THE COMMITTEE ON THE RIGHTS OF THE CHILD

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REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN THE UNITED REPUBLIC OF TANZANIA

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Prepared by:
Geneva Infant Feeding Association (IBFAN – GIFA) - IBFAN global liaison office
www.ibfan.org
Tel. +41 22 798 91 64

SUMMARY

The following <u>obstacles/problems</u> have been identified:

- More than 1 child out of 2 is born without the presence of a skilled attendant;
- Neonatal, infant and under-five mortality rates are high while breastfeeding rates have not substantially progressed in the last 10 years;
- Almost half of the infants are not breastfed within the first hour after delivery. Same proportion lacks exclusively breastfeeding until 6 months of age as well as continued breastfeeding until the age of 2 years. In addition, misconceptions on colostrum have negative effects on infant feeding choices;
- More information on how breastfeeding is promoted and supported during the National Breastfeeding Week would be welcome;
- The International Code on Marketing of Breastmilk Substitutes is not fully implemented;
- The revision of the National Regulation for Marketing of Breastmilk Substitutes and Designated Products has not yet been endorsed and there is only little awareness of its content;
- The activity High Level Steering Committee on Nutrition is not clear with respect to its monitoring role;
- There is no information on breastfeeding-related training and courses to health professionals;
- In 2010, only 37% of the hospitals of the country have ever been certified as "baby-friendly;
- Maternity leave is only available every 3 years and does not cover women in the informal sector;
- HIV mother-to-child transmission rate is still high (15.8%);
- There are no emergency preparedness plans and guidelines with specific reference to infant and young child feeding.

<u>Our recommendations</u> include:

- Ensure that **all births are assisted by skilled birth attendants;**
- **Promote optimal breastfeeding practices to the population** through national, targeted campaigns;
- Ensure **adequate training of health professionals** on breastfeeding-related issues;
- Review, implement and enforce the **National Regulation for Marketing of Breastmilk Substitutes and Designated Products** in order to fully implement the International Code;
- Ensure that the High Level Steering Committee on Nutrition is carrying out **a monitoring function**;
- Extend the **implementation of the Baby-Friendly Hospital Initiative** throughout the country;
- Allocate **maternity leave benefits to all working mothers, for all their pregnancies;**
- Strengthen awareness-raising efforts on **HIV mother-to-child transmission**, in particular through initiatives such asmothers support group;
- Provide integrated response to ensure **protection and support of breastfeeding in emergencies** through the implementation of a **national plan** and designation of **persons to coordinate activities**.

1) General points concerning reporting to the CRC Committee

In January 2015, the CRC Committee will review Tanzania's combined 3rd to 5th periodic report.

At the last review in 2006 (Session 42), the Committee recommended in its Concluding Observations that the State party *"undertake all necessary measures to **reduce infant and under-five mortality rates**, including by improving prenatal care and preventing communicable diseases;"* it also recommended the development of "*appropriate national strategies to address the critical nutritional needs of children, particularly among the most vulnerable groups, through a **holistic and intersectoral approach that recognizes the importance of feeding practices**;"* (§ 45, emphasis added)

At last review of Tanzania in 2012 (Session 49), the CESCR Committee raised the same issue, noting *"with concern the high infant, under-5 and maternal mortality, and the low number of births that are assisted by a skilled birth attendant, especially in rural areas"* (§ 24). Thus, the CESCR Committee recommended that "*the State party take urgent steps to reduce **the high infant and under- 5 mortality** and to ensure that **births are assisted by skilled birth attendants**"* and to *"intensify its efforts to **improve women's access to basic obstetric and neonatal care**, reproductive health services and to basic health-care centres, in particular in rural areas."* (Concluding Observations § 25, emphasis added)

