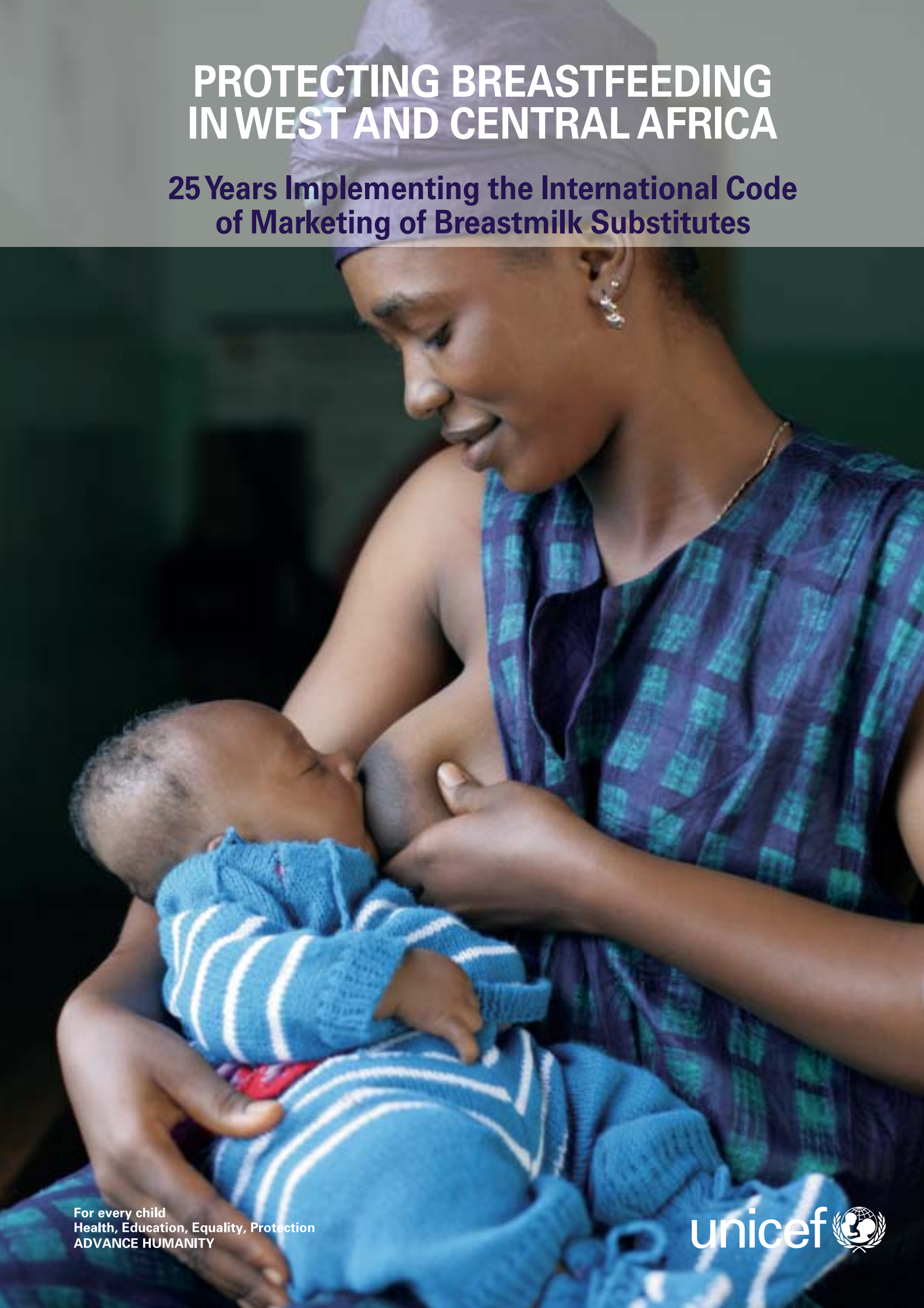
PROTECTING BREASTFEEDING IN WEST AND CENTRAL AFRICA

25 Years Implementing the International Code of Marketing of Breastmilk Substitutes



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Ellen Sokol, Victor Aguayo, David Clark

Foreword by Pr. Dora Akunyili

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FOREWORD

Child malnutrition has become a global embarrassment, particularly in the developing world, where malnutrition is the attributable cause of more than half of all child deaths. In West and Central Africa – a region with some of the highest child malnutrition and mortality rates worldwide – 56 percent child deaths could be averted if children were not malnourished.

The protection, promotion and support of exclusive breastfeeding in the first six months of life is acknowledged as the single most critical strategy if West and Central Africa is to achieve the Millennium Development Goal for the reduction of child mortality; however, the rate of exclusive breastfeeding in the region (20 percent) remains among the lowest in the world. Breastfeeding is a tradition in every culture in the region regardless of socio-economic status; when mothers are not in a position to breastfeed, the services of other mothers are sought. Unfortunately, in the late 1960's, breastfeeding took a dangerous downward trend when it started to be discouraged through the aggressive marketing of commercial breastmilk substitutes; as a result, traditional infant feeding practices started to shift towards more 'modern' feeding practices. It was therefore timely, that UNICEF and WHO called on all governments to protect, promote and support breastfeeding and to enable women to breastfeed their infants exclusively from delivery to six months of age.

In West and Central Africa, the protection, promotion and support of exclusive breastfeeding is acknowledged as the single most critical strategy to achieve the Millennium Development Goal for the reduction of child mortality; however, the rate of exclusive breastfeeding in West and Central Africa (20 percent) remains among the lowest in the world.

In countries like Nigeria, manufacturers and distributors of breastmilk substitutes have tried to promote artificial feeding using inappropriate promotional gimmicks. They start by emphasizing that breastmilk substitutes are good for infants from four months and above while distributing free samples of commercial breastmilk substitutes in health facilities (sometimes under the guise that sick mothers cannot breastfeed and sick infants cannot suckle).

I am a typical example of mothers that hardly breastfed their babies because of aggressive marketing of breastmilk substitutes. Looking back, I now know why my children were often sick. Being a medical doctor's wife, as soon as I put to bed, I would receive dozens of donations of breastmilk substitutes. I realised the importance of breastfeeding when I had my last baby in 1988 and breastfed him for a long time. I cannot remember him ever being sick.

Unethical marketing practices sometimes take criminal dimension, when low quality or expired breastmilk substitutes are sold, putting children in double jeopardy. In 2001, a world-renowned manufacturer of infant formula imported in Nigeria nine 40-feet containers of expired skimmed milk powder to be used in the production of breastmilk substitutes. Without the vigilance of the National Agency for Food and Drug Administration and Control (NAFDAC), the expired milk would have been used and sold to the unsuspecting public. Another case was that of a man in Abuja who was mixing cassava flour, milk and sugar, and packing it in recycled containers of breastmilk substitutes. He confessed that he had done that for years. The case is currently in a Nigerian court. Nobody knows how many infants died silently.

In 1990, policy makers from more than 30 countries met at the Spedale degli Innocenti in Florence (Italy) on *Breastfeeding in the 1990s* and issued the *Innocenti Declaration*. In the *Declaration* they affirmed that breastfeeding "reduces the incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality, contributes to women's health by reducing the risk of breast and ovarian cancer, and by

increasing the spacing between pregnancies, provides social and economic benefits to the family and the nation, and provides most women with a sense of satisfaction when successfully carried out".

It was noted that these benefits increase with exclusive breastfeeding in the first six months of life and continued breastfeeding until 24 months and beyond. The *Innocenti Declaration* also reflected both the right of the infant to nutritious food - as enshrined in the Convention on the Rights of the Child – and the spirit of the support required for breastfeeding. The *Innocenti Declaration* required member states to put in place the following before 1995:

- Appoint a national breastfeeding coordinator
- Establish a multi-sectoral breastfeeding committee
- Ensure that all maternity facilities practice all *Ten Steps to Successful Breastfeeding*
- Take action to give effect to the principles and aims of all articles of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions
- Enact legislation to protect the breastfeeding rights of working women

A lot has been achieved in the past twenty-five years in order to ensure that the Code of Marketing of Breastmilk Substitutes translates into improved protection of optimal breastfeeding practices in West and Central Africa. Starting with Nigeria in 1990, and Burkina Faso and Cameroon in 1993, countries in West and Central Africa have set up interdisciplinary national committees comprising representatives from the public sector, the private sector and civil society, to handle the various stages of Code implementation. Laws, decrees or regulations have been enacted to implement the Code. Training has been provided to health workers, Code watchers and informants in local communities, and other stakeholders. Training manuals, Code handbooks and guidelines have been produced. Campaigns have been mounted prohibiting the commercial promotion of breastmilk substitutes, complementary foods, feeding bottles and teats in any form that may interfere with international recommendations and national policies on infant and young child feeding. Advocacy to government policy makers has resulted in financial and technical support to the full implementation of the Code.

However, sometimes weak or lack of regulatory control measures have greatly hindered the implementation of the Code and subsequent World Health Assembly resolutions. For example, when I took over the mantle of leadership in NAFDAC, I realized the need to build a strong regulatory environment to ensure strict and appropriate implementation of the guidelines for the marketing of breastmilk substitutes. We have been monitoring and assessing the level of compliance with the Code by manufacturers and marketers and have instituted stiff penalties for non compliance. We carried this initiative forward through spearheading the formation of the West African Drug Regulatory Authorities Network (WADRAN), so as to build an effective partnership towards the establishment of strong regulatory mechanisms in West Africa for the enforcement of the Code and subsequent World Health Assembly resolutions.

The importance of enforcement and continuous monitoring of Code implementation cannot be overemphasized. Ensuring adherence to the Code entails the imposition of penalties that are widely publicized and stiff enough for defaulting manufacturers and marketers. We have used these tools effectively, with consignments of expired, adulterated and counterfeit infant formula confiscated and destroyed by NAFDAC. Such activities cannot be effectively and continuously undertaken without the legislative and financial backing of the government.

There is no doubt that the consensus required for agreeing on the legal instrument and its implementation requires government leadership. Countries that have not yet implemented the Code may not perceive the problem as a primary government responsibility, thereby doing a great disservice to the future of their nation. Such countries therefore need to urgently enact the enabling legislation to protect breastfeeding and implement the Code accordingly. Technical support and the input of health professionals are critical as their opinions influence the government, manufacturers and marketers, and the consumers.

Currently, increasing commitment to the Millennium Development Goals offers a new impetus to improve breastfeeding practices. In addition to reducing child mortality, improved breastfeeding practices contribute to reduce poverty and malnutrition and improve maternal health (Millennium Development Goals 1 and 5 respectively) meaning that three of the eight Millennium Development Goals are directly linked to breastfeeding protection, promotion, and support.

