



health

Department:
Health
PROVINCE OF KWAZULU-NATAL



Improving breastfeeding in the context of HIV

KZN's Breakthrough on Breastfeeding

2010 – 2014

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ONE OF SOUTH AFRICA'S GREATEST CHALLENGES IS TO ENCOURAGE WOMEN TO BREASTFEED EXCLUSIVELY FOR SIX MONTHS FROM BIRTH

02

INTRODUCTION

04

MIXED MESSAGING LEAD TO MIXED FEEDING

06

POLITICAL LEADERSHIP AND COMMITTED ADVOCACY

CONTENTS

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Mothers in rural South Africa who chose to feed their infants formula milk faced enormous challenges. It was virtually impossible to maintain safe and hygienic feeding practices and as a result babies often succumbed to diarrhoea – a disease easily prevented by exclusive breastfeeding for the first six months of the infant's life.

10

**KWAZULU-NATAL
LEADS THE WAY
TO THE TSHWANE
DECLARATION**

14

**THE ROAD
FROM TSHWANE
2011 TO 2014**

16

**CRITICAL
ELEMENTS IN
THE PROCESS**

24

**ACKNOWLEDGE-
MENTS**



survival ^

× 14

CHILDREN WHO
ARE EXCLUSIVELY
BREASTFED ARE 14
TIMES MORE LIKELY
TO SURVIVE THE
FIRST SIX MONTHS
OF LIFE THAN NON-
BREASTFED CHILDREN

INTRODUCTION

A baby born in South Africa today is likely to be breastfed within the first hour after birth, regardless of the mother's HIV status. Exclusively breastfeeding a baby up until the age of six months is a life-saving intervention. As recently as 2010, however, providing HIV-positive mothers with infant formula was still the norm in many parts of the country. This was until a determined team of policy makers and academics from KwaZulu-Natal began advocating for the life-saving qualities of breast-milk, a call that began to reverberate at a national level, leading to radical policy changes aimed at supporting breastfeeding in the context of HIV.

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When the first reports of HIV-transmission through breast-milk emerged in the early nineties, the immediate reaction of global medical authorities at that time was to discourage breastfeeding.

With conflicting evidence regarding the risk of HIV transmission through breastfeeding, the World Health Organisation (WHO) guidelines at that time discourage HIV-positive mothers from breastfeeding altogether.¹

The use of infant formula within the context of HIV stipulated that in cases where it is acceptable, feasible, affordable, sustainable and safe (AFASS criteria), HIV-positive mothers should give their infants replacement-feeding from birth to

prevent HIV transmission. The same guidelines stipulated that in the absence of a safe, alternative feeding option, exclusive breastfeeding is an option until alternative feeding options become feasible. In South Africa, while many HIV-positive mothers did not meet the AFASS criteria, they were nevertheless discouraged from breastfeeding.²

In 1999, research emerging from South Africa provided evidence that exclusive breastfeeding could be safer than originally thought, however, insufficient supportive evidence was available at the time.³ Despite further research from South Africa supporting exclusive breastfeeding in the context of HIV⁴, there was little policy change at the global level reflecting this new evidence. This contributed to further confusion in programme implementation as it was evident that most HIV-positive mothers were not able to meet the AFASS criteria and neither were they able to exclusively breastfeed or exclusively formula-feed their infants.²

¹ WHO (2010). Summary of evidence for the revised WHO Principles and Recommendations on HIV and Infant Feeding. www.who.org

² Health Systems Trust (2003). The National Evaluation of the PMTCT www.hst.org

³ Coutsoudis et al (1999). Influence of infant feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. *Lancet*, 354:471-476

⁴ Coovadia et al (2007). Mother-to-Child Transmission of HIV-1 during exclusive breastfeeding in the first 6 months of life: an intervention cohort study. *Lancet* 2007. 369:1107-1116



SOUTH AFRICA'S NEW REGULATIONS WILL CONTRIBUTE SIGNIFICANTLY TOWARDS CHILD SURVIVAL THROUGH THE PROTECTION, PROMOTION AND SUPPORT OF BREASTFEEDING

MIXED MESSAGES LEADS TO MIXED FEEDING

Global data following the implementation of PMTCT with the provision of free infant formula showed that while the HIV-infection rate went down, there was a sharp increase in infant mortality from diarrhoea among these infants.⁵

— Established global evidence has shown that exclusive breastfeeding prevents both the incidence of and mortality from diarrhoea⁶, which is commonly associated with mixed feeding practices and is often the result of poor infant formula feeding practices.