In addition, the CEDAW Committee raised the issue of maternal at its last review in 2008 (Session 41). The CEDAW Committee recommended that Tanzania *"strengthen its efforts to **reduce the incidence of maternal and infant mortality**"*, to *"make every effort to raise awareness of and increase **women's access to health-care facilities and medical assistance** by trained personnel, especially in rural areas"* and to adopt *"measures to increase knowledge of and access to affordable contraceptive methods, so that women and men can make informed choices about the number and **spacing of children**."* (Concluding Observations § 40, emphasis added). The CEDAW Committee also expressed concerns about the fact that *"**maternity leave is only available every three years** and that the private sector employers are not bound by these Standing Orders"*, as well as about the *"**precarious situation of the high number of women in the informal sector**, mainly in the agricultural sector as well as in other activities such as small business, food processing and handicraft"*, especially with regard to their limited access to social security benefits. (§ 35, emphasis added)

2) General situation concerning breastfeeding in Tanzania

General data

	1990	2010	2011	2012	2013
Annual number of births, crude (thousands)[1]	-	-	-	1898.3	-
Birth rate, crude (per 1,000 people)[2]	-	41	40	40	-
Neonatal mortality rate (per 1,000 live births)[3]	43.3	22.6	21.8	21.1	20.7
Infant mortality rate (per 1,000 live births)[4]	101.3	41.4	39.2	37.7	36.4
Under-five mortality rate (per 1,000 live births)[5]	167	61.4	57.2	53.9	51.8
Maternal mortality ratio (per 100,000 live births)[6]	529[7]	460	-	-	410
Delivery care coverage:[8]					
Skilled attendant at birth	-	48.9%	48.9%	48.9%	-
Institutional delivery	-	50.2%	50.2%	50.2%	-
C-section	-	4.5%	4.5%	4.5%	-

Breastfeeding and nutrition data[9]

	1996	1999	2004-2005	2010	2012
Early initiation of breastfeeding (within one hour from birth)	58.8%	-	59.3%	48.7%	49%
Children exclusively breastfed (0-5 months)	28.9%	32%	41%	49.8%	50%
Children ever breastfed	97.3%	95%	96.4%	96.9%	-
Introduction of solid, semi-solid or soft foods (6-8 months)	94.6%	90.7%[10]	90.9%	92%	93%
Breastfeeding at age 2	45.6%	48%	55.4%	51%	51%
Median duration of any breastfeeding (in months)	22	21	21	20.9	-
Median duration of exclusive breastfeeding (in months)	1	1.1	1.8	2.4	-

[1] UNICEF country statistics, available at: www.unicef.org/infobycountry/tanzania_statistics.html
[2] World Bank data, available at: http://data.worldbank.org/indicator/SP.DYN.CBRT.IN/countries
[3] UN Inter-agency Group for Child Mortality Estimation (IGME) data, 2014, available at: www.childmortality.org/;
[4] UN IGME data, 2014, see above;
[5] UN IGME data, 2014, see above;
[6] World Bank data, available at: http://data.worldbank.org/indicator/SH.STA.MMRT/countries
[7] This figure refers to 1996
[8] Data refer to the years 2008-2012. Source: UNICEF country statistics, see above;
[9] Demographic and Health Survey (DHS) 1996, available at: http://dhsprogram.com/pubs/pdf/FR83/FR83.pdf; DHS 1999, available at: http://dhsprogram.com/pubs/pdf/FR112/FR112.pdf; DHS 2004-2005, available at: http://dhsprogram.com/pubs/pdf/FR173/FR173-TZ04-05.pdf; DHS 2010, available at : http://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf; Data for 2012 were retrieved from Save the Children, *State of the World's Mothers 2012*, see above
[10] This figure refers to age 7-9 months

	1996	1999	2004-2005	2010	2012
Stunting (in children under 5)	43%	44%	38%	35%	43%[11]

General observations

It is of serious concern that the **rates of neonatal, infant and under-five mortality, as well as the rate of maternal mortality, are high**. High neonatal and maternal mortality rates are strongly correlated with the poor delivery care coverage: indeed, **more than one woman out of two gives birth without the assistance of a skilled birth attendant**.