To invest on breastfeeding is to invest in our children, and to invest in our children is to invest in our present and future. We commend and thank those who have worked relentlessly, to protect, promote, and support breastfeeding across member states in West and Central Africa: UNICEF, WHO, and other organizations and individuals who have given support to national authorities in planning, implementing, monitoring and evaluating national policies and programs.

There is no doubt that the consensus required for agreeing on the legal instrument and its implementation requires government leadership. Countries that have not yet implemented the Code may not perceive the problem as a primary government responsibility, thereby doing a great disservice to the future of their nation (...) We commend and thank those who have worked relentlessly, to protect, promote, and support breastfeeding across member states in West and Central Africa.

This report comes at a most critical point to revolutionalise the strategic thinking of governments, civil society and individuals after twenty-five years of the Code's existence. I therefore recommend it to all governments, policy makers, regulatory authorities, health workers, administrators, consumer rights' groups, religious bodies, infant food manufacturers and distributors, trade associations, professional associations, advertisement regulatory bodies, the media, researchers, students and the general public. It is a highly valuable reference document. Posterity will remain eternally grateful to Ellen Sokol, Victor Aguayo and David Clark who are well known child survival specialists, for putting this report together.

Pr. Dora Nkem Akunyili, Director General

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SUMMARY

In 1981, the World Health Assembly (WHA) adopted the International Code of Marketing of Breastmilk Substitutes out of concern that inappropriate marketing practices of breastmilk substitutes were contributing to the alarming decline in breastfeeding rates worldwide and the increase in child malnutrition, morbidity and mortality rates, particularly in developing countries. The WHA urged member states to implement the International Code "in its entirety". Since 1981, the WHA has adopted a number of relevant resolutions concerning infant feeding and the use of breastmilk substitutes. These resolutions serve to keep the International Code up to date with advances in scientific knowledge and changing marketing practices. These resolutions enjoy the same status as the International Code.

In West and Central Africa, Nigeria was the first country to implement the International Code (1990). Since then, of the 24 countries that comprise West and Central Africa, 12 have laws, decrees or regulations that implement all or most of the provisions of the International Code (Benin, Burkina Faso, Cameroon, Cape Verde, DR Congo, Gabon, Gambia, Ghana, Mali, Niger, Nigeria and Senegal); three have a legal instrument that implements a few of the provisions of the International Code (Guinea, Guinea Bissau, and Sao Tome and Principe); six countries have either a draft of a law or decree that is awaiting final government approval, or have established a government committee that is studying how best to implement the International Code (Chad, Congo, Côte d'Ivoire, Mauritania, Sierra Leone, and Togo); only three countries have not taken any action, to implement the International Code (Central African Republic, Equatorial Guinea and Liberia).

Nations in West and Central Africa have faced a range of challenges in their efforts to implement the International Code. Currently, 25 years after the International Code was adopted, different countries in the region are at different stages in the process of adopting and enforcing legislation to implement the provisions of the International Code and subsequent relevant WHA resolutions. This review of progress in the implementation of the International Code in West and Central Africa identifies eight major lessons learned:

1. Championship in linking infant feeding and child survival to national priorities is essential to advance national action to regulate the marketing of breastmilk substitutes. Governments change, priorities change, economic pressures sometimes outweigh child survival interests and, in some countries, war and civil unrest challenge efforts to advance infant feeding and child survival. In West and Central Africa - a region where nearly all mothers breastfeed - protecting breastfeeding is not always perceived as a problem requiring government attention. As a result, drawing the attention of policy makers to the need to regulate the marketing of breastmilk substitutes can be a challenge. In the eighties, after the endorsement of the International Code by the WHA in 1981, no country in West and Central Africa had translated the provisions of the International Code into a national legislative framework. Early attempts by manufacturers of breastmilk substitutes to self regulate their marketing practices led some governments to hold off on stronger national measures, believing them to be unnecessary. The experience in West and Central Africa shows that national implementation of the International Code requires championship, coordination and perseverance. In Ghana, for example, a number of years of information, advocacy, and consultation were needed before the Breastfeeding Promotion Regulation was adopted in 2000. Involve-

ment of all stakeholders throughout the process was important. Having the Ghana Infant Nutrition Action Network (GINAN) and UNICEF as a steady an authoritative voice throughout the entire drafting and endorsement process was crucial to Ghana's ultimate success in adopting the regulation.

2. A clearly defined scope is essential for national legislation on the marketing of breastmilk substitutes to be effectively implemented. Legal instruments modeled on the International Code, leave room for marketing techniques that are harmful to breastfeeding. In West and Central Africa, as in other countries, the provision about which it has been most difficult to achieve consensus among all parties in national legal frameworks is the scope or, more simply, what products to include within the ambit of the law. The commercial promotion of follow-up formulas, growing-up milks and complementary foods has harmed efforts to promote exclusive breastfeeding by reinforcing ideas about the inadequacy of exclusive breastfeeding and the benefits of the early introduction of other infant foods. However, the increased knowledge about the centrality of exclusive breastfeeding in the first six months of life for optimal child survival, growth and development has led to a clearer understanding of the need to regulate the marketing of a wider range of breastmilk substitutes. As a result, most of the laws in West and Central Africa cover the full range of infant foods in their scopes. Proper communication with all concerned parties about the rationale and scope of the proposed legislative framework facilitates the drafting and adoption process. Lack of information sharing throughout the process can lead to the belief that the proposed legislative framework will prohibit the sale of products within its scope.

3. International declarations and statements are among the most important stimuli for national action to implement the International Code. UNICEF and WHO statements and initiatives linked to child feeding, nutrition and survival have been among the most important stimuli for action to implement the International Code at the national level. In 1989, WHO and UNICEF issued the statement Protecting, Promoting and Supporting Breastfeeding: the Special Role of Maternity Services, which listed the Ten Steps to Successful Breastfeeding. In 1990, the Innocenti Declaration was also a major impetus for Code implementation in the region. An operational target of the Declaration was for all governments to take action to implement the International Code. In 1991, WHO and UNICEF launched the Baby Friendly Hospital Initiative to encourage health facilities to adopt the Ten Steps to Successful Breastfeeding. In West and Central Africa, UNICEF and WHO worked simultaneously on two complementary strategies: one to encourage health facilities to implement the Ten Steps to Successful Breastfeeding and the other to encourage governments and manufacturers of breastmilk substitutes to end the provision of free supplies to national health care systems. These efforts led to a flurry of policy and program action. The Global Strategy for Infant and Young Child Feeding (2000) and the Framework for Priority Action on HIV and Infant Feeding (2002) have been crucial instruments to advance action in favor of the full implementation of the International Code in West and Central Africa.

4. Ensuring the support and leadership of health professionals is essential to endorse and enact national legislation on the marketing of breastmilk substitutes. In most countries in West and Central Africa where a legislative framework on the marketing of breastmilk substitutes has been adopted, the impetus for national legislation has originated with health professionals in the Ministry of Health and the National Breastfeeding Committee; these professionals were convinced of the centrality of breastfeeding for child nutrition and survival. However, in some countries in West and Central Africa, knowledge and understanding among health care providers about infant feeding, child survival and the International Code is often poor. A large proportion of physicians and other health practitioners are not yet aware of the evidence for the Ten Steps to Successful Breastfeeding and still believe that artificial feeding is a good alternative to breastfeeding. Uninformed health workers who do not understand the purpose of regulating the marketing of breastmilk substitutes often oppose or fail to promote such regulations, particularly the regulations that apply to their professions. In countries where public funding for education, training and research is lacking, offers from infant food companies to health workers to fill in the gaps become more attractive. In the interface between health systems and national legislation on the marketing of breastmilk substitutes, priority attention needs to be given to put end the provision of: a) free supplies of breastmilk substitutes to health facilities; and b) private sector's "information and education" support to health providers; both practices influence negatively health workers' advice and support to mothers on breastfeeding.

5. Training on Code implementation is instrumental to national implementation of the International Code. Support from organizations such as UNICEF, WHO, IBFAN and ICDC (International Code Documentation Center) has been instrumental to national implementation of the International Code. These organizations have provided information, knowledge and advocacy support to persuade government officials of the need for national legislation on the marketing of breastmilk substitutes; they have also provided the technical support needed to draft and disseminate national legislative frameworks and to strengthen national capacity for monitoring and enforcing the legal framework. UNICEF and WHO regional offices have played an important role in supporting regional partners and country programs in policy advocacy, technical support, quality assurance, program communication and knowledge dissemination on infant feeding, nutrition and child survival, including issues related to the proper use of breastmilk substitutes in regular programs, emergency situations and in the context of HIV/AIDS. IBFAN-Africa and IBFAN member groups have played an important role in bringing to public attention threats to optimal infant feeding and in demanding national and international action. The groups have used survey findings to lobby their govern-

ments to enact legislation on the marketing of breastmilk substitutes. ICDC has provided important support to organize training courses on Code implementation for most countries in West and Central Africa.

6. Effective implementation of the International Code at the national level requires provisions and capacity related to monitoring compliance with the legislative framework. To be effective, legislation must be monitored. Effective implementation of the International Code at the national level requires that the national legislative framework for the marketing of breastmilk substitutes include provisions related to monitoring. A lesson learned from the experience in Ghana is the importance of establishing an independent monitoring body -The National Breastfeeding Promotion Regulations Coordinating Committee - that can submit its findings and recommendations to a designated government enforcement agency that has the capacity to impose penalties. Relevant monitoring agencies need to be adequately equipped for the task, including adequate staff training and standardized and field-tested monitoring survey tools to carry out effectively its monitoring role. Regional organizations such as the Economic Community of West African States and the West African Health Organization should encourage national governments to base their legislative and monitoring frameworks on a regional model.

7. Effective implementation of the International Code at the national level requires provisions and capacity to enforce the legislative framework. To be effective, legislation must be enforced. Effective implementation of the International Code at the national level requires that the national legislative framework for the marketing of breastmilk substitutes include provisions related to its enforcement. The experience in West and central African countries also shows that officials who are in charge of enforcing the provisions of national legislation need to have strong knowledge on infant feeding, nutrition, and child survival issues and understand well how the International Code relates to these issues. Enforcement becomes easier and more effective when – like in Nigeria - national regulations detail the penalties that will be imposed for Code violations. Penalties must be clearly defined and severe enough to deter violations including as is the case of Nigeria, the suspension of product registration when breastmilk substitutes are advertised or otherwise promoted. In Nigeria, the designation of the National Agency for Food and Drug Administration and Control (NAFDAC) as the agency responsible for enforcing compliance with the International Code has been a crucial step in the implementation of the national legislative framework for the marketing of breastmilk substitutes. In addition to the authority to enforce, the enforcing agency also needs budgetary authority to enforce compliance with the national legislation.