Aggravating the situation was the fact that before 2007, South Africa lacked a clear public health strategy on infant feeding in the context of HIV.⁷ As a result, nurses and lay counsellors struggled to help women make a choice that is emotionally influenced but objective at the same time. No health worker was willing to take the risk of encouraging a

mother to breastfeed in case the mother transmitted HIV to her baby. The difficult socio-economic conditions of many mothers at the time, especially in the rural and urban poor areas, further aggravated this situation. In addition, AFASS criteria meant that only those with access to electricity and running water could safely formula-feed and would therefore receive free infant formula supplies. This situation thus appeared to reward a relatively privileged minority of women while ignoring the needs of those mothers without access to electricity and running water.⁸

Promoting and providing Infant formula became an easy route for health workers despite emerging evidence that the domestic circumstances of many mothers in the country did not meet the necessary hygienic and safe criteria, which in turn led to increased rates of diarrhoea and pneumonia among infants.²

⁵ Thior I et al (2006). Higher Early Mortality (7 Months) in Formula-Fed than Breastfed Infants. JAMA 2006;296:794-805

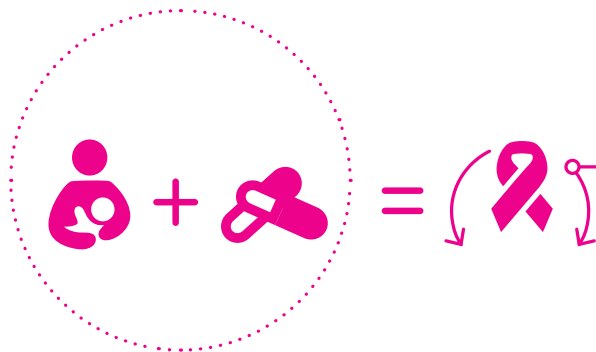
⁶ WHO (2000). Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis. WHO Collaborative Study Team on the Role of Breastfeeding on Prevention of Infant Mortality. Lancet, 355(9202):451-5

⁷ DoH (2007). Infant Feeding Policy

⁸ Doherty et al (2007). Effectiveness of the WHO/UNICEF guidelines on infant feeding for HIV-positive women: results from a prospective cohort study in South Africa. AIDS, 21(13):1791-7

At the height of the free infant formula era 2001–2009, an estimated 5.2 million South Africans were infected with HIV – the highest in the world. Young women bore the brunt of the epidemic, with one out of every three women aged between 25 and 39 years old testing positive for HIV. By 2009, the overall HIV-prevalence amongst 15 to 49-year-old pregnant women treated in public health clinics had stabilised at 29.4 per cent with parts of KwaZulu-Natal bearing the highest burden of HIV, as high as 46.4%.⁹

By this time it was evident that the situation had to change. The impetus came from the province worst affected by HIV, KwaZulu-Natal where, for every ten women who attended antenatal clinics in the province in 2009, almost four tested HIV-positive.⁹



RESEARCH HAS SHOWN THAT A COMBINATION OF BREASTFEEDING AND ANTIRETROVIRAL TREATMENT CAN SIGNIFICANTLY REDUCE THE RISK OF TRANSMITTING HIV TO BABIES THROUGH BREASTFEEDING

⁹ DoH (2010). National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009. www.doh.gov.za



POLITICAL LEADERSHIP & COMMITTED ADVOCACY

By mid-2000, emerging global research increasingly demonstrated the negligible risk of HIV-transmission through exclusive breastfeeding and the use of antiretroviral treatment (ART). Furthermore, the availability and use of ART during breastfeeding became widespread. As a result, WHO released its 2009 Rapid Advice Guidelines that led to the revision of its recommendations on infant feeding. For the first time, WHO recommended that HIV-positive mothers, or their infants, take ARVs for the duration of breastfeeding period to prevent HIV transmission.¹⁰

¹⁰WHO (2009). New WHO Recommendations: Preventing Mother-To-Child Transmission www.who.org



It was within this context that KwaZulu-Natal began revising its recommendations for mothers living with HIV – a process that ran parallel with the WHO's preparations to introduce new guidelines promoting breastfeeding for all mothers regardless of their HIV status. The KwaZulu-Natal Department of Health resolved to move rapidly as the lives of thousands of children's were at stake.

