

Southern Africa Food Lab & Western Cape Government
Food and Nutrition Security Strategy Design Lab I Final Input Note
Promoting breastfeeding through workplace interventions

Introduction

Maternal and child health is a basic, non-negotiable human right. The International Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) of 1989 declares in Article 12 that the state should “*ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*”. An abundance of guidelines, policies, and programmes exist to address maternal and child health. However, despite commitment towards the cause, mothers and babies still die and suffer from preventable conditions worldwide (Bhutta et al., 2013).

Literature overview

Global evidence shows that breastfeeding holds benefits for mothers and babies from both rich and poor nations (Rollins et al., 2016). The uniqueness of breastfeeding is that it provides infants and young children with the one complete food that ensures health, while care is the mode of delivery. Optimal breastfeeding therefore provides the three pillars of well-being (food, health and care) while contributing to the realisation of infants and young children’s right to adequate food [Convention on the Rights of the Child (CRC) Art24.2(c)] and the highest attainable standard of health (CRC Art 24.1). Simultaneously, mothers have the right to appropriate post-natal care (CEDAW Art 12.2) and the right to paid maternity leave [(CEDAW Art 11.2(b)] which, in turn, could support breastfeeding (Engesveen et al., 2005).

Unfortunately, the real time situation is that the world at large remains an uncooperative place for mothers who want to breastfeed their babies (Rollins, et al. 2016). Contrary to world views, successful breastfeeding is not the sole responsibility of the mother, but implicates many stakeholders in various settings (Engesveen, 2005). To reach the World Health Organisation’s (WHO) recommendation of six months exclusive breastfeeding and continued breastfeeding thereafter, women need a supportive and conducive environment (Rollins et al., 2016).

The 2016 Lancet series on Breastfeeding proposed a conceptual model (Figure 1) portraying the components of an enabling environment for successful breastfeeding. The model includes the determinants of breastfeeding at a structural, settings and an individual level. The structural level refers to any social factors that affect the general population; including the media, advertising and social trends. At the settings level, health systems and services, community and family and the workplace and employment is emphasized, since it affects breastfeeding decisions and behaviour over time (Rollins et al., 2016). At an individual level, women’s breastfeeding behaviour is influenced by her personal attributes (her age, weight, education, confidence) as well as that of her baby (child’s sex, wellbeing, and temperament).

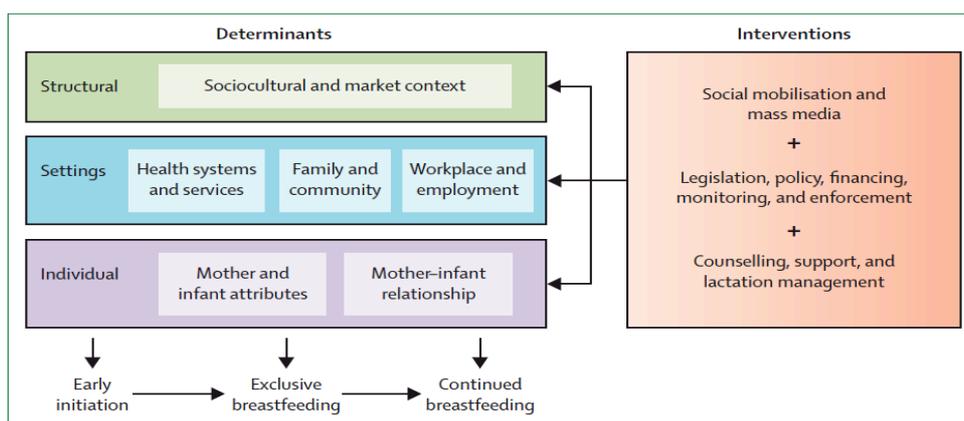


Figure 1: The components of an enabling environment for breastfeeding - a conceptual model

The authors of the suggested model in Figure 1, conducted a systematic review of interventions to improve breastfeeding practices according to the settings in the conceptual model i.e.: health systems and services, family and community and workplace and employment. In addition, available data on policies to address structural factors that create enabling environments for breastfeeding, was reviewed. Combined interventions delivered simultaneously in more than one setting was also examined. Four outcomes were assessed, namely breastfeeding initiation within 1 hour after birth; exclusive breastfeeding up to 6 months; continued breastfeeding from 12 – 23 months and any breastfeeding up to 6 months of age.

