# Infant and young child feeding in South Africa: stop the crying, beloved country

Nutrition during the first 1 000 days of life, i.e. from pregnancy to a child's second birthday, has been shown to present a golden opportunity for nutrition interventions.[1-3] Therefore, it is critical to improve feeding and care practices during this period to enhance children's growth, nutritional status, health and development.[1,3]

A global public health recommendation[4] explicitly states that infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods, while breastfeeding continues for up to two years of age and beyond.[4]

This recommendation has been widely advocated and cited, and in spite of the fact that increasingly consistent evidence has emerged to support it,[5-9] available global trend data indicate very slow advancement in improving overall exclusive breastfeeding rates (33-38%) over the last decade in 86 developing countries.[10] However, countries which have shown strong commitment (willingness) to improving infant and young child feeding, with particular reference to exclusive breastfeeding, have made significant progress, (> 20% increase on average in 20 countries).[10]

One example of a country that has demonstrated commitment to act on issues pertaining to child health is Brazil. It has reached Millennium Development Goal 4 three years ahead of 2015 by focusing on primary care and by incorporating infant and young child feeding into this package of care.[11] At the World Public Health Nutrition Congress in Rio de Janeiro, in April 2012, the Brazilian Breastfeeding Network and the National Strategy for Healthy Complementary Feeding launched an integrated network *("Amamento e Alimenta")* in order to further enhance current strategies.[11]

In the development of a global scaling-up model for evidence-based breastfeeding promotion, Pérez-Escamilla et al stipulated that evidence-based advocacy is the basis for generating the political drive needed to pass legislation and policies to protect, promote and support breastfeeding at hospital and community level. [12] This political-policy alignment is seen as critical for the creation of resources needed to support workforce development and programme delivery.[12]

The South African National Department of Health, Directorate: Nutrition has pledged its commitment to address the dismal state of infant and young child feeding in our country at the highest level of governance. The Tshwane Declaration for the Support of Breastfeeding in South Africa was announced at a national breastfeeding summit held in August 2011.[13] This declaration incorporated the decision that free formula milk will no longer be issued at public health facilities, unless authorised by a qualified health professional. It adopted the 2010 World Health Organization human immunodeficiency virus (HIV) and infant-feeding guidelines, specifying that all HIV-infected mothers should breastfeed their infants and receive antiretroviral drugs. It also stated that national regulations on the International Code of Marketing of Breast-milk Substitutes should be finalised and adopted into legislation within 12 months from the meeting date.[13] Subsequently, a year later, the regulations relating to the labelling and advertising of foodstuffs for infants and young children were gazetted in December 2012.[14] This document included legislation of the Code of Marketing of Breast-milk Substitutes in South Africa. Currently, the infant and young child feeding policy (2008) is also being updated to reflect the decisions stipulated in the Declaration.

This progress is commendable and the momentum should be maintained. The commitment and capacity that has been built and pledged at national level should now be filtered down to provincial and district level to address the many barriers which still hamper the progress regarding improved infant and young child feeding.[13]

There are multiple influences at different levels in a mother's environment which can either support or hinder her ability and efforts to optimally feed her children. Those implicated include family, community, employers, business, media, hospitals and health services, and the state authority or local government, as a result of policy changes.[15] Healthcare workers are the crucial link between policy and practice.[16] In the featured article by Kassier and Veldman, *Cry the beloved bottle: infant-feeding knowledge and the practices of mothers and caregivers in an urban township outside Bloemfontein, Free State province,*[17]one of the study findings stated that clinic staff members were a major source of infant-feeding information. Various other research studies that have been conducted in South Africa support these findings. In two independent studies carried out in the Mpumalanga province,[18,19] as well as at study sites in the Western Cape, Eastern Cape and KwaZulu-Natal,[20] it was found that most mothers made their decisions regarding infant-feeding choices based on the information that the healthcare workers provided. Since the attitudes, personal preferences, knowledge and resources available to healthcare workers impacted on the decisions made by mothers, the authors concluded that particular attention should be paid to appropriate training of healthcare workers.[18,19]

It has been shown that breastfeeding counselling that is delivered by trained health professionals[21] and community health workers is an effective intervention to improve exclusive breastfeeding rates.[22] In the example from Brazil, the health authority informed 34 000 healthcare professionals in Brazil about the new country strategies for infant and young child feeding, and addressed some of the resistance and barriers to this new focus by working in teams, training in-house, using CPD activities, investing in peer education and enhancing interdisciplinary co-operation. They subsequently trained 4 000 tutors in local epidemiological problems, infant and young child feeding and nutrition, reflective practice and communication skills. In general, this major achievement was ascribed to pooled resources, team work and collective efforts (personal communication with

Jaime P, nutritionist, Brazilian Ministry of Health, at the World Public Health Nutrition Congress in Rio de Janeiro, in 2012).