A team of committed advocates demonstrating both technical leadership and political will, took the first steps towards implementing life-saving changes that would ultimately lead to nationwide improvements in infant feeding practices for all children.

Since KwaZulu-Natal was the epicentre of the HIV epidemic in South Africa, the region generated a wealth of research opportunities on the safety of exclusive breastfeeding within the context of HIV. As a result, awareness in the province around the issues concerning infant and young child feeding had been raised significantly since the early 2000s.^{2,3,4,8,10}

Whenever research findings from within the province were published, these were presented directly to the Provincial Maternal, Child and Women's Health and Nutrition Directorates. Consequently, the KwaZulu-Natal Department of Health began a process of motivating for policy revisions that would address the issues around the provision of free


formula milk for HIV infected mothers and the availability of antiretroviral treatment for mothers who chose to breastfeed.

The results of one particular study published in 2009, Kesho Bora (Swahili for "a better future") which was undertaken in Burkina Faso, Kenya and South Africa, further strengthened the team's resolve to drive for change. Before the Kesho Bora study the risks and benefits of continuing antiretroviral during breastfeeding were not known. Evidence from the study showed that a combination antiretroviral drugs during pregnancy, delivery and breastfeeding supported the 2009/2010 revised WHO guidelines. This offered new hope to mothers living with HIV to safely breastfeed their infants.¹¹

On World AIDS Day 2009, President Jacob Zuma announced new regimens for ARV therapy announcing that all HIV-infected pregnant women, regardless of their CD4 count would access ARVs for the duration of their pregnancy.¹² At the time, research had shown that HIV-positive mothers could safely breastfeed their infants while the infants received daily doses of Nevirapine (NVP) for the duration of the breastfeeding period.¹⁰ This provided the final impetus for the KwaZulu-Natal Department of Health to reassess the provincial infant feeding policy which at the time still made provision for free infant formula for PMTCT clients.

¹¹WHO (2010). Guidelines on HIV and Infant Feeding www.who.org

¹²DoH (2009). World AIDS Day press release



SOUTH AFRICA HAS COMMITTED TO ACTIVELY SUPPORTING BREASTFEEDING, BUT A LACK OF UNDERSTANDING OF THE BENEFITS OF BREASTFEEDING AMONG THE POPULATION HAS HINDERED PROGRESS



IN ACCORDANCE WITH THE
TSHWANE DECLARATION,
MOTHERS ARE NO
LONGER OFFERED
REPLACEMENT FEEDING
IN HEALTH FACILITIES AND
ARE ENCOURAGED AND
SUPPORTED TO BREASTFEED
THEIR INFANTS

KWAZULU-NATAL LEADS THE WAY TO THE TSHWANE DECLARATION

In early 2010, meetings were held with district management officials to sensitise and brief them on KwaZulu-Natal's new proposed Infant and Young Child Feeding policy (IYCF). A breakthrough took place on the 20 April 2010 when the KwaZulu-Natal Head of Department of Health approved the implementation of Infant and Young Child Feeding counselling on the prevention of mother to child treatment interventions. This included a decision to stop the issuing of free infant formula to HIV-positive mothers in the PMTCT programme, effective from 1 January 2011.¹³

Given the high infant mortality rates and media coverage of the regular stock-outs of infant formula for PMTCT clients, Department of Health KwaZulu-Natal, supported by researchers within the province, was positioned to embrace the global evidence and accept the WHO 2010 guidance

which called for countries to support one IYCF strategy, namely to either support breastfeeding with ARV treatment to the mother or the child or to avoid breastfeeding completely.¹¹ In 2010, ahead of a national policy meeting, KwaZulu-Natal's Department of Health took the decision to support breastfeeding with ART.

In December 2010, the KwaZulu-Natal government announced that all mothers, including those who were HIV-positive, would be encouraged to exclusively breastfeed their babies up to six months of age.