In summary, the meta-analyses indicated that breastfeeding practices were highly responsive to interventions delivered in health systems, communities, and homes. Maternity leave and workplace interventions were shown to be beneficial, although studies were few and generally limited to high-income settings. The largest effect of interventions on breastfeeding outcomes were achieved when interventions were delivered in combination (Rollins et al., 2016).

With more and more women joining the workforce, it is becoming increasingly important to pay attention to issues such as maternity leave, breastfeeding breaks and facilities for breastfeeding or expressing of breastmilk in the workplace (Rollins et al., 2016). Unfortunately, most studies report negative effects of work on breastfeeding. Women's work is the foremost reason provided for not breastfeeding or early cessation of breastfeeding (Rollins et al., 2016). The consequences of work on breastfeeding are multi-dimensional and include fatigue, practicality and intensity (Rollins et al., 2016). Women who plan to return to paid work after giving birth are less likely to initiate or continue breastfeeding, especially if the workplace support is minimal or absent (Barber-Madden et al., 1987; Yimyam et al., 1999; Rojjanasrirat 2004, Chatterji & Frick, 2005; Cardena & Major, 2005, Johnston & Espisito, 2007; Abdulwadud & Snow, 2008; Hirani & Premji, 2009). Short maternity leave (<6 weeks) leads to a four times increase in the odds of either not establishing breastfeeding or early cessation of breastfeeding (Rollins et al., 2016).

The benefits of workplace breastfeeding support for employers range from having a more content (Galtry, 1997; Ortiz et al., 2004) and productive workforce, due to less employee absenteeism (Cohen et al., 1995) to increased loyalty and lower staff turnover (Galtry, 1997). Employees are enabled to achieve a healthy work-life balance and there are fewer financial implications for the mother and family when the child is exclusively breastfed. Breastfed babies have a lower incidence of illness, thus saving both the family and country on health care costs, with resultant lower morbidity and mortality rates (Bhutta et al., 2008).

For these reasons, workplaces are excellent settings for interventions to encourage and assist the initiation and continuation of exclusive breastfeeding (Cohen et al., 1995; Ortiz et al., 2004).

Problem statement – THE CHALLENGE

In South Africa (SA), infant feeding practices are sub-optimal, with rates of breastfeeding, especially exclusive breastfeeding, remaining low over time, regardless of the implementation of various child health interventions. The EBF rates for SA infants under the age of 6 months are reported to be a meagre 7.4% (Shisana et al, 2013); the lowest in the world. SA currently uses the following routine indicators for EBF monitoring: 1) percentage of mothers initiating breastfeeding within one hour after birth; 2) percentage of babies exclusively breastfed at 14 weeks (coinciding with the HepB3 immunisation). The potential to monitor more indicators should be investigated and supported, especially percentage of infants 0-6 months exclusively breastfed (Du Plessis et al, 2016).

Although the latest Western Cape EBF figures are on the rise (according to the 14 week indicator), it is far from ideal (Personal correspondence: Western Cape, Sub-Directorate Nutrition).

The Tshwane Declaration of Support for Breastfeeding in SA was signed by the Minister of Health in 2011. It symbolised a commitment of political will at the highest level, as well as a commitment by all stakeholders in SA to work together to ensure the promotion, protection and support of breastfeeding. The need to address challenges around maternity protection for working mothers were expressed in the Declaration as follows:

“We specifically resolve that:” ...“Legislation regarding maternity among working mothers is reviewed in order to protect and extend maternity leave, and for measures to be implemented to ensure that all workers, including domestic and farm workers, benefit from maternity protection, and to include an enabling workplace;” (Tshwane Declaration, 2011).

Although there has been progress on some commitments from the Tshwane Declaration (Du Plessis & Pereira, 2013); little attention has been paid to workplace support for breastfeeding mothers. This may, in part, be due to a lack of understanding regarding the importance and impact of breastfeeding, and also a negative perception thereof. The perceived cost implications of implementing interventions to ensure maternity protection and support for employed breastfeeding mothers may also be a reason that workplace support is lagging behind other breastfeeding support interventions.