8. Integration into a multi-pronged strategy to advance child feeding, nutrition and survival is essential to ensure effective national implementation of the International Code. Adopting legislation to regulate the marketing of breastmilk substitutes will not, by itself, improve infant feeding practices. Governments, United Nations agencies, humanitarian and development NGOs, health professionals, media professionals, civil society and individuals need to work in partnership towards revitalizing facility-based, community-based and media-based protection, promotion and support to breastfeeding – particularly early initiation of breastfeeding and exclusive breastfeeding through the first six months of life. This needs to be seen and advanced as a central component of Africa-wide efforts to improve child feeding, nutrition and survival and reach Millennium Development Goals 1 and 4 for the reduction of child malnutrition and mortality. In DR-Congo, for example, the enactment of the law regulating the marketing of breastmilk substitutes is placed in the context of a multi-pronged plan of action to strengthen policies and programs for the protection, promotion and support of improved infant feeding practices. The plan is implemented through concerted program action at the community level (through community-based resource persons, women's support groups and NGO-supported programs), the health facility level (in hospitals, maternities and mother-and-child health services) and the media (television, radio and printed journals).

In conclusion, nations in West and Central Africa have made tremendous progress in implementing the International Code. However, there is still work to be done before each country has a legislative framework, the legal instruments and the human capacity needed to monitor and enforce compliance with the International Code. The momentum achieved over the last 25 years needs to continue and be intensified. In countries where a law has been adopted, health workers need to be well informed to ensure that they support the provisions of the law in their day-to-day practice and within the health care system. Officials need to be trained to monitor compliance with the International Code and monitoring and reporting tools need to be developed. Media outreach needs to be developed and sustained to inform the general public and infant food manufacturers, distributors and detailers about the provisions of the law. Additionally, resources need to be channeled to law enforcement. Countries with a law still in draft form need to be supported to advance progress to the adoption of legal measures. Special efforts are needed to determine why some countries have taken no action to implement the Code.

It is now acknowledged that in West and Central Africa - the region of the world with the highest infant mortality rates and the lowest exclusive breastfeeding rates - policy and program action to protect, promote and support improved breastfeeding practices - particularly exclusive breastfeeding in the first six months of life - have the potential to be the single most important child survival intervention. Twenty-five years after its adoption by the World Health Assembly, the International Code of Marketing of Breastmilk Substitutes remains as important as ever for child survival in West and Central Africa.

1

BREASTFEEDING PRACTICES IN WEST AND CENTRAL AFRICA

West and Central Africa is house to 350 million people; an estimated 61 million of the total population are children younger than five years. Countries in West and Central Africa have some of the highest child malnutrition and mortality rates worldwide. In this region, three million children younger than five years die annually, most of them from preventable causes; their deaths represent 26 percent of child deaths worldwide.

As part of the Millennium Development Goals (MDGs), nations in West and Central Africa have pledged to ensure a two-thirds reduction in underfive mortality by 2015, from the base year 1990. In 1990, the regional underfive mortality rate in West and Central Africa was 209 child deaths per 1,000 live births; in 2004, this rate fell to 191 child deaths per 1,000 live births; this means an 8.6 percent reduction over a 14-year period (i.e. an average 0.6 percent decrease per year).

The causes of child mortality in West and Central Africa do not differ substantially from one country to another; the estimated distribution of causes of death is: neonatal disorders, 26 percent; malaria, 21 percent; pneumonia, 21 percent; diarrhea, 17 percent; measles, 6 percent; HIV/AIDS, 4 percent; other causes, 5 percent. Malnutrition is the attributable cause of 56 percent of child deaths; this means that 56 percent of child deaths in West and Central Africa could be averted if children were not malnourished.

In 2004, the regional prevalence of child malnutrition (underweight) in West and Central Africa was 28.4 percent. This means that in West and Central Africa, 17.2 million children younger than five years are malnourished. Children who are malnourished have lowered resistance to infections and are at a higher risk of death from common childhood diseases such as diarrhea, pneumonia, malaria, and measles. Moreover, malnourished children who survive are often caught in a vicious cycle of recurring infections and growth faltering, often with irreversible damage to their physical growth and learning ability.

As part of the MDGs, nations in West and Central Africa have pledged to ensure a one-half reduction in child underweight by 2015 from the base year 1990. In 1990, the regional prevalence of child underweight was 32.0 percent; in 2004, it fell to 28.4 percent; this means an 11.3 percent reduction over a 14-year period (i.e. an average 0.8 percent decrease per year).

Countries in West and Central Africa have some of the highest child malnutrition and mortality rates worldwide. In this region, three million children younger than five years die annually; malnutrition is the attributable cause of 56 percent of these child deaths; this means that 56 percent of child deaths in West and Central Africa could be averted if children were not malnourished.

In West and Central Africa, infants and young children are particularly affected by malnutrition as demonstrated by the fact that 34 percent (one third) of children 6-23 months old are underweight. Poor feeding practices – particularly suboptimal breastfeeding and complementary feeding practices for infants and

Note

For the purpose of this document, West and Central Africa comprises the 24 countries included in UNICEF's West and Central Africa Region; these are: Benin, Burkina Faso, Cameroon, Cape Vert, Central Africa Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone and Togo.

young children - are the major cause of child malnutrition along with common illnesses often exacerbated by intestinal parasites.

Young children are particularly affected by malnutrition as demonstrated by the fact that 34 percent (one third) of children 6-23 months old are underweight. Poor feeding practices – particularly sub-optimal breastfeeding and complementary feeding practices for infants and young children - are the major cause of child malnutrition along with common illnesses often exacerbated by intestinal parasites.

Breastfeeding is a universal practice in West and Central Africa. Breastfeeding initiation rates are above 90 percent in all countries (with the exception of Gabon) and children are breastfed for a long time as reflected by the fact that the mean duration of breastfeeding in West and Central African countries is 20 months. However, the rate of exclusive breastfeeding is lower than in any other region in the world: in West and Central Africa, only 20 percent of infants younger than six months are exclusively breastfed, with rates of exclusive breastfeeding as low as 2 percent in Chad, 4 percent in Sierra Leone, and 5 percent in Côte d'Ivoire. However, some countries in the region have shown remarkable progress in the proportion of infants younger than six months who are exclusively breastfed; between 1990 and 2004, exclusive breastfeeding rates increased from 3 percent to 19 percent in Burkina Faso, 7 percent to 24 percent in Cameroon, 4 percent to 53 percent in Ghana, 9 percent to 25 percent in Mali, 3 percent to 17 percent in Nigeria, and 6 percent to 34 percent in Senegal.

In West and Central Africa, breastfeeding is a universal practice, as reflected by a mean duration of breastfeeding of 20 months. However, the rate of exclusive breastfeeding is lower than in any other region in the world as only 20 percent of infants younger than six months are exclusively breastfed.

It is encouraging to see that breastfeeding is deeply rooted in the tradition and practice of countries, communities, and caregivers; it is also encouraging to see that there have been significant and sustained increases in the protection, promotion and support of exclusive breastfeeding. However, West and Central Africa remains the region of the world with the highest infant mortality rates and the lowest exclusive breastfeeding rates worldwide. Therefore, if improved breastfeeding practices - particularly early initiation of breastfeeding within one hour after birth and exclusive breastfeeding through the first six months of life – are protected, promoted and supported through results-oriented policy action and program implementation, breastfeeding has the potential to become the single most important child survival intervention in West and Central Africa.

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2

WHAT IS THE INTERNATIONAL CODE AND WHY IS IT NECESSARY?

Twenty-five years ago, billboards and radio spots beckoned mothers to make their babies strong and healthy by feeding them with manufactured milk specially formulated to replace breastmilk. Booklets and leaflets given out to mothers in the maternity and other mother and child services of the health care system assured women that commercial breastmilk substitutes would make it safe and easy to feed their infants if mothers lacked enough breastmilk or while women were at work.

The promotional materials did not mention that children who are not breastfed are at a higher risk of diarrhoea and respiratory infections, two of the most common causes of infant malnutrition, morbidity and mortality in developing countries. They also failed to inform mothers and health care providers that nearly every mother has enough milk to feed her child and that women can continue to breastfeed their children when they go to work away from their homes. Moreover, health workers were not informed about how to best support mothers from the moment of birth so that breastfeeding becomes easy and rewarding.

When costly commercial infant formula is over-diluted to make it last longer or when formula is fed in unsterilized bottles with unclean water, the risk of malnutrition, disease and death is magnified as children are deprived of the nutritional and immunological properties of breastmilk and exposed to the dangers of artificial feeding. Billboards, posters and leaflets were intended for women who could afford commercial breastmilk substitutes and who were educated enough to read the preparation instructions so as to reduce the risks of artificial feeding. However, manufacturers and distributors of commercial breastmilk substitutes did not always take the responsibility for the consequences of their marketing practices on less fortunate women (i.e. the vast majority of women in developing countries). As the bottle-feeding trend spread from economically well-off families to the general population in developing countries, a raise in child malnutrition, disease and death followed as only a limited number of families had adequate access to the breastmilk substitutes, clean water, fuel, sterilization facilities and literacy levels required to make appropriate use of commercial infant formula.

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As the bottle-feeding trend spread from economically well-off families to the general population in developing countries, a rise in child malnutrition, disease and death followed as only a limited number of families had adequate access to the breastmilk substitutes, clean water, fuel, sterilization facilities and literacy levels required to make appropriate use of commercial infant formula.

2.1. Marketing of breastmilk substitutes: A historical perspective

Up until the 19th century, nearly all children were breastfed, whatever the culture or country, home setting or economic status. In the rare situations when a mother died or was unable to breastfeed because

work kept her away from her child or because she was sick, the alternative was to look for another woman to breastfeed the child. Similarly, when women of aristocracy were persuaded or chose to leave their babies to the care of nurses or nannies, the babies were put to another woman's breast. These women, called wet nurses, were either friends, relatives or women paid for their services. Breastfeeding was the norm and the solution to a breastfeeding problem was to look for other mother, not for other milk. In the late 19th century, however, some families began to introduce various infant feeding products to either supplement or substitute for breastmilk.

Up until the 19th century, nearly all children were breastfed, whatever the culture or country, home setting or economic status. Breastfeeding was the norm and the solution to a breastfeeding problem was to look for other mother, not other milk.

One of the first commercial breastmilk substitutes was invented in 1867. The product was a mixture of toasted flour and condensed milk marketed by a Swiss food company[1]. At that time, most infants who were fed breastmilk substitutes did not survive. For example, in a region of Germany where the majority of children were fed a mixed gruel of flour and water to replace breastmilk, fifty percent of infants died; as a result the infant mortality rate in this region was four times the infant mortality rate in Norway, where breastfeeding was the norm[2].

When commercial breastmilk substitutes became more available in Europe and North America, the practice of breastfeeding began to decline at alarming rates. As birth rates in industrialised countries dropped, manufacturers of breastmilk substitutes sought out new markets; developing countries, with high birth rates, became an attractive market to baby food manufacturers. By the end of World War II, many infant food manufacturing companies were selling their breastmilk substitutes in countries under colonial rule in Africa and Asia.