¹³DoH:KZN (2010). KZN DOH, Circular Minute No: G68/2010, Ref No: 29/10/P

In light of this new evidence, and the WHO policy revision in 2010, the South African National Department of Health revised its clinical PMTCT guidelines. The national Department of Health announced that from 1 April 2010 all HIV-exposed babies born to mothers who were not taking lifelong anti-retroviral therapy (ART) would receive daily Nevirapine from birth to six weeks of age. Breastfed babies would receive Nevirapine for the duration of the breastfeeding period (up to 12 months of age), thereby minimising the risk of HIV-transmission. These guidelines were linked to reaching the Millennium Development Goals related to improving maternal and infant mortality.¹⁴

At the time, no other province in South Africa had undertaken an extensive review and policy change on IYCF in the context of HIV to the extent that KwaZulu-Natal Department of Health had.

This raised questions from civil society, academics and health professionals on this unprecedented move by KwaZulu-Natal Department of Health which prompted the National Department of Health to convene a National Breastfeeding Consultative Meeting in August 2011. It was at this meeting that the Tshwane Declaration was put forward by the National Minister of Health, Dr Aaron Motseledi endorsed by civil society, academia and development partners.

Dr. Motseledi declared South Africa to be a country that actively promotes, protects and supports exclusive breastfeeding for all women with infants aged up to 6 months, regardless of their HIV status, continued breastfeeding up to two years for HIV negative mothers, and up to 12 months for HIV-positive mothers, while their infants receive daily Nevirapine. National government committed to continue to take action to demonstrate this commitment, including the mainstreaming of breastfeeding in all relevant policies, legislation, strategies and protocols.¹⁵

¹⁴DoH (2010). National Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission), Department of Health, South African National AIDS Council

¹⁵DoH (2011). THE TSHWANE DECLARATION OF SUPPORT FOR BREASTFEEDING IN SOUTH AFRICA: 24 August 2011



PROMOTION, SUPPORT AND PROTECTION OF EXCLUSIVE BREASTFEEDING FOR THE FIRST SIX MONTHS OF AN INFANT'S LIFE, AND CONTINUED BREASTFEEDING UNTIL THE CHILD IS TWO YEARS OLD, ARE HIGH-IMPACT PUBLIC HEALTH INTERVENTIONS THAT ARE INTERNATIONALLY RECOGNISED TO OPTIMISE CHILD SURVIVAL



SAVES
LIVES []

**BREASTFEEDING SAVES
LIVES BY PROTECTING
BABIES FROM DIARRHOEA
AND PNEUMONIA – THE
BIGGEST KILLERS OF
INFANTS AND CHILDREN
IN SOUTH AFRICA**

THE ROAD FROM TSHWANE [2011–2014]

Since the Tshwane Declaration of 24 August 2011, South Africa revised the Infant Feeding Policy,¹⁶ has reviewed the ARV guidelines and has progressed to providing as a priority all HIV-positive pregnant women and breastfeeding mothers with fixed dose combinations of ART.

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It is envisaged that by January 2015, all HIV positive-pregnant women and breastfeeding mothers will be provided with life-long antiretroviral treatment, regardless of CD4 count to prevent mother-to-child transmission of current and future pregnancies and improve their own health.

Known as Option B+, this strategy to reduce maternal mortality and decrease the transmission rate of HIV and reverse mortality rates of children means that a triple-drug antiretroviral regimen is taken throughout pregnancy, delivery and breastfeeding. The treatment continues for life, regardless of the mother's CD4 count or clinical stage.

The process to change the Infant and Young Child Feeding policy in KwaZulu-Natal took longer than was

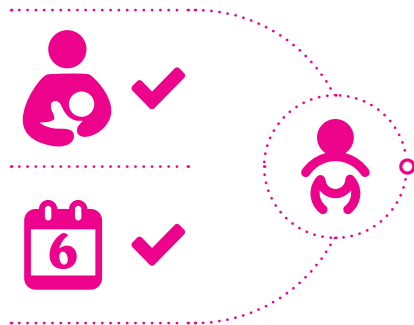
initially planned. The provincial Department of Health had anticipated that the process would take a year at most, but the process as described here, took a full three years.

The KwaZulu-Natal experience clearly shows is that it is imperative to have clear, realistic dates and committed champions to drive the process throughout its critical stages. Without these drivers, the change process is unlikely to be successful and even the most noble and ambitious goals will not come to fruition. These champions and advocates should have the technical leadership to provide clear communication and consistent messages that reach stakeholders at all levels in a timely manner. In an era of evidence-based programming it is equally critical to have a strong evidence-based advocacy strategy targeting health workers and the broader community.