Overview of the Western Cape’s breastfeeding initiatives

In the Western Cape much has been done to respond to the Tshwane Declaration. A Policy framework and implementation plan for Breastfeeding Restoration has been formulated. The restoration plan was aligned with the Tshwane Declaration and included focus areas related to Policies and Practices and Healthcare Practices.

Districts were requested to formulate plans to facilitate the policy framework and implementation plan at district level in line with the Provincial timelines as indicated in the Breastfeeding Restoration plan (Circular 164/2012: Western Cape Policy Framework and Implementation Plan for Breastfeeding Restoration).

Key areas to be addressed and included in district plans are stipulated as follows:

- Role of Mother Baby Friendly Initiative (all facilities accredited by 2015) in both maternity and non-maternity health facilities
- Implementation of Kangaroo Mother Care
- Provision of free formula in public health facilities (on prescription)
- Infant feeding counselling
- Creation of a platform to co-ordinate infant feeding and monitoring of the processors contained within it
- Creation of a breastfeeding friendly workplace for public health workers at all levels
- Strengthening of the Integrated Management of Childhood Illnesses in both the facility and community based arena
- Development of a monitoring and evaluation system for breastfeeding practices

Progress on implementation of the Breastfeeding Restoration plan in the Western Cape (Source: SAHR, 2016)

The Mother Baby Friendly Initiative (MBFI) is implemented in 94% of the public birthing units in the Western Cape as a mechanism to create an environment which enables breastfeeding as the optimal infant feeding choice. Implementation of MBFI requires that practices in the birthing unit is reviewed to remove obstacles hindering the establishment of breastfeeding. An infant feeding counselling guideline was developed which guides counsellors (or any healthcare worker) through supporting a mother to make an informed infant feeding choice. Community Health Workers (CHW) are trained on infant feeding as part of the implementation of MBFI to foster support for the mother once she is discharged from the birthing unit. Some birthing units have lactation consultants who volunteer their services, but this is not uniform or consistent throughout the province.

Breastfeeding Peer Counselling Programmes (BPCP) driven by NPOs and funded by sub-structures (two sub-districts constitute one sub-structure) place breastfeeding peer counsellors at midwife obstetric units and basic antenatal care sites in the Metropole district. They work 4 hours a day and are paid a stipend. The identified BFP counsellors (BFPC) are capacitated to deliver peer to peer counselling and are trained in a 20-hour or updated national breastfeeding course. There is also an attempt to capacitate the BFPC in the other interventions and keep them up to date as guidelines and policies change. The BFPC are tasked with educating pregnant women on the infant feeding education package, supporting mothers without companions (when they can) and supporting (and educating) postnatal women on breastfeeding and it's management. Part of their function is also to foster the establishment of community support groups but this has been difficult to implement and they are subsequently facility based counsellors.

The Western Cape (WC) has furthermore created sentinel sites for human milk banks and has drafted guidelines for the management of expressed breast milk.

The WC has standardised key messages through provincial documents, initiatives and policies as much as possible. The first 1000 days campaign was launched in 2016 and it was envisaged that the campaign will include a communication campaign (<https://www.westerncape.gov.za/general-publication/first-1-000-days-campaign>).

The Province has progressively worked towards reducing the usage of infant formula creating an environment in which mothers must be enabled to make informed decisions and by reinforcing the criteria for the prescription of infant formula based on set criteria.

The Western Cape Department of Health's Breastfeeding Policy drafted in 2012 was communicated with all public health facilities but only advocates for implementation of maternity protection legislation in public health facilities. Health facilities are voluntarily establishing comfort rooms for staff members that can be utilised as space for expressing breastmilk.

Furthermore, the Western Cape Household Food Security and Nutrition Strategy, 2016 states in Section 5.1 Pillar 1: Food Assistance under Programmes targeting children; Programme 4: Promoting breastfeeding and improved complimentary feeding, that:

"...the Western Cape Government will advocate for safer and more appropriate facilities for women in the workplace who are breastfeeding children up to the age of six months. In particular, support of these interventions will include:

- *Advocacy for the establishment of breastfeeding friendly workplaces, including day centres;*
- *Establishment of an Infant and Young Child Feeding workgroup*
- *Finalisation of a policy on Human Milk Banking and*
- *Monitoring of the implementation of Regulation 991: Foodstuffs, Cosmetics and Disinfectant Act (54/1972) which provides regulations relating to foodstuffs for young children*

As a major employer, the WCG will set the example in this respect, and will use available opportunities to encourage this in the workplace of other spheres of government."