When commercial breastmilk substitutes became more available in Europe and North America, the practice of breastfeeding began to decline at alarming rates. By the end of World War II, many infant food manufacturing companies were selling their breastmilk substitutes in countries under colonial rule in Africa and Asia.

The trend towards artificial feeding in developing countries began with rich families who were usually in positions of power. In such families, men were often educated in Europe or North America, where artificial infant feeding was associated with power, authority, influence and status. The trend quickly spread to the rest of the population. In the 1960s, the practice of breastfeeding was in rapid decline in many parts of the world. In Mexico, for example, the proportion of six-month old infants who were breastfed dropped from 100 percent to 9 percent between 1960 and 1970[3]. In Singapore the number of three-month old infants who were breastfed dropped from 80 percent in 1951 to 5 percent in 1971[4].

2.2. Advertising and promotion: The link to declining breastfeeding rates

It took until the 1970s for policy makers in international arenas to recognize the link between the marketing of commercial breastmilk substitutes and the decline in breastfeeding practices around the world. One woman made the link ahead of others: Dr. Cicely Williams. Dr. Williams was a pediatrician who worked in Singapore in the late 1930s and later became the first Director of Maternal and Child Health at the World Health Organization. In 1939, she made a speech to the Rotary Club of Singapore entitled *Milk and Murder*. In her speech, she pointed out that infants were dying as a result of inadequate feeding practices, and that "misguided propaganda on infant feeding should be punished as the most criminal form of sedition, and those deaths should be regarded as murder"[5]. However, it took an additional 40 years before others began to take up the topic of infant feeding and called for government action for the protection, promotion and support of breastfeeding.

By the 1960s European and North American manufacturers of breastmilk substitutes were exporting varieties of infant formula brands to countries throughout Africa, Asia and Latin America. These companies were using a wide spectrum of marketing techniques to increase the sales of their products. Their marketing methods ranged from billboards to advertising on radio and newspapers, and included the provision of free samples of infant formula to mothers and service providers through health care facilities and "milk nurses" hired by infant formula companies as sales representatives.

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Advertising became widespread. For example, in 1970, a survey in Sierra Leone documented 246 radio commercials for three commercial breastmilk substitutes over a period of one month[6]. Meanwhile, roadside billboards in Nigeria featured a chubby smiling baby holding a can of *SMA* formula alongside the phrase, "Welcome to Nigeria, where *SMA* babies are healthy and happy"[7].

Some physicians began to express their concern about the growing number of cases of diarrhoea and malnutrition among infants attending their hospitals and clinics worldwide. Dr. Derrick Jelliffe of the Food and Nutrition Institute in Jamaica became a vocal proponent of the importance of breastfeeding and denounced the harmful effects of the marketing of breastmilk substitutes on children's nutrition, health

and survival. In the early 1970s, Dr. Jelliffe published an article entitled *Commerciogenic Malnutrition*, a term he coined to describe the impact of product marketing on infant health, nutrition and survival[8]. His research drew attention to the problems caused by artificial feeding. Another pediatrician, Dr. Catherine Wennen, was one of the first to draw attention to the widespread and aggressive marketing she saw while working in Nigeria in the 1960s and wrote about the growing number of infants and young children who became malnourished and sick due to bottle feeding[9].

In the early 1970s, Dr. Derrick Jelliffe published an article entitled Commerciogenic Malnutrition, a term he coined to describe the impact of product marketing on infant nutrition, health and survival. His research drew attention to the problems caused by artificial feeding in the Caribbean. Dr. Catherine Wennen, was one of the first to draw attention to the widespread and aggressive marketing she saw while working in Nigeria in the 1960s and wrote about the growing number of infants and young children who became malnourished and sick due to bottle feeding.

Despite the efforts of individual physicians to publicize this budding child survival crisis, the public remained largely ignorant and government and international agencies had yet to respond. When the British magazine *The New Internationalist* published an interview with Dr. David Morley and Dr. Ralph Hendrickse - two pediatricians with extensive work experience in developing countries - the problem was finally thrust into the limelight. The two physicians described the negative consequences that the marketing of commercial breastmilk substitutes was having on breastfeeding practices and children's nutrition, health and survival in developing countries[10].

Public awareness increased in 1974 with the publication and distribution of twenty thousand copies of a booklet called *The Baby Killer* by British charity War on Want. The cover depicted a severely malnourished African baby inside a feeding bottle. The authors illustrated the story with a multitude of examples of marketing and promotion of commercial breastmilk substitutes, drawn mainly from Africa[11]. Soon after the publication *The Baby Killer*, the United Nations system addressed the impending disaster for the first time. The World Health Assembly - composed of health officials from all member states of the World Health Organization - adopted a resolution recognizing a decline in the practice of breastfeeding and that the decline was "one of the factors contributing to infant mortality and malnutrition"; in Resolution WHA27.43, the World Health Assembly urged Member States to take legal measures to control the marketing of commercial breastmilk substitutes.

Public outrage over the consequences of the marketing of commercial breastmilk substitutes on infant feeding, nutrition and survival in the developing world mounted in the early 1970s. In Switzerland, a group of students translated The Baby Killer into German. Health professionals from around the world testified about the marketing techniques used by manufacturers of commercial breastmilk substitutes to encourage mothers and health providers to feed children breastmilk substitutes and trial judges admonished some manufacturers of breastmilk substitutes to change their marketing practices and avoid further accusations of "immoral and unethical" conduct[12].

Despite lawsuits and legal actions, most manufacturers of breastmilk substitutes continued to market their products as before. In 1975, the release of a film entitled *Bottle Babies* led to additional public reproach against their marketing practices. The film depicted the realities of women living in poverty, yet attempting to bottle feed their babies in the 'modern and more nutritious way' using over-diluted feeds and unsafe water.

In 1975, the release of a film entitled Bottle Babies led to additional public reproach against the marketing of breastmilk substitutes in developing countries. The film depicted the realities of women living in poverty, yet attempting to bottle feed their babies in the 'modern and more nutritious way' using over-diluted feeds and unsafe water.

A group in the United States decided to launch a consumer boycott against Nestlé, which ultimately became the longest and largest consumer boycott in history. In 1978, Senator Edward Kennedy chaired a hearing in the United States to probe into advertising, promotion and use of infant formula in developing countries. The United States Senate hearing led to further publicity and Senator Kennedy ultimately asked WHO and UNICEF to hold an international meeting on the marketing of infant formula and other breastmilk substitutes[13].

In 1979, a joint UNICEF-WHO Meeting on Infant and Young Child Feeding was attended by government delegates and representatives of UN agencies, NGOs and manufacturers of breastmilk substitutes, as well as experts in nutrition, pediatrics, public health and marketing. The most significant of the recommendations to result from the international meeting was that an international code on the marketing of infant formula and other breastmilk substitutes should be adopted. The meeting delegates further recommended that infant formula should not be marketed or even available in a country unless the marketing of infant formula was in accordance with such a code or legislation[14].

A period of drafting and discussions among the parties to the meeting ensued and in 1981, the WHA voted 118 to 1 in favor of Resolution WHA34.22 adopting the *International Code of Marketing of Breastmilk Substitutes* (the International Code). Unlike international conventions and regulations, a recommendation of the World Health Assembly is not binding on member states. To have legal stature at the national level, the International Code needs to be translated into national legislation and regulations. With Resolution WHA34.22 (1981), the World Health Assembly urged member states to implement the

International Code "in its entirety" and to monitor compliance with the International Code.

In 1981, the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes. The World Health Assembly urged member states to implement the International Code "in its entirety" and to monitor compliance with the International Code. Since 1981, the World Health Assembly has adopted a number of relevant subsequent resolutions concerning infant feeding and the use of breastmilk substitutes. These resolutions serve to keep the International Code up to date with advances in scientific knowledge and changing marketing practices over the years. These resolutions enjoy the same status as the International Code.

Since 1981, the World Health Assembly has adopted a number of relevant subsequent resolutions concerning infant and young child feeding. Most of these resolutions have reiterated the urgent need for governments to implement the International Code and subsequent resolutions at the national level. Some of the later resolutions clarify questions that have arisen since 1981 and serve to keep the International Code up to date with advances in scientific knowledge and changing marketing practices over the years.

In 1986, for example, Resolution WHA39.28, pointed out that "follow-up milks" (formula marketed for older infants) are not necessary, while Resolution WHA47.5 in 1994 clarified ambiguities in relation to free and low-cost supplies, stressing that such supplies of breastmilk substitutes, bottles or teats should not be allowed in any part of the health care system. More recent resolutions have clarified that the optimal duration of exclusive breastfeeding is six months (Resolution WHA54.2, 2001) and have urged that complementary foods not be marketed or used in ways that undermine exclusive and continued breastfeeding (Resolution WHA49.15, 1996). Resolutions have also called for Member States to ensure that financial support and other incentives for programs and health professionals working in the field of infant and young child health and nutrition do not create conflicts of interest and that Code monitoring is carried out in a transparent manner free from commercial interest (Resolution WHA49.15, 1996). The International Code and all subsequent World Health Assembly resolutions enjoy the same status.

The International Code in Summary[15]

The International Code applies to the marketing of infant formula, any other product marketed or otherwise represented to be a breastmilk substitute, and to feeding bottles and teats.

For the **general public**:

- No advertising or other form of promotion to the public;
- No product samples to mothers;
- No contact between marketing personnel and pregnant women or mothers;
- Materials on infant feeding may only be provided upon government approval and must explain the superiority and benefits of breastfeeding as well as the health hazards associated with artificial feeding; such materials may not have pictures or text that idealize bottle feeding or refer to product brand names;
- Unsuitable products, such as sweetened condensed milk, should not be promoted for young children and all food products must meet applicable standards.

For the **health care system**:

- No promotion in healthcare facilities
- No donations of free or low-cost supplies;
- No gifts to health workers;
- Product samples allowed only for evaluation and research;
- Product information to health workers restricted to scientific and factual matters;
- Health workers should never give samples to pregnant women, mothers or families.

For **labelling**:

- No pictures of infants, or other words or images idealizing artificial feeding;
- Must clearly state the superiority of breastfeeding;
- Must include preparation instructions;
- Must include warning about the health hazards of improper preparation.

The Code and subsequent relevant resolutions by the World Health Assembly also spell out the responsibilities of various actors in ensuring their effective implementation and monitoring:

For **governments**:

- Adoption of national legislation, regulations or other suitable measures;
- Application of measures on the same basis to all involved in manufacturing and marketing designated products;
- Establishment of transparent and independent monitoring mechanisms, free from commercial influence.

For **manufacturers and distributors of designated products**:

- Monitor marketing practices, independently of any other measures taken to implement the Code;
- Ensure that their conduct at every level conforms to the principles and aim of the Code, and subsequent relevant resolutions by the World Health Assembly;
- Apprise each staff involved in marketing of the International Code and subsequent relevant resolutions by the World Health Assembly, and their responsibilities under them.

