- Provide adequate support to HIV-positive women to enable them to successfully carry out the recommended infant feeding practice, including ensuring access to antiretroviral treatment or prophylaxis
- Develop and implement a communication strategy to promote appropriate feeding practices aimed at decision-makers, health workers, civil society, community workers, mothers and their families
- Implement and enforce the International Code Marketing of Breastmilk substitutes and subsequent WHA resolutions

Guidelines for scoring			
Criteria	**Results (**√*Check that apply)*		
	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV	2	1	0
	2		
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation	1	0.5	0
	1		
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
		0.5	
8.4) HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
	1		
8.5) Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV positive mothers.	1	0.5	0
	1		
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	1	0.5	0
		0.5	
8.7) HIV positive breastfeeding mothers, who are supported through	1	0.5	0

provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.		**0.5**	
8.8) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
		0.5	
8.9) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5	0
	1		
Total Score:	**8/10**		

Information Sources Used:

1. National Consolidated Guidelines: for the prevention of mother to child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults; DOH 2015.
2. IYCF policy 2013
3. MBFI revised and adapted Assessments, reassessments and self appraisal tools , SA context 2014

Conclusion:

From a policy point of view South Africa has developed very sound guidelines. Following the 2011 Tshwane Declaration South Africa took a policy decision to withdraw the issuing of free infant formula to HIV positive mothers and this had an immediate impact as the PMTCT review has shown increased exclusive breastfeeding rates amongst mothers on the PMTCT programme.

Gap: There is still a challenge in terms of strengthening counselling and support for breastfeeding mothers who are HIV positive. All health workers need to have a full buy- in supporting mothers with the correct counseling messages according to the official policy..

Recommendations

There is a need for strong advocacy and on-going in-service updates on information on HIV and AIDS including new evidence to ensure health workers are conversant and can disseminate the information to empower mothers.

Indicator 9: Infant and Young Child Feeding during Emergencies

Key question: *Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies?* (See Annex 11)

Background:

Infants and young children are among the most vulnerable groups in emergencies. Absence of or inadequate breastfeeding and inappropriate complementary feeding increase the risks of undernutrition , illness and mortality. In emergency and humanitarian relief situations the emergency-affected host country and responding agencies share the responsibility for protecting, promoting and supporting optimal infant and young child feeding practices and minimizing harmful practices. Concise Operational guidance on how to ensure appropriate feeding in emergency

situations and comply with international emergency standards has been developed by an interagency Infant Feeding in Emergencies Core Group and was adopted at WHA 63.23 in 2010 (Infant and Young Child Feeding in Emergencies. Operational Guidance for emergency and relief staff and program managers, version 2.1, 2007, IFE Core group http://www.ennonline.net/resources/6). Practical details on how to implement the guidance summarized in the Operational Guidance are included in companion training materials, also developed through interagency collaboration as well as part of the UN Nutrition Cluster capacity building materials. All these resources are available at www.ennonline.net/IFE

Guidelines for scoring			
Criteria	**Scoring (√Check that apply)**		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
	2		
9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
			0
9.3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers: a) basic and technical interventions to create an enabling environement for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding	1	0.5	0
			0
b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsollicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	0.5	0
			0

9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
	2		
9.5) a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel. b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
			0
	1	0.5	0
			0
Total Score:	**4/10**		

Information Sources Used:

1. Act No. 16 of 2015: Disaster Management Amendment Act, 2015,
2. City of Tshwane D isaster Management Plan (Updated) Level 1, Disaster Management Centre, 2011

Conclusions:

While South Africa has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance, the country also a Disaster Management Act (2002) which was amended in 2015 and is managed by the National Disaster Management Centre (NDMC). The NDMC is housed in the Ministry of Cooperative Governance & Traditional Affairs**.** The Act provides for an integrated multisectoral and multidisciplinary process of planning and implementation of measures aimed at disaster prevention, mitigation, emergency preparedness, rapid and effective response, post disaster recovery and rehabilitation. It also provides for the the establishment and functioning of national, provincial and municipal disaster management centres. An Intergovernmental Committee on Disaster Management (ICDM) comprising all government ministries including that of Health was established.
are represented on the
Gap: IYCF Programme in the Department of Health does not seem to be linked to the national disaster manangement process at national or at sub-national levels.