The Western Cape seems to be doing well on the health systems and services front. Within government, structures for breastfeeding support have been put in motion, but outside of the public service environment, no formal structures for this cause exist, except for the NPO "La Leche League" and the activist group "Normalise Breastfeeding". There are efforts to address

the socio-cultural and market context through social and mass media. However, the elements lacking in the Western Cape's approach seems to be a broad-based and visible advocacy strategy aimed at families and communities and workplace and employment. The current focus on the broader communities and families are limited to advocacy weeks (e.g. Pregnancy week in Feb, Human Milk banking week in March, Breastfeeding week in Aug and Nutrition week in October). There is a need for a continuous mass media advocacy campaign on breastfeeding support, protection and promotion (Du Plessis et al, 2016; Personal correspondence: Western Cape, Sub-Directorate Nutrition).

While monitoring and enforcement of policies and legislation are mentioned, there is no discussion about financing and the role players responsible for the listed interventions are not assigned (Personal correspondence: Western Cape, Sub-Directorate Nutrition).

Furthermore, the Western Cape is a major exporter in the fruit and wine industry. Many women work on farms; more than men in numbers. Women on farms are usually employed seasonally which poses a particular challenge for food and nutrition security. But it also offers opportunities to intervene with breastfeeding promotion, protection and support initiatives.

General recommendations

When looking at the evidence and various country case studies, it is clear that successful protection, promotion, and support of breastfeeding lies in a multi-layered approach across the various levels of government and society (Engesveen et al., 2005; Rollins et al., 2016).

The Tshwane Declaration echoed this "whole-of-society" approach to redress the poor breastfeeding situation in SA in the following statement:

"...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, HCWs and managers, researchers, the private sector, employers, the women's sector, the media and every citizen" (Tshwane Declaration, 2011).

Literature suggests that breastfeeding success starts with engendering a positive attitude within society as a whole towards breastfeeding. Currently, restrictions on breastfeeding in public spaces; insufficient maternity leave for working mothers; and unsupportive workplace environments where breastfeeding or expressing of breastmilk is not catered for undermine breastfeeding success. Breastfeeding is not seen as the norm and is generally viewed as an individual's personal decision, unrelated to society as a whole. Furthermore, if a mother decides to breastfeed, it is viewed as her sole responsibility to make it work, which neglects the supportive and protective role of the family, community and greater society in the success thereof. The Innocenti Declaration states that an enforcement of a 'breastfeeding culture' needs to take place and needs to supplant the current 'bottle-feeding culture'. This move towards changing societal perception of breastfeeding as a high value practice should be achievable in today's mass employment of social marketing and innovative communication formats (Du Plessis et al., 2016). A health promotion programme initiated in 2014 focussed on maternal and child health, the "MomConnect"¹ programme (Reducing Maternal and Child Mortality through strengthening Primary Health Care in South Africa, 2013) is foreseen as a programme that could advance the health of children within the first 1000 days period in SA in future (Motsoaledi, 2015). Also, existing resources should be used and shared, for example the well-packaged information developed for the Lancet Breastfeeding Series 2016 launch (Du Plessis, et al. 2016).

Most children (64%) (Eddy, Thomson-de Boor, & Mphaka, 2013) in South Africa live with single mothers. When fathers are present and involved they can provide valuable support to breastfeeding mothers. As mentioned above, work remains a barrier to consistent breastfeeding. It's useful to point out that this is likely to include both paid work, and unpaid care work (Gouws & Van Zyl, Mikki, 2014). According to the latest time use survey in South Africa from 2010, women do on average 8 times more household work than men do, including childcare work (RSA, 2013). If a father is present, and relieves the burden of