It is a fact that breastfeeding is one of the most effective interventions to reduce child mortality and to tackle pneumonia, diarrhoea and newborn infections, the 3 main baby killers.[12] Thus, the implementation of an **environment that enable mothers to breastfeed** by protecting them from commercial pressures, promoting optimal breastfeeding practices and supporting them in their efforts is crucial to put an end to premature deaths of infants and young children.

Breastfeeding data

Although there have been improvements in the breastfeeding rates in the recent years, to date **1 child out of 2 is still neither breastfed within the first hour after birth nor exclusively breastfed until 6 months of age** (the median duration of exclusive breastfeeding was about two months and a half only in 2010).

Early introduction of complementary foods is another problem that needs to be addressed. *"At present* [2010, editor's note]*, **the vast majority of infants are given water, juice, porridge or other foods before they are three months old, which exposes them to harmful bacteria and parasites.** Some babies are even given water before they taste their mother's milk, while in certain ethnic groups, **the misconception persists that colostrum is dirty and should be***

[11] This figure refers to "child stunting" with no specification of age. Source: Save the Children, *State of the World's Mothers 2012*, available at: www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/STATE-OF-THE-WORLDS-MOTHERS-REPORT-2012-FINAL.PDF

[12] UNICEF, *Pneumonia and diarrhoea. Tackling the deadliest diseases for the world's poorest children*, 2012, availbale at : http://www.unicef.org/media/files/UNICEF_P_D_complete_0604.pdf;
UNICEF UK, *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK,* 2012, available at : http://www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resources.pdf;
Bhutta *et al., What works? Interventions for maternal and child undernutrition and survival*, The Lancet, 2008, 371 (9610) : 417-440, available at: http://www.who.int/nutrition/topics/Lancetseries_Undernutrition3.pdf

discarded."[13](emphasis added) Besides, despite the WHO recommendation on continued breastfeeding until 2 years of age, only half of the children aged 2 benefit of the optimal nutrition provided by mother's milk.

Breastfeeding and contraception

Breastfeeding has a **contraceptive effect** and thus, helps women to **naturally space pregnancies**. However, even though the country has a high fertility rate[14], only 32.8% of women were aware of the lactational amenorrhea as of 2010.[15]

3) Government efforts to encourage breastfeeding

National policies

The **Food and Nutrition Centre**[16] was established in 1973 and is responsible for planning and implementing health and nutrition-related policies. The current **Food and Nutrition Policy**[17] was approved in 1992 and it is still into force. Some changes and updates are currently being reviewed so that the policy can fit into the current economic, social and political situation. The policy points out the **high rate of malnutrition** among children and more specifically, for children aged 0-6 years, it mentions **inadequate breastfeeding and weaning** among its underlying causes. **Adequate post-delivery leave** for women to breastfeed, for working and non working women, **promotion of optimal breastfeeding practices** including continued breastfeeding until age 2, and **strengthened education on infant and child feeding for parents, communities and caregivers** are some of the core points to reduce malnutrition mentioned in the policy.[18]

In 2011, the United Republic of Tanzania adopted the **National Nutrition Strategy 2011/12-2015/16[19] (NNS)**, where several targets and challenges related to breastfeeding are listed. This Strategy includes, for example, the target of **raising the prevalence of exclusive breastfeeding**

[13] UNICEF, *Children and Women in Tanzania, 2010*, p. 179 available at: www.unicef.org/tanzania/SITAN_Mainland_report.pdf
[14] In 2012, the fertility rate in Tanzania was 5.29 per woman. Source: WHO, http://apps.who.int/gho/data/node.country.country-TZA?lang=en
[15] DHS 2010, see above, p. 68
[16] For more information on the Food and Nutrition Centre, see www.lishe.org
[17] Tanzania Food and Nutrition Policy, 1992, available at: www.tzonline.org/pdf/thefoodandnutritionpolicy.pdf
[18] Tanzania Food and Nutrition Policy, 1992, see above, p. 21-22.
[19] Ministry of Health and Social Welfare, *National Nutrition Strategy 2011-12/2015-16*, available at: https://extranet.who.int/nutrition/gina/sites/default/files/TZA%202011%20National%20Nutrition%20Strategy.pdf