For **non-governmental organizations and others concerned**:

- Draw the attention of government, manufacturers or distributors to activities which are incompatible with the principles and aim of the International Code and subsequent relevant resolutions by the World Health Assembly.


DE LA SANTE
DIRECTION DE LA SANTE
DE LA FAMILLE
DIRECTION REGIONALE
DE LA SANTE DU CENTRE-EST
CARNET DE SANTE
DISTRICT SANITAIRE DE:
FORMATION SANITAIRE DE:
NOM DE L'ENFANT:

3

THE INTERNATIONAL CODE IN THE CONTEXT OF CHILD SURVIVAL

It was out of concern for the nutrition, survival, growth and development of young children that the World Health Assembly adopted the International Code in 1981. Nations were concerned about aggressive and inappropriate marketing practices of breastmilk substitutes, which were contributing to an alarming decline in breastfeeding rates and the associated increase in malnutrition, morbidity and mortality rates among infants and young children, particularly in developing countries. Twenty-five years later, breastfeeding and the International Code, which protects breastfeeding, are just as if not more important for child survival than they were in 1981.

Knowledge about the importance of infant and young child feeding, particularly breastfeeding, has vastly surpassed what was known in 1981. Appropriate feeding practices play a crucial role in achieving optimal survival, growth and development. Breastmilk is a living substance that fulfils all of a baby's nutritional requirements in the first six months of life and has the additional advantage of containing antibodies that help protect the baby against common childhood illnesses throughout infancy and early childhood.

Research continues to reveal benefits to the child from breastmilk and breastfeeding; these benefits simply cannot be replaced or replicated. Breastmilk is safe and clean, always at the right temperature, inexpensive and nearly every mother has more than enough for her baby. There is also an important positive relationship between breastfeeding and birth spacing.

Breastfeeding and the International Code - which protects breastfeeding - are just as if not more important for child survival than they were in 1981. Research continues to reveal benefits to the child from breastmilk and breastfeeding that simply cannot be replaced or replicated. It is safe and clean, always at the right temperature, inexpensive and nearly every mother has more than enough for her baby. There is also an important positive relationship between breastfeeding and birth spacing.

Infants and young children who are not breastfed are at a much higher risk of malnutrition, which leads to poor growth and development, illness, and death. In the developing world, the risk of death from diarrhea and pneumonia for infants who are not breastfeed is seven and five times greater respectively, in the first five months of life than that for babies who are exclusively breastfed[16]. Moreover, babies who are not breastfed are six times more likely to die from infectious diseases during the first two months of life than infants who are breastfed. The risk is still nearly three times higher for four-to-five month old infants[17]. Recent research also shows that 22 percent of neonatal deaths could be averted if infants started breastfeeding within the first hour after birth[18].

Babies who are partially breastfed or not breastfed at all are fed with some type of breastmilk substitute, often by bottle. Bottle feeding under conditions of poverty often leads to increased child malnutrition, morbidity and mortality. For bottle feeding to be safe there must be access to clean water, fuel and facilities to boil the water and sterilize the equipment, adequate income to purchase adequate quantities of breastmilk substitutes for as long as needed, and a level of literacy that allows to follow carefully the instructions for adequate mixing and sterilization.

Recent international policy measures recognize more than ever the importance of breastfeeding for child survival, growth and development. World leaders at the United Nations Millennium Summit in September

2000 acknowledged that more than a billion people are subject to extreme poverty and the associated "dehumanizing conditions"[19]. The leaders at the summit responded by adopting the *Millennium Declaration* with its goals designed to ameliorate the serious challenges that exist to humankind. For children under five years old, two crucial goals by the year 2015 are: a) to reduce by half the proportion of children who are underweight; and b) to reduce by two-thirds the rate of mortality in children; rates of child malnutrition and mortality in 1990 are used as the baseline.

With less than 15 years left to attain the Millennium Development Goals, policy makers were encouraged by a 2003 study published in *The Lancet* by the Bellagio Study Group, an international group of renowned researchers. The study concluded that the goal of reducing underfive mortality by two-thirds is within the reach of nations with interventions that are available today, without waiting for new vaccines, drugs or technologies. The group identified breastfeeding together with appropriate complementary feeding as the two most important child survival interventions, capable of reducing underfive mortality by 20 percent in the 42 countries that accounted for 90 percent of the world's child deaths in 2000[20].

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Building on the Millennium Development Declaration and Goals, UNICEF and the World Health Organization developed the *Global Strategy for Infant and Young Child Feeding* – a comprehensive strategy for revitalizing the global commitment to improving infant and young child feeding, nutrition and, ulti*mately, survival, growth and development. The Global Strategy was endorsed by the World Health Assembly and UNICEF's Board of Directors in 2002*; it reinforces the public health recommendation for optimal infant feeding: "infants should be exclusively breastfed for the first six months of life to achieve optimal survival, growth and development. Thereafter, to meet their evolving requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond." Implementing the International Code is one of the key steps of the *Global Strategy*.

In 2002, building on the Millennium Development Declaration and Goals, UNICEF and WHO endorsed the Global Strategy for Infant and Young Child Feeding to revitalize the global commitment to improving infant and young child feeding, nutrition and, ultimately, survival, growth and development. Implementing the International Code is one of the key steps of the Global Strategy.

In 2005, policy makers who gathered in Florence, Italy to celebrate the 15th anniversary of the 1990 *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* reiterated the urgency of achieving the Millennium Development Goals and, in particular, improving infant feeding practices. The 2005 *Innocenti Declaration on Infant and Young Child Feeding* underlines that: "inappropriate feeding practices – suboptimal or no breastfeeding and inadequate complementary feeding – remain the greatest threat to child health and survival globally. Improved breastfeeding alone could save the lives of more than 3,500 children every day, more than any other preventive intervention".

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4

THE INTERNATIONAL CODE IN THE CONTEXT OF HIV/AIDS

In the late 1980s, researchers discovered that the human immunodeficiency virus (HIV) can be transmitted from a mother to her baby through breastfeeding. Between 5 percent and 20 percent of babies born to HIV-infected mothers can contract HIV from breastfeeding[21]. This knowledge can lead to a fear of breastfeeding by women who are aware that they carry the HIV infection as well as by women who do not know their HIV status. Currently, over 90 percent of women who live in developing countries are unaware as to whether or not they are infected with HIV as HIV testing is not widely available and even when it is available many women prefer not to know their HIV status[22].

The possibility of mother-to-child transmission of HIV through breastfeeding implies that HIV-positive mothers face a dilemma when deciding how to feed their children; it also implies that policy makers face a dilemma when determining how to counsel health care providers, families and communities about infant feeding options.

If HIV-positive mothers avoid breastfeeding completely, they eliminate the risk of transmitting the HIV infection to their infants in the postnatal period. However, in settings such as West and Central Africa, the percentage of infants and young children who would die from infections other than HIV as a result of not being breastfed is much higher than that of children who would become infected with the HIV virus through breastfeeding.

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As discussed earlier, studies have demonstrated that infants who are not breastfed during the first months of life are at a much higher risk of dying of infectious diseases than infants who are breastfed[23]. When breastfeeding is exclusive, the difference in child survival rates is even more marked. There is also evidence that when HIV-positive mothers breastfeed exclusively during the first few months of life, the rate of mother-to-child transmission of HIV is lower and the level of HIV-free survival among their infants is higher than among the infants of HIV-positive mothers who mix breastfeeding with breastmilk substitutes[24]. Therefore, exclusive breastfeeding remains a life saving practice for the vast majority of children living in conditions where replacement feeding is not acceptable, feasible, affordable, sustainable and/or safe.

Exclusive breastfeeding remains a life saving practice for the vast majority of children living in conditions where replacement feeding is not acceptable, feasible, affordable, sustainable and/or safe.

Thus, while it is vital that individual HIV-positive women be provided unbiased information about the benefits and risks of different infant feeding options so that women can make an informed choice, it is more important than ever that governments protect, promote and support exclusive breastfeeding, so as to maximize HIV-free child survival rates in the general population.

In the early 1990s, WHO, UNICEF and other interna-

tional agencies developed a first set of policy guidelines on HIV and infant feeding; since then, these guidelines have evolved as new knowledge on the interface between HIV, infant feeding and child survival has become available. The current guidelines state that all HIV-negative mothers and women who are unaware of their HIV status should be encouraged and supported to exclusively breastfeed their infants for the first six months of life and continue breastfeeding with adequate and safe complementary foods until 24 months and beyond. Concerning HIV-positive women (i.e. HIV-infected women with a positive HIV test) the current guidelines state that:

"Exclusive breastfeeding is recommended for HIV-positive women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended".

"At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breastmilk can be provided. Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding"[25].

Current guidelines state that HIV-negative mothers and mothers who are unaware of their HIV status should breastfeed their infants exclusively during the first six months of life. In the case of HIV-positive women, exclusive breastfeeding is recommended for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

The five conditions (acceptable, feasible, affordable, sustainable and safe) have been defined as follows: replacement feeding is considered *acceptable* when the mother is not under any social or cultural pressure not to use replacement feeding or when she can cope with such pressure and can deal with any stigma that might be attached to replacement feeding. Replacement feeding is considered *feasible* when the family has time, knowledge, skills and other resources to properly prepare and feed the baby 10-12 times per day. Replacement feeding is considered *affordable* when the family can pay the cost of purchasing/producing, preparing and using replacement foods including all ingredients (fuel, clean water, soap, equipment) and any necessary health care costs without compromising the health and nutrition of the family. Replacement feeding is considered *sustainable* when the family is assured of a reliable supply of replacement food for one year or longer. Finally, replacement feeding is considered *safe* if the feeds can be prepared, stored and fed hygienically and fed in nutritionally adequate quantities[26].

In 2003 a group of United Nations agencies developed the *Framework for Priority Actions on HIV and Infant Feeding* as a way of recommending key actions that governments can take related to infant and young child feeding in light of the special circumstances associated with the HIV/AIDS pandemic[27]. Implementation of the International Code is one of the five priority areas for action identified in the Framework.

It is important that policy makers do not misunderstand the purpose of the International Code in the context of HIV/AIDS. The Code does not restrict the availability of breastmilk substitutes for mothers who make an informed choice to use them nor does it prevent governments, social welfare agencies or health care facilities from providing breastmilk substitutes to mothers who choose to use them. However, when planning a program that includes procurement and delivery of breastmilk substitutes, governments should carefully ensure that certain conditions are met. Breastmilk substitutes should only be offered to women who are known to be HIV-positive and for whom replacement feeding is acceptable, feasible, affordable, sustainable and safe. In addition, the government must be able to ensure that mothers have access to enough breastmilk substitutes without interruption for as long as their children need them.