There has also been recent progress in this regard in South Africa. The KwaZulu-Natal province has taken the lead on the challenge of training and re-training healthcare workers in infant and young child feeding.[23] A further example is the Western Cape where a breastfeeding restoration plan has recently been released in an effort to facilitate the realisation of the Tshwane Declaration.[24] Similar efforts should be intensified in all provinces as a matter of urgency.

The featured article also rightly points out that bottle-feeding does not provide a safe alternative to breastfeeding, mainly because of poor caregiver knowledge and education, as well as lack of resources that result in poor hygiene and suboptimal infant and young child feeding practices.[17] These are known facts in South Africa and it is regrettable that so far, faster progress has not been achieved. Factors that could influence a mother's decision to formula feed have been documented as a lack of breastfeeding knowledge and experience, as well as a perceived insufficiency of breastmilk.[19,25, 26] There is also a lack of family and community support for breastfeeding,[13,27, 28] a situation that has led to many mothers opting to formula feed, despite the fact that it is not affordable, feasible, acceptable, sustainable and safe.[29]

Other major identified barriers that still need to be overcome to successfully scale up breastfeeding promotion include the widespread violation of the World Health Organization Code of Marketing of Breastmilk Substitutes (globally),[12] lack of public facilities for breastfeeding,[30] challenges for working mothers to breastfeed in the workplace, including insufficient maternity leave and facilities at work that are not supportive of breastfeeding.[12,13,28,30] Factors which might contribute to the failure to strengthen breastfeeding programmes include the inability to address resistance from stakeholders and inadequate engagement with user groups by institutions who present such programmes.[12] The Tshwane Declaration states that "promotion, protection and support of breastfeeding requires commitment and action from all stakeholders, including government and legislators, community leaders, traditional leaders and healers, civil society, healthcare workers and managers, researchers, the private sector, employers, the women's sector, the media and every citizen".[13] This challenge needs to be communicated to all the mentioned stakeholders, while innovative ways of engaging these groups should be investigated.

The infant and young child feeding agenda has been advanced in South Africa, driven by evidence-based advocacy and through the creation of a political-policy alignment. The unresolved mentioned issues should now be acted upon appropriately and timeously. If the challenge of turning commitment into action is not met, optimal child growth and development and improvement in human and economic capital will evade us, and South Africa will remain trapped in the refrain: "Cry the beloved country". We may not allow this to happen.

***Lisanne du Plessis,*** MNutrition, RD(SA), RNT(SA)
Senior Lecturer, Community Nutrition, Division of Human Nutrition
Faculty of Medicine and Health Sciences, Stellenbosch University
E-mail: lmdup@sun.ac.za