There is a need for increased and on-going consultation with communities to increase the implementation and support of the IYCF policy change. Where facilities and communities have good support through NGOs, clinic committees and well-informed community health workers, the implementation has been smooth with little resistance.

16 DoH (2013). Infant and Young Child feeding Policy www.doh.gov.za

However, there is a need to ensure that regardless of how well a policy is implemented the monitoring systems need to be in place to track progress. Since the last national Demographic and Health Survey of 2003, KwaZulu-Natal has shown improvements in exclusive breastfeeding rates, timely and appropriate infant feeding practices and improved child nutrition indicators.¹⁷



THE FOREMOST GLOBAL RESEARCHERS IN THIS FIELD PROVIDED RESEARCH FINDINGS SUPPORTING EXCLUSIVE BREASTFEEDING, FOR THE FIRST SIX MONTHS OF LIFE, WITHIN THE CONTEXT OF HIV

¹⁷HSRC (2013). Data analysis on infant feeding practices, and anthropometry in children under five years of age: South Africa SANHANES, 2012

CRITICAL ELEMENTS IN THE PROCESS

01 TECHNICAL LEADERSHIP

02 POLITICAL WILL AND STRONG
ADVOCACY

03 BUILDING STRONG PARTNERSHIPS
AND COALITIONS

04 EVIDENCE-BASED ADVOCACY

05 CLEAR COMMUNICATION AND
CONSISTENT MESSAGING

06 COMMUNITY-BASED APPROACH –
TRAINING OF HEALTHCARE WORKERS



01

TECHNICAL LEADERSHIP

During any given policy process, role-players will encounter a number of critical decision-making points where technical leadership is integral to prevent the process from stalling. Competency in communicating these decisions and translating it into audience-specific language is another critical factor in driving the policy change process forward.

In KwaZulu-Natal's case, technical leadership was evident on both the academic as well as the political front. Arguably the foremost global researchers in this field Professors Anna Coutsoydis and Nigel Rollins (University of KwaZulu-Natal's Department of Paediatrics and Child Health at the time) provided research findings supporting exclusive breastfeeding within the context of HIV, passionately advocating for the benefits of breastfeeding.

Within the government policy environment, Professors Coutsoydis and Rollins found a synergy with then KZN premiere Dr. Zweli Mkhize, then MEC for Health Dr Sibongiseni Dhlomo and KZN Health Director of Nutrition Ms. Lenore Spies. Recognised and experienced practitioners, these leaders in their fields were willing to take on the responsibility of their decisions as guided and supported by their sound technical knowledge base and public health programme experience.

¹⁸DoH:WC (2001). Breastfeeding & HIV – A summary guide for health workers in South Africa
Provincial Administration of the Western Cape – Nutrition Directorate Nov 2001

¹⁹DoH:WC (2002). Breastfeeding & HIV –An information Booklet for Health Workers in South Africa
Provincial Administration of the Western Cape – Nutrition Directorate Jan 2002



A HEALTHIER AND LIFE-SAVING ENVIRONMENT FOR MOTHERS AND CHILDREN DOES NOT HAPPEN BY CHANCE. IT REQUIRES STRONG POLITICAL LEADERSHIP AND TECHNICAL EXPERTISE TO PUT THE POLICIES IN PLACE TO ACHIEVE THESE GOALS

02

POLITICAL WILL AND STRONG ADVOCACY

A healthier and life-saving environment for mothers and children does not happen by chance. It requires strong political leadership and technical expertise to put the policies in place to achieve these goals.

The KwaZulu-Natal Premier at the time of initiating the policy change, Dr. Zweli Mkhize was not only well-positioned to lead such a process; he also had the credentials to add clout to the endeavour. A medical doctor by profession and the former provincial Minister for Health, Dr. Mkhize was not far removed from patients' health experiences and struggles.

Dr Sibongiseni Maxwell Dhlomo, also a medical doctor and Provincial MEC for Health at the time, was no stranger to championing programmes promoting child health. He had demonstrated an interest in and knowledge of nutrition-related programmes from the start of his tenure, and wanted to see the potential benefits reaching the most vulnerable citizens of KwaZulu-Natal.