The provision of breastmilk substitutes to HIV-positive mothers should be done in a way that does not promote the use of breastmilk substitutes by mothers who are HIV-negative or unaware of their HIV-status. Rather than accepting donations of breastmilk substitutes from manufacturers, governments should purchase what they need according to negotiated contracts. In this way, governments can avoid becoming dependent on donations and at the same time, they will be able to ensure a reliable supply to cover their needs. Moreover, in accordance with World Health Assembly Resolution 47.5 (1994), manufacturers and distributors may not donate breastmilk substitutes in any part of the health care system.

5

THE INTERNATIONAL CODE IN THE CONTEXT OF EMERGENCIES

According to WHO, some 150 million people worldwide have been affected by some type of emergency every year over the last century. Emergencies - drought, floods, earthquakes, tsunamis, famine, epidemics, ecological catastrophes, wars, civil unrest and severe political and economic decline - may be natural or human-induced[28]. According to a recent survey, more than fifty UNICEF country programs expect some form of instability each year[29]. Of the 40 million refugees and displaced persons created by such situations, 5.5 million are children under five years old[30].

Studies have shown that in emergency situations, malnutrition, disease and death rates in underfives are higher than in any other age group because of the increased incidence of infectious diseases and soaring rates of undernutrition. Under normal circumstances, two-thirds of the deaths of children under five years old worldwide occur during the child's first twelve months of age. The proportion of deaths occurring during those first twelve months in emergency situations depends largely on how infants are fed. Thus, in times of emergency and crisis, protecting, promoting and supporting optimal breastfeeding practices takes on a more critical importance in saving lives. The aim and principles of the International Code and relevant subsequent resolutions by the World Health Assembly become vital for protecting infants and young children in emergency situations.

In emergency situations, the proportion of infant deaths depends largely on how infants are fed. Thus, in times of emergency and crisis, protecting, promoting and supporting optimal breastfeeding practices takes on a more critical importance in saving lives. The aim and principles of the International Code become vital for protecting infants and young children in emergency situations.

In emergency situations, when food is lacking, milk is frequently requested or donated in various forms for distribution to affected populations. Donations of breastmilk substitutes and feeding bottles and teats come from many sources, usually with good intentions but nearly always stemming from a lack of information. Media coverage can create the impression that breastfeeding in such situations is impossible and that breastmilk substitutes are absolutely necessary for most children. Yet, it is well documented that the use of breastmilk substitutes in emergency situations, especially for infants, can result in even greater malnutrition, morbidity and mortality rates.

In emergency situations there will be infants who, for one reason or another, will not be breastfed. These include infants who have been separated from their mothers, infants whose mothers are ill or have died, infants whose mothers' milk production has become very low, those whose mothers have chosen not to breastfeed after testing positive for HIV or those who were being artificially fed prior to the emergency situation. Resolution WHA47.5 (1994), in addition to urging an end to free supplies in the health care system, also addresses supplies in the context of emergency situations and urges governments to "exercise extreme caution when planning, implementing or supporting emergency relief operations (…) by ensuring that supplies of breastmilk substitutes (…) are given only if all the following conditions apply: a) infants need to be fed on breastmilk substitutes, as outlined in the guidelines concerning the main health

and socioeconomic circumstances in which infants have to be fed on breastmilk substitutes (see WHA39.28); b) the supply of breastmilk substitutes can be maintained for as long as the infants concerned need them; and (c) the supply is not used as a sales inducement".

> *Resolution WHA47.5 (1994), urges governments to "exercise extreme caution when planning, implementing or supporting emergency relief operations by ensuring that supplies of breastmilk substitutes are given only if all the following conditions apply: 1) infants need to be fed on breastmilk substitutes; b) the supply of breastmilk substitutes can be maintained for as long as the infants concerned need them; and (c) the supply is not used as a sales inducement".*

UNICEF, WHO and a large group of NGOs have been actively working to find ways to ensure that the provisions of the International Code and Resolution 47.5 are applied. Guidelines developed for staff and policy makers in emergency situations include detailed recommendations regarding procurement, distribution and management of breastmilk substitutes in emergency situations[31]. The guidelines recommend that all donations of breastmilk substitutes, feeding bottles, teats and commercial baby foods should be refused. For the few infants who need to be fed with breastmilk substitutes, generic (unbranded) formula is recommended as the first choice. If generic breastmilk substitutes are not available, the guidelines recommend that staff purchase locally produced breastmilk substitutes that are manufactured and packaged in accordance with the standards of the Codex Alimentarius. Staff should choose brands that are labeled in a language that can be understood by the users, with labels that are in compliance with the requirements of the International Code. In some cases these products may need to be relabeled prior to distribution.

The guidelines also stipulate conditions that reduce the dangers of artificial feeding. Breastmilk substitutes should only be distributed on an individual basis after assessment of need; the supply should be large enough to last as long as the infant needs it. There should be no promotion of the product at the place where it is distributed. It is also recommended that the breastmilk substitute be dispensed in short, regular intervals (i.e. weekly for example). In addition to the breastmilk substitute, emergency staff should ensure the availability of feeding cups and soap (to clean feeding cups and preparation utensils), ensure that there is a way to properly measure the quantities of formula powder and water needed to prepare the breastmilk substitute, ensure that there are adequate amounts of fuel for the safe preparation of the feeds, and ensure that there is a clean and safe place for the preparation and storage of the breastmilk substitute.

6 THE INTERNATIONAL CODE IN WEST AND CENTRAL AFRICA

6.1. State of implementation of the International Code

According to the latest information available, of the 24 countries that comprise West and Central Africa, 12 have laws, decrees or regulations in place that implement all or most of the provisions of the International Code (Benin, Burkina Faso, Cameroon, Cape Verde, DR Congo, Gabon, Gambia, Ghana, Mali, Niger, Nigeria and Senegal); three have in place a legal instrument that implements only a few of the provisions of the International Code (Guinea, Guinea Bissau, and Sao Tome and Principe); six of the 24 countries have either a draft of a law or decree that is awaiting final government approval, or have established a government committee that is studying how best to implement the International Code (Congo, Côte d'Ivoire, Mauritania, Sierra Leone, Togo and Chad); there are only three countries in the region that have not taken any action, to implement the International Code (Central African Republic, Equatorial Guinea and Liberia).

Of the countries in the region that have implemented all or most of the provisions of the International Code, Nigeria was the first to do so in 1990. Burkina Faso and Cameroon followed in 1993 and Senegal in 1994. Benin, Niger, Ghana and Gabon adopted decrees in 1997, 1998, 2000 and 2004 respectively. Cape Verde also adopted a decree in 2004. In 2005, Nigeria, issued regulations that enabled the 1990 decree to be better implemented in the country.

State of Code Implementation in West and Central Africa

12

Most or many provisions Law

Benin
Burkina Faso
Cameroon
Cape Verde
DR Congo
Gabon
Gambia
Ghana
Mali
Niger
Nigeria
Senegal

3

Few provisions law

Guinea[1]
Guinea-Bissau
Sao Tome & Principe[1]

5

Measure drafted awaiting final approval

Congo
Cote d'Ivoire
Sierra Leone
Togo
Chad

1

Being studied

Mauritania

1

No action

Central African Republic

2

No information

Equatorial Guinea
Liberia

Notes

1. Government also has a draft law

Most recently, in 2006, Gambia adopted relevant regulations under the national Food Act, the Democratic Republic of the Congo signed a law implementing the International Code that was published in the Official Journal in September 2006; in Mali, the Ministries of Health, Agriculture, and Industry and Trade adopted an inter-ministerial decree implementing the International Code. Efforts are underway in Burkina Faso, Cameroon and Niger to review and strengthen their existing national laws.

As these figures show, nations in West and Central Africa have made very significant progress in implementing the International Code. However, there is still work to be done before each country not only has a law, regulation or other suitable measure, but also the legal instruments and human capacity necessary to monitor and enforce compliance with the Code.

Nigeria was the first country in the region to implement the International Code (1990). Since then, nations in West and Central Africa have made very significant progress in implementing laws, regulations or other suitable measures in accordance with the International Code. However, there is still work to be done before each country has both the legal instruments and the capacity necessary to monitor and enforce compliance with the International Code.

6.2. Challenges to implementation of the International Code

When 118 countries voted in favor of the International Code at the World Health Assembly in 1981, it may have seemed a straightforward task for each country to translate the International Code into a national law or regulation. However, governments, professionals, NGOs, and others working to improve infant feeding, nutrition and child survival soon realized that ending inappropriate marketing practices that encourage mixed feeding, early introduction of complementary foods and ultimately, low rates of exclusive breastfeeding would require much more than adopting laws or decrees drawn verbatim from the articles of the International Code.

Countries in West and Central Africa, like countries in the world, have faced a range of challenges in their efforts to implement the International Code. Currently - 25 years after the International Code was adopted - countries in the region are at different stages in the process of adopting and enforcing legislation to implement the provisions of the International Code at the national level. Countries at the earlier stages of the process can learn much from the countries that have been more successful.

6.2.1. Getting on the national agenda

One of the more difficult challenges in implementing the International Code in West and Central Africa has been drawing the attention of policy makers to the need to regulate the marketing of breastmilk substitutes. In a region where nearly all mothers breastfeed, it is more difficult than elsewhere to convince governments of the necessity of a legislative framework to protect breastfeeding. Protecting, promoting and supporting breastfeeding is not always perceived as a problem requiring government attention.

In a region where nearly all mothers breastfeed, protecting, promoting and supporting breastfeeding is not always perceived as a problem requiring government attention.

In the first decade following the adoption of the International Code by the World Health Assembly in 1981, a few countries in the region took action to adopt some of the provisions of the International Code at the national level. In the early 1980s, Benin, Gabon and Sao Tome adopted decrees prohibiting advertisements of breastmilk substitutes. In 1982, Guinea Bissau issued a national decree requiring that feeding bottles be sold only with a prescription and prohibiting the commercial promotion of breastmilk substitutes, complementary foods, feeding bottles and teats. The Democratic Republic of the Congo did not ban advertisements outright at the time, but set up a system of vetting whereby advertisements of breastmilk substitutes had to be pre-approved by the National Center for Human Nutrition. However, during this period no country in the region translated all or most of the provisions of the International Code into a national legislative framework.

Early attempts by manufacturers of breastmilk substitutes to self regulate their marketing practices led some governments to hold off on stronger national measures, believing them to be unnecessary. In 1975, the International Council of Infant Food Industries, the precursor to the current International Association of Infant Food Manufacturers, issued a code of ethics. National associations of infant food companies adopted similar codes. However, the industry codes lacked marketing restrictions. Even mass media advertising was not prohibited so long as breastfeeding was mentioned as the first choice for infant feeding.

In the first decade following the adoption of the International Code by the World Health Assembly in 1981, a few countries in the region took action to adopt some of the provisions of the International Code at the national level. However, no country in the region translated all or most of the provisions of the International Code into a national legislative framework until Nigeria did in 1990.