¹The programme uses cellphone technology to register pregnant women in both public and private health care. Information and instructions are communicated to pregnant mothers to ensure a healthy pregnancy and delivery of a healthy baby. After delivery, the messages switch over to focus on information on the health needs of a new-born (including messages on exclusive breastfeeding, immunisation, family planning for the mother, oral rehydration during diarrhoea, check-up periods at the clinic) and continue for up to one year after birth (Reducing Maternal and Child Mortality through strengthening Primary Health Care in South Africa, 2013).

housework that a mother carries it will allow her more time for breastfeeding and resting. Workplaces play a valuable role here in their support for new fathers to be able to take time to support mothers to breastfeed and care for infants. In households with more than one child fathers can also take over the work of caring for the other children while a mother breastfeeds. Of course this equal share of housework should not only happen when a mother is breastfeeding, but if longer term gender equal relationships are cultivated it is more likely that fathers will carry the burden of house and care work to allow mothers to breastfeed. Flexible work hours and paid parental leave for all parents support this over the long term. It also creates a societal norm of wider support for maternal and infant health. The MenCare Global Fatherhood campaign (www.men-care.org, and <http://waba.org.my/a-sharing-fathers-day/>) provides resources for advocacy, media campaigns and interventions that encourage men's involvement in maternal, infant and child health.

In 2016, the Labour Laws Amendment Bill [PMB 5 – 2015] – now [B26-2016] was proposed to the national portfolio committee of labor. The bill proposes important improvements to paid parental leave in South Africa. The bill is also matched with the accompanying Unemployment Insurance Fund amendment bill, which dictates how UIF payments will be managed. The bill introduces a set level of maternity benefits at 66% of full salary, 10 days leave for parents who are not biological mothers (mostly fathers), and paid leave for adoptive parents. The bill has been approved by the portfolio committee and will go for vote in the national assembly in 2017 (<https://pmg.org.za/committee-meeting/23770/>). These changes are important for breastfeeding because it improves the benefits paid for maternity leave, but in addition it also allows mothers' partners to support them to breastfeed. More information about the new leave provisions is available here: <http://www.genderjustice.org.za/card/new-parental-leave-provisions-south-africa-explained/>

Since the best outcomes for breastfeeding is achieved when interventions are implemented concurrently (Balkam et al., 2011) the interventions suggested in the conceptual model (Figure 1), i.e.: social mobilisation and mass media; legislation, policy, financing, monitoring and enforcement; and counselling, support and lactation management should work in synergy for greatest success. However, specific workplace interventions that have been shown to be effective are discussed below and should be taken up in a comprehensive package for breastfeeding workplace support in the Western Cape.

Putting in place Mother and Baby Friendly work policies should be the starting point to galvanise workplace interventions. The scarce information available indicates that policies pertaining to maternity leave are effective at increasing the rates of exclusive breastfeeding (RR 1.52 [1.03–2.23]). Studies have also highlighted that longer duration of maternity leaves serves as a powerful predictor for sustaining BF practices of working mothers (Rollins et al., 2016). Corporate wellness programmes that support breastfeeding and an organizational culture supportive of breastfeeding contribute to an enabling workplace environment for breastfeeding (Duckett et al., 1999).

Providing time, space and physical facilities to breastfeed and nursing breaks at the workplace are considered low-cost interventions that can reduce the obstacles that working mothers face when they want to continue breastfeeding when returning to work. These include: on-site child care, storage facilities, privacy, and provision of time to breastfeed or express breast milk, or access to lactation consultants. Educating working mothers about management of breastfeeding with employment will enable them to plan and manage breastfeeding with their work (Lewallen et al., 2006). Enhancing employers' awareness about the benefits of breastfeeding accommodation at the workplace can help employers in revisiting their existing workplace policies. Providing job-flexibility to working mothers greatly supports breastfeeding (Hirani, 2013) (Please also refer to Addendum 1: **Proposed practical action steps for breastfeeding support in the workplace**).

Specific recommendations for the Western Cape

At a workshop jointly convened by the Southern Africa Food Lab and the Western Cape Government on 8 & 9 and 23 March, facilitated discussions on the topic of this paper brought to light two specific actions that could be taken forward. These were:

1. updating the Western Cape Department of Health Breastfeeding policy and implementing it across the 9 other government departments; and
2. exploring the role of accreditation bodies to create an enabling environment for breastfeeding mothers on farms.

The table below lays out what should be done, by whom, when and at what cost.