Recommendations:

The Nutrition/MCH Directorates need to engage in advocacy efforts with disaster management structures at various levels in order to ensure that the basic elements of IYCF in emergencies are included in the disaster management plans.

Indicator 10: Mechanisms of Monitoring and Evaluation System

Key question: Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices? (Annex 12)

Background:

Monitoring and evaluation (M & E) components should be built into all major infant and young child feeding programme activities and collection of data concerning feeding practices integrated into national nutritional surveillance and health monitoring systems or surveys. Periodic monitoring or management information system data should be collected systematically, analysed and considered by programme managers as part of the planning, management and implementation process. When appropriate, both baseline and follow-up data should be collected to measure outcomes.

Unified criteria on the use of internationally agreed-upon indicators and data collection strategies should be considered, in an effort to increase availability of comparable data. It is important to devise strategies to assure that results of important evaluation are used to assure evidence-based decision making.

Guidelines for scoring			
Criteria	**Scoring (√Check that apply)**		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	*2*	*1*	*0*
	2		
10.2) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions	*2*	*1*	*0*
	2		
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels	*2*	*1*	*0*
	2		
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers	*2*	*1*	*0*
	2		
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	*2*	*1*	*0*
	2		
Total Score:	**10/10**		

Information Sources Used:

1. The MNCWH dashboard reports (2015/6)
2. Demographic Health Survey: (2008)
3. SANHANES report 2012
4. District Health Information System (2015/16)

Conclusion:

Survey and routine data on IYCF is used to inform planning for IYCF interventions. South Africa has well established mechanisms for monitoring and evaluating not only nutrition but other health intervention programmes.

Gaps:

There is no comprehensive routine data on key IYCF indicators.eg exclusive breastfeeding, mixed feeding, continuous breastfeeding and predominant breastfeeding rates. Such data ia mainly collected during surverys. Routine data exclusive breastfeeding is at 14 weeks and not 6 months. There is also a dearth of information on complemetatrry feeding.

Recommendations:

Data collection system of IYCF needs to be strengthened to include all key indicators.

Part II: Infant and Young Child Feeding Practices

In Part II comprises of specific numerical data on each infant and young child feeding practice. The assessors used data from national wide surveys where available[13]. The data thus collected was entered into the report template. The achievement on a particular target indicator was then rated i.e. **Red, Yellow, Blue and Green.** The cut off points for each of these levels of achievement were selected systematically, based on an analysis of past achievements on these indicators in developing countries. These are incorporated from the WHO's tool.

Definition of various quantitive indicators have been taken from " WHO's Indicators for assessing infant and young child feeding practices - 2008" Available at: http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/ (Annex 12)

13 One source of data that is usually high in quality is the Demographic and Health Survey (DHS)(4) conducted in collaboration with Macro International and national research organizations, with support from USAID. If this source of data is used the data are likely to be comparable across countries. Other sources of data include UNICEF's Multiple Indicator Cluster Surveys (MICS) (5) and the WHO Global Data Bank on Breastfeeding (6). In some countries recent national surveys may have been conducted. It is important to assess the scope and quality of any data sources being considered for use.