Getting breastfeeding and the International Code on the national political agenda in countries in the region has been difficult; maintaining interest over time has been even harder. Governments change, priorities change, economic pressures sometimes outweigh child survival interests and, in some countries, war and civil unrest have challenged every effort to advance child feeding, nutrition and survival.

6.2.2. Achieving consensus for effective national measures

Once a country has made the commitment to implement the International Code, it faces the challenge of

drafting the legislative framework and achieving sufficient support within the relevant government bodies to adopt a legal instrument. In most countries, the impetus for a national law to implement the International Code originates with the National Breastfeeding Committee and/or with health professionals in the Ministry of Health: with those who are convinced of the centrality of breastfeeding for child survival and nutrition.

Before a law can be adopted, the initiators must garner support from a variety of interested parties in the government and the country. Once initial language is proposed, the draft is scrutinized by other ministries such as education, women's affairs, trade and communications. Drafts may also be circulated for comment by parties outside the government including pediatric and other professional organizations, NGOs, pharmacists and infant food manufacturers and distributors.

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Over the years it has become clear that legal instruments modeled on the International Code, leave room for marketing techniques that are harmful to breastfeeding. The International Code was drafted through a process of compromise and consensus; manufacturers of breastmilk substitutes played a significant role in the early drafts of the International Code. Moreover, knowledge about optimal infant feeding has grown over the last 25 years. During the same period, new marketing practices and products that were not known when the Code was drafted have been developed.

In West and Central Africa, as in other countries, the provision about which it has been most difficult to achieve consensus among all parties in national legal frameworks is the scope or, more simply, what products to include within the ambit of the law. When the International Code was debated and drafted in 1981, infant food companies lobbied heavily for a scope that would cover only infant formula, which is defined internationally as a product formulated to satisfy the nutritional requirements of infants up to four to six months of age[32]. The Codex Alimentarius Commission is currently revising the international standard with a proposed language that would describe infant formula as a "breast-milk substitute specially manufactured to satisfy, by itself, the nutritional requirements of infants during the first months of life up to the introduction of appropriate complementary foods"[33].

While companies stated their willingness to stop the advertisement, free distribution, and other forms of promotion of standard infant formula, they wanted to continue their usual marketing practices for other infant food products. This led to an increase in the promotion of a range of specialized infant milks and formulas targeted for infants older than four to six months (usually referred to as follow-up milks), milks for toddlers and young children, baby cereals and other infant foods. Throughout the 1990s, it was common to see advertisements and promotions in health care facilities for follow-up milks, often recommending their introduction in the infant's diet at four months[34]. Some companies used the same or similar brand names for standard formula and follow-up formula, thus advertising indirectly the company's standard infant formula and getting around the ban on promotion for infant formula[35].

Throughout the 1990s, it was common to see 'follow-up formula' being advertised and promoted in health care facilities for introduction in the infant's diet at four months. Some companies used the same or similar brand names for standard formula and follow-up formula, thus advertising indirectly the company's standard infant formula and getting around the ban on promotion for infant formula.

During the same period, some manufacturers of breastmilk substitutes were distributing posters and promotional materials to be displayed in health care facilities in Burkina Faso, Cote d'Ivoire, Ghana, Senegal, and Togo. These materials touted baby cereals for use from the first month of life and free samples were distributed to mothers in maternities with instructions to use them from the age of two months[36]. By 2000, it was less common to find companies marketing infant formula for introduction before four months of life; however, baby cereals were still heavily marketed in health services frequented by pregnant women and new mothers, thus encouraging mothers to complement their breastmilk before the recommended six months. In 2000, health facilities in Togo were displaying calendars featuring mothers with babies, a teddy bear and the brand name of a line of baby foods[37]. At the National Institute for Public Health in Abidjan, bright yellow posters advertising a well known infant cereal were displayed in six different services that cared for babies or pregnant women[38]. Companies have also been reported to use the health care system to distribute gifts bearing brand names of infant cereals to new mothers and pregnant women. Colorful materials meant to be educational have also been distributed widely carrying messages about the benefits of introducing commercial baby foods, usually well before six months.

The commercial promotion of follow-up formulas, growing-up milks and complementary foods has harmed efforts to promote exclusive breastfeeding by reinforcing ideas about the inadequacy of exclusive breastfeeding and the benefits of the early introduction of other infant foods. However, the increased knowledge about the centrality of exclusive breastfeeding in the first six months of life for optimal child survival and development has led to a clearer understanding of the need to regulate the marketing and promotion of a wider range of breastmilk substitutes. As a result, most of the draft laws that governments in West and Central Africa have proposed cover the full range of infant foods in their scopes.

Such proposals sometimes have lead to strong lobbying by infant food companies and other commercial interests. In Cote d'Ivoire, for example, representatives of several infant food companies were invited to participate in a national workshop to develop a draft law to implement the International Code. The industry representatives strongly opposed the inclusion of complementary foods or foods marketed for infants older than six months within the scope of the draft[39]. The scope in the final draft, which was revised during a second workshop in 2004, was broad, but the law has yet to be adopted by the government (see lessons learned, below). In 1991, before Gabon adopted a national decree, the Ministry of Public Health signed a directive forbidding companies to advertise or in any way promote milks and foods for infants (laits et aliments pour bébés)[40]. In 1992, the Ministry had to specifically demand some manufacturers of breastmilk substitutes to comply with the 1991 directive by stopping their television advertisements for baby cereals. In 1996, a manufacturer requested permission to resume the advertising campaign on television. The company argued that the International Code did not apply to complementary foods and that the spot would be educational; it also made veiled threats of economic repercussions that would flow from enforcing the advertising prohibition.

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6.2.3. Lack of support from health professionals

When health professionals are informed and concerned about infant feeding practices, they can become strong and influential actors in persuading governments to implement the International Code and in making national legislation effective in their countries. Conversely, health professionals who lack knowledge about the importance of breastfeeding, the *Baby Friendly Hospital Initiative* (BFHI), the *Global Strategy for Infant and Young Child Feeding*, and the *Millennium Development Goals* on child nutrition and survival, can pose obstacles to the implementation of the International Code at the national level.

When health professionals are informed and concerned about infant feeding practices, they can become strong and influential actors in persuading governments to implement the International Code and in making national legislation effective in their countries.

In West and Central Africa, knowledge and understanding among health care providers about infant feeding, child survival and the International Code is often poor. While the *Baby Friendly Hospital Initiative* has made major inroads in sensitizing health workers, there remains a large proportion of physicians and other health practitioners who are not aware of the basis and evidence for the *Ten Steps to Successful Breastfeeding* and still believe that artificial feeding is a good alternative to breastfeeding. For example, a survey in Burkina Faso and Togo in 2000 indicated that of 186 health care providers interviewed, only 38 had ever heard of the International Code, and only about half had heard of the *Baby Friendly Hospital Initiative*[41].

In West and Central Africa, knowledge and understanding among health care providers about infant feeding, child survival and the International Code is often poor. Although major inroads in sensitizing health workers have been made, there remains a large proportion of physicians and health practitioners who still believe that artificial feeding is a good alternative to breastfeeding.

Uninformed physicians and other health workers who do not understand the purpose of regulating the marketing of breastmilk substitutes often oppose such restrictions or fail to promote them, particularly the restrictions that apply to their professions. Where access to equipment and medical supplies is limited and public funding for education, research, and training is lacking, offers from infant food companies to fill in the gaps become more attractive. Moreover, some paediatric and professional associations have strong links and ties to infant food companies that provide funding for conferences, meetings and other professional society events. Besides providing incentives to health professionals, infant food manufacturers can also affect the attitudes of health care providers towards breastfeeding. For example, in Gabon, an infant food manufacturer distributed to physicians an article that had been published in Paris; the article quoted the adage "Mieux vaut un biberon bien préparé qu'un sein de mauvaise humeur." ("Rather a well prepared bottle than a cranky breast")[42].

6.2.4. Making national measures effective

Making all sectors aware of a new legislative framework is an important way to make the law work. Governments and associations need to use all the means available to inform infant food manufacturers and distributors, professional organizations, the general public and the media about the purpose, content and scope of the law.

However, countries that have adopted strong national legislation have faced a number of challenges. To be effective, legislation must be monitored and enforced. Relevant government agencies have not always been adequately equipped for the task and inappropriate marketing of breastmilk substitutes has, in some countries, continued even after the adoption of national legislation.

To be effective, legislation must be monitored and enforced. Relevant government agencies have not always been adequately equipped for the task and inappropriate marketing of breastmilk substitutes has, in some countries, continued even after the adoption of national legislation.

For example, a study published in 2003, showed comparable levels of Code violations in Burkina Faso - which had national legislation on the marketing of breastmilk substitutes - and Togo (which did not at the time); this illustrated well that having a national law to regulate the marketing of breastmilk substitutes is a pre-requisite, but not a sufficient condition on its own to protect, promote and support appropriate infant feeding practices in a country. The authors of the study concluded that legislation needs to be accompanied by effective training, information and monitoring systems so that scientific knowledge rather than marketing guides health professionals' practice[43]. Similarly, the 1990 decree in Nigeria could not be implemented for nearly 10 years because it had no provisions related to monitoring and enforcement. In 1999, the government had to amend the decree to designate the National Agency for Food and Drug Administration and Control (NAFDAC) as the agency responsible to monitor and enforce compliance with the Decree.

Having a national law to regulate the marketing of breastmilk substitutes is a pre-requisite, but not a sufficient condition on its own to protect, promote and support appropriate infant feeding practices in a country. Legislation needs to be accompanied by effective training, information and monitoring systems so that scientific knowledge rather than marketing guides health professionals' practice.

In addition to the authority to monitor and enforce, an enforcing agency also needs budgetary authority, manpower and adequate training in order to carry out its tasks to monitor and enforce compliance with the national legislation. Moreover, monitoring and enforcement must be continuous. Penalties must be clearly defined and severe enough to deter violations. In some countries, companies have found it less burdensome to pay a small fine than to stop a lucrative marketing practice. In other countries, implementing provisions such as designation of a responsible authority, procedures for monitoring, and penalties for enforcement were not included in the national legislation.

6.2.5. Free trade and small markets

Countries that have succeeded in the adoption of a national legislative framework have sometimes faced challenges with the provisions related to labeling. The International Code includes provisions on labeling that are important for the protection of consumers. Among others, they require labels to include instructions on the proper use and preparation of breastmilk substitutes as well as warnings against potential health hazards; they also require labels to be written in local languages and to avoid the inclusion of pictures, images or text that may idealize the use of breastmilk substitutes.

Countries have sometimes faced challenges with the provisions related to the labeling of breastmilk substitutes. The International Code requires labels to include instructions on the proper use and preparation of breastmilk substitutes as well as warnings against potential health hazards; they also require labels to be written in local languages and to avoid the inclusion of pictures, images or text that may idealize the use of breastmilk substitutes.