under 6 months from 50% (Tanzania Demographic and Health Survey 2010) **to 60% in 2015**.[20] Another priority area defined by the Strategy is the full implementation of the Tanzanian **National Strategy on Infant and Young Child Nutrition** (MoH, 2004), in particular by ensuring access to skilled behaviour change counselling and support for infant and young child nutrition. Besides, the NNS calls for the full implementation of the Baby Friendly Hospital Initiative (BFHI) throughout the country as well as the development of community-based support networks in the framework of the Baby Friendly Community Initiative (BFCI). Indeed, the NNS states that "Legislation that is needed to create a supportive environment for nutrition is not yet fully developed, updated, enacted and enforced." [21]

Promotion campaigns

Under the NNS, a communication strategy has been designed in order to establish the best ways to change behaviors that could provide barriers to the fight to malnutrition. The strategy was called **National Nutrition Social and Behavior Change Communication Strategy July 2013 – June 2018**[22] and will reach not only women but also those groups that surround them and influence their decisions: families and health service providers. "*A broad range of channels will be used, including individual and group counseling, informal gatherings at community level, formal sessions through health services, school curricula and mass media.*"[23] **Individual and group counseling**, in particular, has been observed as being the most effective way to affect people's behavior and for this reason it will be transposed at health facilities level. Nutrition and malnutrition will be the core topics of the Communication Strategy, therefore breastfeeding and complementary feeding will be also integrated. However, to date, there **is no information available on the activities carried out in implementing this Communication Strategy.**

Furthermore, every year the **National Breastfeeding Week** is celebrated in Tanzania in the first week of August and represents the key promotional initiative for breastfeeding. In 2014, various activities have been organized in health facilities and communities with the support of the Ministry of Health and Social Welfare (MoHSW), but there is no specific information on the type of activities and materials distributed.[24]

[20] National Nutrition Strategy 2011/12-2015/16, see above, p. 16
[21] Idem, p. 11
[22] National Nutrition Social and Behavior Change Communication Strategy July 2013-June 2018, available at: http://scalingupnutrition.org/wp-content/uploads/2014/01/TANZANIA-NATIONAL-NUTRITION-SOCIAL-AND-BEHAVIOR-CHANGE-COMMUNICATION-STRATEGY-2013-latest-1.pdf
[23] NNS 2011/12-2015/16, see above, pp. 29-30
[24] UNICEF Media Centre, *Tanzania, 1 August 2014: Celebrating World Breastfeeding Week*, available at: www.unicef.org/esaro/5440_tanzania2014_world-breastfeeding-week.html

The International Code of Marketing of Breastmilk Substitutes

IBFAN's 2014 *State of the Code by Country*[25] places the United Republic of Tanzania among the countries which have implemented the Code and subsequent WHA resolutions with strong laws[26]. In fact, since 1994 Tanzania has adopted a **National Regulation for Marketing of Breastmilk Substitutes and Designated Products**. However, **its revision has not been endorsed** yet and there is **very poor awareness of its content at all levels and in most sectors**[27].

In addition, the National Nutrition Strategy 2011/12-2015/16 stresses the need for the legislation related to the protection of infant and young child feeding practices, that is yet *"not fully understood by all who have responsibilities for its implementation and enforcement*[28]*",* to be ***"reviewed, implemented, monitored and enforced"***.[29] (emphasis added)

Monitoring

The information available on Tanzania's policies and legislation does not mention any data on the existence of a specific National Breastfeeding Committee or Coordinator. For more than twenty years, the assessment on the breastfeeding indicators and situation has been carried out mainly through the Demographic and Health Surveys, but these do not provide a regular substantial collection of data since they are conducted on a cyclical basis every 3 to 6 years. The Tanzania Food and Nutrition Agency is the only body in charge of the overall management of health and nutrition issues, but it is clear that the creation of sub-bodies and committees would make the monitoring more effective and the collection and analysis of data more frequent.