With more than 25 years' experience working in the South African public health nutrition sector, then Director for Nutrition in KwaZulu-Natal, Ms. Lenore Spies, had already established herself firmly as an advocate for child health. In early 2000, at a time when the Western Cape Department of Health actively promoted formula feeding for HIV positive mothers, under the Directorship of Ms Spies the Western Cape Provincial Nutrition Directorate produced materials on breastfeeding and HIV.^{18,19}

These individuals were willing to take the lead in improving the lives of children in KwaZulu-Natal, a move that would have far-reaching (and life-saving implications) nationwide. Given their prominence as role-players, the proposed Infant and Young Child Feeding policy amendment was set against a backdrop of existing constructive working relationships. In addition, the provincial climate was supportive of changes that could potentially result in tangible benefits for child survival.



PHOTO: UNICEF SOUTH AFRICA

03

BUILDING STRONG PARTNERSHIPS AND COALITIONS

The Infant and Young Child Feeding policy change process required engagement with multiple stakeholders across a myriad of sectors within government and civil society. Civil society organisations are critical role players in mobilising grass-root support for policy changes (and subsequent implementation). Influential leadership in this arena creates an enabling environment for policy revision and change. In the case of the Infant and Young Child Feeding policy implementation process, support for the scale-up of treatment and other medical as well as social support services for people living with HIV was absolutely critical.

An organisation that stood out as far as its “HIV awareness” and “treatment access” campaigns are concerned, was the Treatment Action Campaign (TAC). The commitment of the TAC to engage with issues pertaining to maternal and child health around HIV made them an obvious partner. It was partnerships like these that allowed KwaZulu-Natal to solidify the focus of the Infant and Young Child Feeding Policy change to the interest and benefit of child health.

In addition to strong partnerships with civil society, KwaZulu-Natal also relied on partnerships with international organisations, most notably the United Nations Children’s Fund (UNICEF) who firmly supported the proposed policy changes from the start. A global advocate for maternal and child health, UNICEF played a strong role providing technical and financial support in developing and rolling out the health worker capacity development workshops, promoting the communication strategy for the breastfeeding campaign and leveraging opportunities at national and international platforms for KwaZulu-Natal to share its experience and successes in addressing infant and young child feeding in the context of HIV.



PHOTO: UNICEF SOUTH AFRICA

04

EVIDENCE-BASED ADVOCACY

Research studies pertaining to HIV and infant feeding undertaken by leading academics and research institutions in KwaZulu-Natal, as well as the 2010 WHO Guidelines themselves, were significant in providing a clear, evidence-based direction that stabilised the public health dilemma around infant feeding in the context of HIV in South Africa. At the same time there was new guidance on more efficacious drug regimens for reducing mother-to-child transmission (MTCT) on HIV globally.

The ability to make effective decisions and to lead policy changes relies firmly on collating reliable data. In order to evaluate progress and to make the best choices for child health benefits, the KwaZulu-Natal provincial Department of Health relied on local health data. Hospital and District Health information System (DHIS) data showed more than 50 000 reported cases of diarrhoea in children under five years of age in 2009/10. This was an 8.5 per cent increase from the previous year.

Reported cases of pneumonia in the same age-group also showed an increase of 4.2 per cent from the previous year while nearly 210 000 children reported symptoms. Diarrhoea and pneumonia are the two main causes of childhood death in South Africa – deaths which, according to data, could be prevented if infants were exclusively breastfed for six months. It is estimated that, globally, about 1.1 million child deaths a year (of which 13 per cent are younger than five) could be saved by this life-giving practice.

It was against this backdrop that KwaZulu-Natal was taking the necessary steps to responsive programming towards attaining HIV-free child survival.

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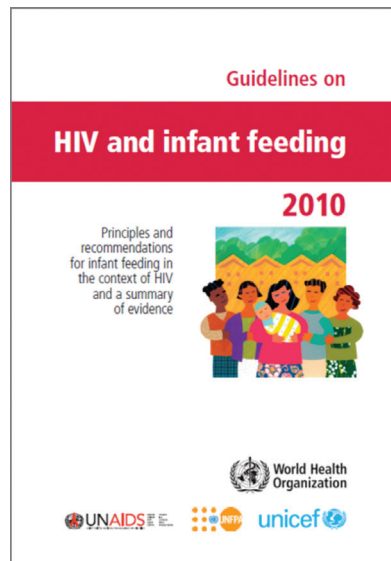
DIARRHOEA AND PNEUMONIA ARE THE TWO MAIN CAUSES OF CHILDHOOD DEATH IN SOUTH AFRICA – DEATHS WHICH, ACCORDING TO DATA, COULD BE PREVENTED IF INFANTS WERE EXCLUSIVELY BREASTFED FOR SIX MONTHS.