Indicator 11: Early Initiation of Breastfeeding

Key question: *What is the percentage of babies breastfed within one hour of birth?*

Definition of the indicator: Proportion of children born in the last 24 months who were put to the breast within one hour of birth

Background: Early breastfeeding helps better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases chances of establishing exclusive breastfeeding early and its success. Evidence from trials has shown that early initiation of breastfeeding could reduce neonatal mortality by 22%.[14]

Guideline:

Indicator 11	*Key to rating adapted from WHO tool* **(see Annex 13)**		**IBFAN Asia Guideline for WBTi**	
Initiation of Breastfeeding (within 1 hour)			*Scores*	*Colour-rating*
	0.1-29%		3	**Red**
	29.1-49%		6	**Yellow**
	49.1-89%	80	9	**Blue**
	89.1-100%		10	**Green**

Data Source:

South African National Health and Nutrition Examination Survey (SANHANES **)** 2012.

Conclusion:

The 2003 SA Demographic Health Survey (SADHS) found 61% mothers initiated breastfeeding within an hour of birth compared with 45% in 1998. The 2012 South African National Health and Nutrition Examination Survey (SANHANES) found that more than 80% mothers initiated breastfeeding within one hour after birth suggesting that BFHI has been effective in increasing breastfeeding initiation rates. With 74% of public hospitals accredited under the MBFI, this figure is expected to be higher.

Recommendations:

An update of the survey results is recommended.

[14] Edmond KM, Zandoh C, Quigley MA et al. Delayed breastfeeding initiation increases risk of neonatal mortality. Pediatrics 2006; 117: 380-386

Indicator 12: Exclusive Breastfeeding

Key question: What is the percentage of babies 0<6 months of age exclusively breastfed[15] in the last 24 hours?

Definition of the indicator: Exclusive breastfeeding under 6 months: Proportion of infants 0–5 months of age who are fed exclusively with breast milk

Background

Exclusive breastfeeding for the first six months is very crucial for survival, growth and development of infant and young children. It lowers the risk of illness, particularly from diarrheal diseases. It also prolongs lactation amenorrhea in mothers who breastfeed frequently. WHO commissioned a systematic review of the published scientific literature about the optimum duration of exclusive breastfeeding and in March 2001, the findings were submitted for technical review and scrutiny during an Expert Consultation. This Expert Consultation recommended a change to "exclusive breastfeeding for 6 months from earlier recommendation of 4 months. The World Health Assembly (WHA) in May 2001 formally adopted this recommendation through a Resolution 54.2 /2001. The World Health Assembly in 2002 approved another resolution 55.25 that adopted the Global Strategy for Infant and Young Child Feeding. Later the UNICEF Executive Board also adopted this resolution and the Global Strategy for Infant and Young Child Feeding in September 2002, bringing a unique consensus on this health recommendation. An analysis published in Lancet[16] clearly points to the role of exclusive breastfeeding during first six months for Infant survival and development.

Guideline:

Indicator 12	*Key to rating adapted from WHO tool* **(see Annex 13)**		**IBFAN Asia Guideline for WBT*i***	
			Scores	*Colour-rating*
Exclusive Breastfeeding (for first 6 months)	0.1 - 11%	8	3	**Red**
	11.1 - 49%		6	**Yellow**
	49.1 - 89%		9	**Blue**
	89.1 - 100%		10	Green

Data Source:

South African National Health and Nutrition Examination Survey (SANHANES) 2012.

Conclusion:

The previous Government policy on IYCF in the context of HIV and AIDS where HIV positive mothers were given free infant formula, was attributed to reduced breastfeeding rates. After the Tshwane Declaration in 2011, this policy was changed and an immediate imopact was noted. Findings from the

[15] Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (2)

[16] Robert E Black, Saul S Morris, Jennifer Bryce. Where and why are 10 million children dying every year? THE LANCET 2003; 361 : 2226-34.

2012-2013 South African Prevention of Mother-to-Child Transmission of HIV Evaluation (SAPMTCTE)[17] revealed that infant feeding practices among HIV exposed infants by province indicated that exclusive breastfeeding at 4 to 8 weeks postpartum nationally increased from 20.4% in 2010 to 54.1% in 2012-2013 (8-day recall data).