Consequently, a **High Level Steering Committee on Nutrition (HLSCN)** has been created in 2011 within the Prime Minister's Office in order to *"coordinate multi-sectorial interventions to reduce child malnutrition and promote optimal breastfeeding."*[30] The work of the HLSCN is supported by a multi-sector Nutrition Technical Working Group chaired by the director of the Tanzanian Food and Nutrition Centre[31]. However, according to the information available, **the HLSCN has only a coordinating role, and does not carry out any monitoring activity.** This is another important reason why a specific Breastfeeding Committee would be desirable.

[25] IBFAN-ICDC, *State of the Code by Country*, 2014. A link to the document and to the previous years' charts can be found at http://ibfan.org/code-watch-reports
[26] Source: IBFAN, www.ibfan.org/art/298-7.pdf
[27] National Nutrition Social and Behavior Change Communication Strategy July 2013-June 2018, p. 4
[28] National Nutrition Strategy 2011/12-2015/16, see above, p. 11
[29] NNS 2011-12/2015-16, see above, § 87, p. 19
[30] UNICEF Media Centre, *Tanzania, 1 August 2014: Celebrating World Breastfeeding Week*, available at: www.unicef.org/esaro/5440_tanzania2014_world-breastfeeding-week.html
[31] Source: Scaling Up Nutrition, Tanzania, available at http://scalingupnutrition.org/sun-countries/tanzania

Moreover, in May 2014, the President of the United Republic of Tanzania launched a new instrument, called the **Reproductive Maternal, Newborn and Child Health (RMNCH) Scorecard[32],** aimed at monitoring and assessing the progress in RMNCH every three months.[33] The data collected and analyzed will touch several indicators related to RMNCH and will constitute a more frequent control on infant and young child feeding issues as well, enabling prompt interventions in those areas where progress is slower. To date, there are **no more details on the Scorecard and on how it will effectively provide an assessment of the breastfeeding situation in the country.**

Courses / Training of Health Professionals

The National Food and Nutrition Centre offers nutrition education and training for practitioners of different levels in order to reduce malnutrition[34], but there are **no information available on specific trainings or courses focused on optimal breastfeeding practices**.

4) Baby-Friendly Hospital Initiative (BFHI)

In 2010, out of the 185 hospitals in Tanzania, **only 68 were ever certified as "baby-friendly**[35], which corresponds to **37% of the total facilities**. Although this figure has been gradually increasing (in 1997, certified "baby-friendly" facilities were only 22), it is still quite low, considering that there is a high number of hospitals in Tanzania and that the annual births in the country are extremely high. However, *"only 50% of all births in Tanzania occur at health facilities"* and *"postnatal care service utilization is still low, at 31% within 2 days after delivery."*[36] This trend should be inverted especially because it is precisely within the health facilities that health care professionals can give the appropriate counseling and assistance to breastfeeding mothers, where family members and caregivers may not have yet the adequate knowledge.

[32] WHO Tanzania, *The United Republic of Tanzania launches the sharpened one plan and the RMNCH Score Card to prevent Maternal, Newborn and Child Mortality*, available at: www.afro.who.int/pt/tanzania/press-materials.html
[33] The Sharpened One Plan 2014-2015 was launched to accelerate progress on the achievement of the goals already set in the 2008-2015 National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, available at: www.who.int/pmnch/countries/tanzaniamapstrategic.pdf
[34] Information retrieved from the Food and Nutrition Centre website www.lishe.org/about-tfnc
[35] Labbok, M.H. (2012). Global Baby-Friendly Hospital Initiative Monitoring Data: Update and Discussion, *Breastfeeding Medicine, 7* (4), 210-222.
[36] WHO Tanzania, *The United Nations in Tanzania recognized for improving Maternal, Newborn and Child Health*, available at: www.afro.who.int/pt/tanzania/press-materials.html

5) Maternity protection for working women

Tanzania's legislation related to maternity protection includes various acts and regulations.[37]

Maternity leave

Scope: The maternity leave provisions of the Employment and Labour Relations Act apply to all employees employed in mainland Tanzania, including those in the public service of the Government of Tanzania. It does not apply to members, whether temporary or permanent, in the service of the Tanzania People's Defense Forces, the Police Force, the Prisons Service, or the National Service