## References

1. Fall CH, Borja JB, Osmond C, et al. COHORTS group. Infant-feeding patterns and cardiovascular risk factors in young adulthood: data from five cohorts in low- and middle-income countries. Int J Epidemiol. 2011;40(1):47-62.
2. Martorell R, Horta BL, Adair LS, et al. Weight gain in the first two years of life is an important predictor of schooling outcomes in pooled analyses from five birth cohorts from low- and middle-income countries. J Nutr. 2010;140(2):348-354.
3. The first thousand days of life [homepage on the Internet]. c 2013.Available from: http://www.thousanddays.org/about
4. World Health Organization. Global strategy for infant and young child feeding. World Health Organization [homepage on the Internet]. 2003. c2013. Available from: http://whqlibdoc.who.int/publications/2003/9241562218.pdf
5. Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding. [Cochrane review] In: The Cochrane Library, Issue 1, 2002. Oxford: Update Sofware.
6. Rabe H, Reynolds G, Diaz-Rossello J. Early versus delayed umbilical cord clamping in preterm infants. [Cochrane review] In: The Cochrane Library, Issue 4, 2004. Oxford: Update Sofware.
7. Bhutta ZA, Ahmed T, Black RE, et al. What works? Interventions for maternal and child undernutrition and survival. Lancet. 2008;371(9610):417-440.
8. Becker GE, Remmington S, Remmington T. Early additional food and fluids for healthy breastfed full-term infants. [Cochrane review] In: The Cochrane Library, Issue 12, 2011. Oxford: Update Sofware.
9. Black RE, Allen LH, Bhutta ZA, et al. Maternal and child undernutrition: global and regional exposures and health consequences. Lancet. 2008;371(9608):246-260.
10. UNICEF. Programming guide: infant and young child feeding. UNICEF [homepage on the Internet]. 2011. c2013. Available from: http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf
11. Magalhães H Jr, Jaime P, Almeida P. Launching of the integration between the Brazilian Breastfeeding Network and the National Strategy on Healthy Complementary Feeding. Rio de Janeiro: World Public Health Nutrition Congress; 2012.
12. Pérez-Escamilla R. Evidence-based breastfeeding promotion: a global scaling up model. Trieste, Italy: Proceedings of the International Society for Research in Human Milk and Lactation Congress, 2012; p. 72-73.
13. Tshwane Declaration for the Support of Breastfeeding in South Africa. S Afr J Clin Nutr. 2011;24(4):214.
14. Department of Health. Regulation R991: regulations relating to foodstuffs for infants and young children. Pretoria: Government Gazette; 2012.
15. Kent G. Nutrition rights: the human right to adequate food and nutrition. Hawaii: University of Hawaii, World Alliance on Nutrition and Human Rights; 2000.
16. World Health Organization. Scaling up, saving lives. WHO [homepage on the Internet]. 2008. c2013. Available from: http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf
17. Kassier SM, Veldman FJ. Cry, the beloved bottle: infant-feeding knowledge and the practices of mothers and caregivers in an urban township outside Bloemfontein, Free State province. S Afr J Clin Nutr. 2013;26(1):17-22
18. Davies A. PMTCT: how "informed "is the literate mother's decision regarding infant feeding options in the Gert Sibande district, Mpumalanga province, South Africa [dissertation]. Stellenbosch: Stellenbosch University; 2005.
19. Van der Merwe M. Comparison of infant feeding practices in two health sub-districts with different Baby Friendly status in Mpumalanga province [dissertation]. Stellenbosch: Stellenbosch University; 2012.
20. Doherty T, Chopra M, Nkonki L, et al. Effect of the HIV epidemic on infant feeding in South Africa: "When they see me coming with the tins they laugh at me." Bull World Health Organ. 2006;84(2):90-96.
21. World Health Organization. Infant and young child feeding: model chapter for textbooks for medical students and allied health professionals. Geneva: WHO; 2009.
22. Tylleskär T, Jackson D, Ingunn NM, et al. Exclusive breastfeeding promotion by peer counsellors in Sub-Saharan Africa (PROMISE-EBF): a cluster randomised trial. Lancet. 2011:378(9789);420-4207.
23. Spies L. The KwaZulu-Natal experience. [Unpublished]. Pretoria: The National Breastfeeding Summit, Department of Health; 2011.
24. Breastfeeding Restoration Core Task Team. Breastmilk: the golden standard for infant feeding. Cape Town: Department of Health, Western Cape Government; 2011.
25. MacIntyre UE, de Villiers FPR, Baloyi PG. Early infant feeding practices of mothers attending a postnatal clinic in Ga-Rankuwa. S Afr J Clin Nutr. 2005;18(2):70-75.
26. Doherty TM, McCoy D, Donohue S. Health system constraints to optimal coverage of the prevention of mother-to-child HIV transmission programme in South Africa: lessons learned from the implementation of the national pilot programme. Afr Health Sci. 2005;5(3):213-218.
27. Brown JE. Nutrition during lactation. Nutrition through the life cycle. California: Wadsworth, 2002; p. 135-189.
28. King S. Helping mothers to breastfeed. Nairobi: African Medical and Research Foundation, 1992; p. 1-5.
29. Doherty T, Chopra M, Jackson D, et al. Effectiveness of the WHO/UNICEF guidelines on infant feeding for HIV-positive women: results from a prospective cohort study in South Africa. AIDS. 2007;21(13):1791-1797.
30. Sowden M, Marais D, Beukes R. Factors influencing high socio-economic class mothers' decision regarding formula-feeding practices in the Cape Metropole. S Afr J Clin Nutr. 2009;22(1):37-44.