The KwaZulu-Natal Initiative for Breastfeeding Support (KIBS) Baseline Survey 2016 found the rate of exclusive Breastfeeding in KwaZulu-Natal province is 45.1% at 14 weeks[18].
Nationally it is anticipated that with this change in policy, exclusive breastfeedingrates with increase substantially.

Indicator 13: Median Duration of Breastfeeding

Key question: Babies are breastfed for a median duration of how many months?

Background

The *"Innocenti Declaration"* and the Global Strategy for Infant and Young Child Feeding recommends that babies continue to be breastfed for two years of age or beyond along with adequate and appropriate complementary foods starting after six months of age. Breastmilk continues to be an important source of nutrition and fluids and immunological protection for the infant and the young child. The continued closeness between mother and child provided by breastfeeding helps in optimal development of the infant and young child.

Guideline:

Indicator 13	*Key to rating adapted from WHO tool* **(see Annex 13)**		**IBFAN Asia Guideline for WBT*i***	
			Scores	*Colour-rating*
Median Duration of Breastfeeding	0.1 - 18months	5.9 months	3	**Red**
	18.1 - 20months		6	Yellow
	20.1 – 22months		9	**Blue**
	22.1 – 24months or beyond		10	Green

Data Source:

South African National Health and Nutrition Examination Survey (SANHANES) 2012.

Conclusion:

The median duration of breastfeeding of 5.9 months falls far below the WHO recommended duration of 24months or beyond.

[17] Goga AE, Jackson DJ, Singh M, Lombard C for the SAPMTCTE study group. Early (4-8 weeks postpartum) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2012-2013. South African Medical Research Council and National Department of Health of South Africa, 2015.
[18] KwaZulu-Natal Department of Health, KwaZulu-Natal Initiative for Breastfeeding Support (KIBS) Baseline Survey Report March 2006

This result is cause for concern and more effort in terms of understanding the reasons for this early cessation of breastfeeding may provide solutions on how to increase this rate. The problem of teenage pregnancies has been cited as a possible reason for this low figure as well as the need to return to work for most mothers.

Indicator 14: Bottle feeding

Key question: *What percentage of breastfed babies less than 6 months old receives other foods or drinks from bottles?*

Definition of the indicator: *Proportion of children 0–23 months of age who are fed with a bottle*

Background

Babies should be breastfed exclusively for the first six months of age and they need not be given any other fluids, fresh or tinned milk formula as this would cause more harm to babies and replace precious breastmilk. Similarly after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from his/her mother's breast, s/he should be fed with a cup (if unable to swallow, breastmilk can be given by means of an infant feeding tube). Information on bottle feeding is useful because of the potential interference of bottle feeding with optimal breastfeeding practices and the association between bottle feeding and increased diarrhoeal disease morbidity and mortality. Bottles with a nipple are particularly prone to contamination.

Guideline:

Indicator 14	*Key to rating adapted from WHO tool* **(see Annex 13)**		**IBFAN Asia Guideline for WBTi**	
			Scores	**Colour-rating**
Bottle Feeding (<6 months)	29.1 - 100%	62.1	3	**Red**
	4.1 - 29%		6	**Yellow**
	2.1 - 4%		9	**Blue**
	0.1 - 2%		10	**Green**

Data Source: Low rates of Exclusive Breastfeeding are still evident in four South African) provinces: Siziba et.al (2015)

Conclusions:

In a study conducted by Siziba et.al (2015) in the four provinces (North West, Gauteng, Free State, and Eastern Cape), 56% of mothers used bottles to feed their infants.

Indicator 15: Complementary feeding

Key question: *Percentage of breastfed babies receiving complementary foods at 6-9 months of age?*

Definition of the indicator: *Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods*

Background

As babies grow continuously and need additional nutrition along with continued breastfeeding, after they are 6 months of age, complementary feeding should begin with locally available indigenous foods being affordable and sustainable. They should be offered soft or mashed foods in small quantities, 3-5 times a day. Complementary feeding should gradually increase in amount and frequency as the baby grows. Breastfeeding, on demand, should continue for 2 years or beyond. Complementary feeding is also important from the care point of view, the caregiver should continuously interact with the baby and take care of hygiene to keep it safe.