Conditions: To qualify for maternity leave, an employee must: 1) give notice of intention to take maternity leave at least 3 months before the expected date of birth, supported by a medical certificate; 2) unless employed on a seasonal basis, have worked for more than 6 months (in total) for the same employer; 3) **not have taken a similar leave within the leave cycle (defined for the purposes of maternity leave as a 36-month period commencing on the anniversary of the employee's employment)**; and 4) **not have taken maternity leave for four terms under the same employer.**

Duration: An employee shall be entitled 84 days (12 weeks) maternity leave.

Compulsory leave: No employee shall work during 6 weeks after childbirth, unless a medical practitioner certifies that the employee is fit to work.

Typically, maternity leave is to commence at any time from 4 weeks before the expected date of confinement and end no earlier than 6 weeks after the actual date of confinement.

An employee may commence maternity leave before the normal starting date if a medical practitioner certifies that it is necessary for the employee's health or that of her unborn child.

Extension: An employee is entitled to 100 days' maternity leave (14 weeks) if she gives birth to more than one child at the same time.

Benefits: Maternity leave benefits change depending on the legislation applied.

Under the **Employment Act**:

- *Conditions* – Paid to a) an insured person who has made at least 36 monthly contributions, of which 12 contributions are made in the 36 months prior to date of confinement; b) upon the receipt by the Director General of a medical certificate from an accredited medical provider, certifying that the woman expects delivery of a child;

[37] Employment and Labour Relations Act, Act 6, 2004, available at: www.ilo.org/dyn/natlex/docs/SERIAL/68319/66452/F437907581/tza68319.pdf; National Social Security Fund Act, Act. No. 28, 1997, available at: www.tic.co.tz/media/National%20Social%20Security%20Fund%20Act%201997.pdf; Community Health Fund Act, Act No. 1, 2001, available at: www.ilo.org/dyn/travail/docs/2243/Community%20Health%20Fund%20Act%202001.pdf

and provided c) **3 years have passed since the day when the last payment was made to the insured person** (unless the child dies within a period of 12 months).

- *Amount* – Maternity leave shall be paid at a rate calculated on an employee's basic wage. "Basic wage" means that part of an employee's remuneration paid in respect of work done during the hours ordinarily worked but does not include allowances, whether or not based on the employee's basic wage, pay for overtime, additional pay for work on a Sunday or a public holiday, or additional pay for night work. Maternity benefits equal to 100% of the employee's average daily earnings shall be payable for a period of 12 weeks.
- *Duration* – Whole leave. A maternity benefit shall be payable for 1 month only to an insured person in the case of still-birth.
- *Benefits are paid by* – the employer.

Under the **National Social Security Act**:

- *Conditions* – Shall be payable for a period of 12 weeks under the National Social Security Fund Act: a) to an insured person who has made at least 36 monthly contributions, of which 12 contributions are made in the 36 months prior to date of confinement; and b) upon the receipt by the Director General of a medical certificate from an accredited medical provider, certifying that the woman expects delivery of a child; provided; c) **3 years have passed since the day when the last payment was made to the insured person** (unless the child dies within a period of 12 months).
  Employers who are registered with the National Social Security Fund are exempted from the maternity benefit requirements under the Employment Ordinance. Further, no insured person shall be entitled at anytime to more than one benefit, and if he qualifies for more benefits than one at the same time he shall be paid the one which is the highest.
- *Amount* – Maternity benefits equal to 100% of the employee's average daily earnings.
- *Duration* – 12 weeks. Maternity benefits shall be payable for 1 month only to an insured person in the case of still-birth.
- *Benefits are paid by* – the National Social Security Fund.