05

CLEAR COMMUNICATION AND CONSISTENT MESSAGING

The ultimate goal of this revised IYCF policy was to increase exclusive breastfeeding rates for all mothers irrespective of their HIV status. However, promoting breastfeeding among all mothers, regardless of their HIV-status, posed a challenge. When the IYCF policy implementation process started, South Africa's exclusive breastfeeding rate for children under 6 months of age was at an extreme low of eight per cent.²⁰

Communication is a key component of breastfeeding advocacy, and multiple channels have to be utilised to ensure a policy's success. In order for the Infant and Young Child Feeding policy change to be successfully implemented, clear and consistent messaging was of the utmost importance. The KZN message focused on the notion that 'All children deserve the best start in life'.



all children deserve the best start in life.

Breastfeed your baby exclusively for six months and continue breastfeeding after six months with the correct complementary foods.

HIV positive mothers can now breastfeed their babies confidently with the new use of medicines.

Let us all help to give children the best start to life, by supporting mothers to breastfeed their children.



If you have questions about breastfeeding, speak to a health worker at your local clinic for more information

06

COMMUNITY-BASED APPROACH – TRAINING OF HEALTHCARE WORKERS

In the lead-up to the phasing out of free infant formula as part of the PMTCT programme, a consultative process was initiated in mid-2009 with a series of face-to-face meetings with various stakeholders, most notably civil society groups with an HIV-focus, academia and the media. A focal area of the communication strategy to prepare the province for the imminent changes in the IYCF policy was a widely visible breastfeeding campaign premised on the belief that “all children deserves the best start in life”. This communication strategy ran from September 2010 to April 2011.²¹

Parallel with the consultative process, a strategy for the rapid scale up of training of nurses, lay counsellors and Community Care-Givers (CCGs) was developed and implemented throughout the 11 districts in KwaZulu-Natal. This was underpinned by an implementation strategy to ensure that the universal adoption of this new IYCF policy was understood, embraced and uniformly implemented across the public health system in the province.

Thanks to the national Department of Health’s Re-engineering of Primary Health Care, the weapon in KwaZulu-Natal’s arsenal was the 10 000 community health care workers employed to function as the link between the household and the health facility. These caregivers go into communities promoting a comprehensive package of services and advising mothers on the most appropriate care for their children. Giving their grounding and capacity in the area of infant feeding, the promotion of exclusive breastfeeding for the infant’s first six months of life with continued breastfeeding up to age 2 years for HIV-negative mothers and 12 months for HIV-positive mothers, is at the forefront of their support to mothers and their infants.

²⁰StatSA (2008). South African Demographic & Health Survey, 2003 www.doh.gov.za

²¹ZoeLife (2011). Documentation of the process of revision and implementation of the new IYCF policy and guidelines in KwaZulu-Natal. Final Report



PHOTO: UNICEF SOUTH AFRICA



THROUGH THE
MOTHER-BABY
FRIENDLY INITIATIVE,
ALL FACILITIES WITH
MATERNITY SERVICES
ARE SUPPORTED TO
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MAINTAIN A POSITIVE
AND AN ENABLING
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ENVIRONMENT

ACKNOWLEDGEMENTS



KwaZulu-Natal Department of Health has initiated a number of new initiatives to strengthen breastfeeding including mother support at hospital level through specially trained Lactation Advisors who assist mothers with initiation after delivery, correct latching and positioning to ensure mothers are confident and skilled to continue breastfeeding successfully after leaving the hospital.

At each health clinic, trained Nutrition Advisors are available to support mothers with breastfeeding and appropriate complementary feeding advice. Through the Mother-Baby Friendly Initiative, all facilities with maternity services are supported to implement and maintain a positive and an enabling breastfeeding environment. The province is also scaling up Human Milk Banks to ensure coverage in every district across the province. These efforts cannot be successful without the diligent work and dedication of health personnel, the management of nutrition and child health programmes and support of development partners and the communities.

The KwaZulu-Natal Department of Health would like to thank all stakeholders for their contribution to the successful implementation of the revised Infant and Young Child Feeding policy.



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