The indicator proposed here measures only whether complementary foods are provided in a timely manner, after 6 months of age along with breastfeeding. Complementary feeds should also be adequate, safe and appropriately fed, but indicators for these criteria were not included because data on these aspects of complementary feeding are not yet available in the country.

Guideline

Indicator 15	WHO's		IBFAN Asia Guideline for WBTi	
Complementary Feeding (6-9 months)	*Key to rating*		*Scores*	*Colour-rating*
	0.1-59%	30.7	3	**Red**
	59.1-79%		6	Yellow
	79.1-94%		9	**Blue**
	94.1-100%		10	Green

Data Source: South African National Health and Nutrition Examination Survey (SANHANES **)** 2012

Conclusion:

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 infant and young child years as well as in adulthood. Only 30.7 percent receive complementary foods at the right time.

Summary Part I: IYCF Policies and Programmes

Infant and young child feeding policies are a key factor for any successful implementation. This also encompasses programme coordination without which many IYCF programmes fail. The table below presence the situation in South Africa concerning policies and programmes.

Targets:	Score **(Out of 10)**
1. National Policy, Programme and Coordination	**8**
2. Baby Friendly Hospital Initiative	**8**
3. Implementation of the International Code	**7**
4. Maternity Protection	**5**
5. Health and Nutrition Care Systems	**7.5**
6. Mother Support and Community Outreach	**6**
7. Information Support	**8**
8. Infant Feeding and HIV	**8**
9. Infant Feeding during Emergencies	**4**
10. Monitoring and Evaluation	**10**
Total out of 100	**71.5/100**

The country scored **71.5** out of 100 on infant and young child feeding policies and programmes (indicators 1-10) which falls under the **BLUE** color coding as indicated in Table 2 based on the IBFAN Asia Guidelines for WBT*i*

Table 2: Total score of are calculated out of 100

Rating	**Scores**	**Colour- rating**
0 – 30.9		**Red**
31 – 60.9		**Yellow**
61 – 90.9 **(71.5)**	**71.5**	**Blue**
91 – 100		**Green**

Conclusions:

Recommendation:

Summary Part II: Infant and young child feeding (IYCF) practices

WHO has set 8 outcome indicators to guide countries on monitoring the impact of their IYCF programmes. These indicators normally form part of national surveys like the Nutrition survey, Demographic Health surveys and Multiple Indicator Cluster Surveys. The table below presence the indicators that have been tracked in South Africa and the gaps thereof.

IYCF Practice	Result	Score
Indicator 11 Starting Breastfeeding (Initiation)	9	
Indicator 12 Exclusive Breastfeeding for first 6 months	3	
Indicator 13 Median duration of Breastfeeding	3	
Indicator 14 Bottle-feeding	3	
Indicator 15 Complementary Feeding	3	
Score Part II (Total)	21	**21 out of 50**

NA – Not available

The country scored **21** out of **50** on the infant and young child feeding Practice (indicators 11-15) based on the IBFAN Asia Guidelines for WBT*i which falls under the red color coding as indicated in Table 3.*

Table 3: Total score of IYCF practices calculated out of 50

Rating	Scores	Colour-rating
0 – 15		Red
16 – 30	**21**	Yellow
31 – 45		Blue
46 – 50		Green

Conclusions

KEY Overall Recommendations:

Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes

Total score of infant and young child feeding **practices, policies and programmes (indicators 1-15)** are calculated out of 150. Based on this scoring, Sotuh Africa was scored at **92.5** out of the **150** placing it in the **BLUE** color coding as shown in Table 4.

Table 4: Total score of IYCF Practices, Policies and Programmes calculated out of 150

Rating	Scores	Colour- rating
0 – 45.5		Red
46 – 90.5		Yellow
91 – 135.5	**92.5**	Blue
136 – 150		Green

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