Paternity leave

Conditions: To qualify for paternity leave, an employee must: 1) be the father of the child; 2) take the leave within 7 days of the birth of a child; 3) unless employed on a seasonal basis, have worked for more than 6 months (in total) for the same employer; and 4) **not have taken a**

similar leave within the leave cycle (defined for the purposes of maternity leave as a 36-month period commencing on the anniversary of the employee's employment).
Duration: The paternity leave entitlement is to a period of 3 days' leave in any leave cycle (36 months).
Extension: The statutory entitlement does not increase according to the number of children that are born within the leave cycle.
Benefits: Paid by the employer.

Breastfeeding breaks

Where an employee is breastfeeding a child, the employer shall allow the employee to feed the child during working hours up to a maximum of 2 hours per day. No mention of total duration of breaks. There is no clarity on whether breaks are paid or not.

6) HIV and infant feeding

In 2013, UNICEF reported a HIV prevalence of 5% among adults (aged between 15 and 49) in Tanzania, with an **estimation of about 100,000 pregnant women living with HIV**.[38] The HIV prevalence rate was 6% in 2006[39] so there has been a slight improvement in the last years, also thanks to the efforts made at national level to raise awareness on HIV-prevention and treatment methods. In 2012, the MoHSW published the **National Guidelines for Comprehensive Care of Prevention of Mother-to-Child Transmission of HIV Services**[40], where substantial information on the PMTCT is provided for the benefit of healthcare professionals and facilities. Nonetheless, the **estimated rate of mother-to-child transmission (MCT) in 2013 was 15.8%**.[41]

The DHS 2010 data reveal that **89% of women and 81% of men know that HIV can be transmitted through breastfeeding**. However, 75% of women and 67% of men know that the risk of mother-to-child transmission can be reduced through the use of antiretroviral drugs during pregnancy.[42] This proportion has increased compared to the previous DHS data, collected in 2004-2005[43], but it is still too low with view to the high rate of MCT and calls for major efforts in order to spread the correct information on this issue. Initiatives such as the

[38] UNICEF data, 2013, available at: http://data.unicef.org/hiv-aids/global-trends
[39] WHO data, available at: http://apps.who.int/gho/data/node.country.country-TZA?lang=en
[40] MoHSW, *National Guidelines for Comprehensive Care of Prevention of Mother-to-Child Transmission of HIV Services*, 2012, available at: http://pmtct.or.tz/resource/tanzania-national-guidelines-for-comprehensive-care-of-pmtct-services-3rd-edition/
[41] UNICEF data, 2013, see above
[42] DHS 2010, see above, pp. 215-216
[43] Idem.

mothers support group created in 2012 in the Njombe Region[44] and aimed at raising awareness on MCT as well as giving psychological support to HIV positive mothers are welcome and should be encouraged, as they represent an **effective way to reach directly the mothers concerned**.

7) Infant feeding in emergencies (IFE)

As pointed out in the NNS[45], **there are no emergency preparedness plans and guidelines with specific reference to infant and young child feeding**. Indeed, when an emergency strikes there should be precise information on how and where to take "*sufficient human, financial and material resources to provide appropriate nutrition care to children and women"*.[46] Tanzania should therefore ensure **integrated response** to protect and support breastfeeding **in case of emergencies** through the implementation of a national plan and designation of persons to coordinate activities.

[44] UNICEF Media Centre, *Tanzania, 4 September 2012: Mothers' support group tackles mother-to-child transmission of HIV*, available at: www.unicef.org/esaro/5440_Tanzania_pmtct_support_group.html
[45] NNS 2011-12/2015-16, see above, § 111, p. 24
[46] Idem.

ANNEX

Regarding Tanzania, several violations of the Code have been reported to IBFAN's International Code Documentation Centre. The report *Breaking the Rules 2014* highlights a violation committed by Nestlé (the Swiss world leader on the market of industrial baby foods). The company runs the *"NIDO 10 Signs of Good Nutrition"* campaign to provide an *"educative and exciting platform"* for consumer interaction especially mothers. The campaign was well supported by radio airtime which allowed discussions among listeners to increase their awareness of the products.

The campaign which was carried out in places like Mwanza, Dodoma and Arusha and supported by radio air time clearly impacts sales and brand appreciation among consumers.