Some countries have added more specific protections to the labeling provisions in their national laws. For example, in Ghana, besides prohibiting images that may idealize the use of breastmilk substitutes, the law prohibits "any photograph, drawing or other graphic representation other than for illustrating the method for preparation of the designated product". This change was deemed necessary because companies reacted to the International Code prohibition by replacing the infant pictures that adorned earlier labels with images of flowers, teddy bears or story book characters that can be just as promotional. In 2004, Ghanaian officials enforcing the new regulations prohibited a container load of commercial infant formula from entering the country because the labels included drawings that idealized the use of infant formula. Although the infant formula company representatives raised the possibility of challenging the regulations on intellectual property grounds, such a challenge has yet to materialize.

Detailed labeling provisions have also resulted in some complications in Cape Verde, a country that imports all of its infant foods from Europe. Importers in the country claim that European exporters do not consider the Cape Verde market large enough to justify a special label. Rather than design a special label for such a small market, exporters would simply cease to export to the country leaving the market open to smugglers and outside any government controls. One solution to this problem could be for the countries in the region to base their laws on a regional model. In that way, the market for particular breastmilk substitutes would be large enough for countries to impose the desired labeling changes. A model law for the francophone region of Africa was first drafted in 1999 and later revised in 2006 during the International Code Implementation Training Course organized by ICDC and IBFAN Africa with the support of UNICEF Regional Office for West and Central Africa. A similar model law was drafted for the Portuguese-speaking countries. Regional organizations such as the Economic Community of West African States and the West African Economic and Monetary Union with the support of the West African Health Organization should be encouraged to develop and enforce regional regulations governing the marketing of breastmilk substitutes.

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6.3. Opportunities to implement the International Code

6.3.1. International declarations and initiatives

UNICEF and WHO initiatives, declarations, and resolutions linked to infant feeding, nutrition and child survival have been among the most important stimuli for action at the national level to implement the International Code. Although a few countries in the region had adopted marketing decrees in the early 1980s, during the rest of that decade there was limited action to implement the International Code. In the late 1980s and early 1990s, initiatives at the international level contributed to re-stimulate policy and program action at the national level.

In 1989, WHO and UNICEF issued the statement *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*, which listed the *Ten Steps to Successful Breastfeeding*. In 1991, the two international agencies launched the *Baby Friendly Hospital Initiative* as a way to encourage hospitals worldwide to adopt the *Ten Steps to Successful Breastfeeding*, which were aimed at changing hospital practices that were harmful to breastfeeding.

International agencies had realized that harmful practices in health care systems were a major contributing factor to falling breastfeeding rates. Health care services were failing to protect, promote and support breastfeeding, as they followed protocols and procedures that interfered with the initiation and establishment of optimal breastfeeding practices. Health staff had insufficient expertise and experience in supporting mothers to breastfeed as their training often favored artificial feeding as a more 'modern' and 'scientific' option than breastfeeding.

> *In 1991, UNICEF and WHO launched the Baby Friendly Hospital Initiative (BFHI) as a way to encourage hospitals worldwide to adopt the Ten Steps to Successful Breastfeeding -aimed at changing hospital practices that were harmful to breastfeeding. Before the launch of BFHI, many health care services were failing to protect, promote and support breastfeeding. Health staff had insufficient expertise and experience in supporting mothers to breastfeed as their training often favored artificial feeding as a more 'modern' and 'scientific' option breastfeeding.*

The *Ten Steps to Successful Breastfeeding* require that health care staff acquire training in breastfeeding counseling skills; that babies not be separated from their mothers; that breastfeeding be initiated soon after birth; that breastfeeding on demand be encouraged and that newborns be given no food or drink other than breastmilk unless medically indicated until they are six months old. Bottle feeding in the early days puts infants at risk for infection and interferes with establishing the infant's suckling capacity and thus stimulation of lactation, usually leading to breastfeeding failure and artificial feeding. Before the *Baby Friendly Hospital Initiative* gained a foothold, most maternities separated babies from their mothers; babies were cared for by health care staff in nurseries and were fed glucose, herbal teas or infant formula by bottle.

Most hospitals had a ready supply of these products because infant food companies had been donating large quantities of breastmilk substitutes on a regular basis under the guise of 'supporting' governments and health care systems. Hospitals became dependent on what was known as *free supplies* and mothers were discharged with free samples of the formula brand used during their hospital stay. Donating breastmilk substitutes to health care facilities became a successful marketing technique for companies that manufactured and/or distributed breastmilk substitutes as mothers often interpreted hospital use of infant formula as an endorsement of a given particular brand of breastmilk substitute.

Ending free supplies of breastmilk substitutes to the health care system was built in as one of the goals of the *Baby Friendly Hospital Initiative*; UNICEF and WHO worked simultaneously on two complementary strategies: one to encourage health facilities to implement the *Ten Steps to Successful Breastfeeding* and the other to encourage governments and manufacturers of breastmilk substitutes to put an end to the provision of free supplies to the health care system; these efforts led to a flurry of government action.

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In 1992, the Ministries of Health in Congo, Cote d'Ivoire and Gabon issued decrees or directives banning free supplies of breastmilk substitutes to the health care system. Similarly, the Ministry of Health in Benin adopted a national breastfeeding policy that banned free donations of breastmilk substitutes to health facilities. The Ministry of Health in Niger, issued a letter circular to the heads of all Maternal and Child Health services forbidding breastmilk substitutes and the use of feeding bottles in their services. The government of Nigeria reached an agreement with the industry association whereby the companies would no longer supply free breastmilk substitutes. The Ministry of Health in Cameroon wrote to the International Association of Infant Food Manufacturers acknowledging its efforts to end free supplies and informing the association that a national decree implementing the Code was forthcoming.

The *Innocenti Declaration*, adopted in 1990 by a group of high level policy makers from 32 countries and several United Nations agencies was also a major impetus for Code implementation in the region. Appointing a national breastfeeding coordinator and a national committee was one of the four operational targets of the Declaration. As countries began to form national breastfeeding committees, some were charged with the task of Code implementation. For example, after Benin adopted its

national breastfeeding policy in 1992, the national breastfeeding committee began considering the development of a national law to implement the Code.

Another operational target of the *Innocenti Declaration* was for all governments to take action to implement the International Code of Marketing of Breastmilk Substitutes by the year 1995. At the time the *Innocenti Declaration* was adopted, only nine countries in the world, one being in West and Central Africa (Nigeria), had a law implementing all or nearly all of the provisions of the International Code[44]. By the end of 2005, the number had grown to 76 worldwide, with ten in West and Central Africa[45].

The adoption of the Innocenti Declaration for the protection, promotion and support of breastfeeding (1990) was a major impetus for Code implementation in West and Central Africa. One of the four operational targets of the Declaration was for all governments to take action to implement the International Code of Marketing of Breastmilk Substitutes by the year 1995. At the time the Innocenti Declaration was adopted, only nine countries in the world, one being in West and Central Africa (Nigeria), had a law implementing all or nearly all of the provisions of the International Code. By the end of 2005, the number had grown to 76 worldwide, with ten in West and Central Africa

6.3.2. Training on Code implementation and other support from international organizations

Support from organizations such as UNICEF, WHO and IBFAN has been instrumental to country level implementation of the International Code in West and Central Africa. These organizations have provided information, knowledge and advocacy support to persuade government officials about the need for national legislation on the marketing of breastmilk substitutes; they have also provided the technical support needed to draft and disseminate national legislative frameworks as well as the support needed to strengthen national capacity for monitoring and enforcing the legal framework. The support provided by UNICEF and WHO has come from national and regional offices as well as from headquarters. Since 1995 UNICEF has employed a full-time lawyer to provide legal support to country and regional offices in legislative drafting. UNICEF regional offices have played an important role in supporting regional partners and country programs in policy advocacy, technical support, quality assurance, program communication and knowledge dissemination on infant feeding, nutrition and child survival, including issues related to the proper use of breastmilk substitutes in regular programs and emergency situations as well as in the context of HIV/AIDS.

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IBFAN member groups have played an important role in bringing to public attention threats to optimal infant feeding and in demanding international action. After the International Code was adopted, the network grew and took on the objective of monitoring marketing practices in countries around the world and publicizing the results of their surveys. The groups have used survey findings to lobby their governments to enact legislation to regulate the marketing of breastmilk substitutes. The Ghana Infant Nutrition Action Network (GINAN) was one of the earliest proponents for Code implementation in the region. In 1987, the local NGO initiated a campaign in Ghana to sensitize relevant organizations and other stakeholders about the International Code. By 1988, the group was involved in a meeting with the Ghanaian Ministry of Health and other government officials that set the pace for developing national regulations. The group was instrumental in keeping the process alive; its efforts finally paid off in 2000 when the government issued the Breastfeeding Promotion Regulation of Ghana. The IBFAN network for French-speaking Africa began in 1989. A sub-regional office was set up in Ouagadougou in 1992; in 1995 it became the regional office for francophone Africa. Eleven countries in the region have national groups that belong to the IBFAN network. These groups have consistently monitored company compliance with the Code in their countries and have been instrumental in lobbying their governments to enact strong national legislative frameworks.

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Training of government representatives on Code implementation has had high impact in the region. In the mid-1980s, the International Code Documentation Centre (ICDC) was created to keep track of government actions to implement the International Code as well as actions by manufacturers of breastmilk substitutes to comply with the International Code. In 1991, a WHO-UNICEF international meeting in the Netherlands assessed progress on Code implementation over the ten-year period since the adoption of the Code. At this meeting, it became clear that working towards the Innocenti target of global Code implementation by 1995 would require an accelerated effort. ICDC was encouraged to expand and accelerate its work so as to speed up the pace of Code implementation worldwide.

With support from UNICEF, WHO and the government of the Netherlands, ICDC initiated its first series of Code Implementation Training Courses for government policy makers, United Nations staff and NGO staff who were interested in stimulating national action on Code implementation. During the training, participants learn about the Code, why it is necessary and how to translate it into national measures. ICDC developed Model Laws in different languages and formats for different regions of the world to assist legislative draftsmen. West and Central Africa was represented at the first international Code Training Course in 1992 in Penang, Malaysia by members of GINAN.

The International Code Documentation Centre (ICDC) was created in the mid-1980s to keep track of government actions to implement the International Code as well as actions by manufacturers of breastmilk substitutes to comply with the International Code. National IBFAN groups, IBFAN-Africa, who and UNICEF provided vital support for ICDC to facilitate a series of Code implementation training courses in English, French and Portuguese for countries in West and Central Africa. The region has also benefited from training courses that have focused on monitoring skills such as the monitoring training course for West Africa in 2003 hosted by the National Nutrition Agency of Ghana.

National IBFAN groups, IBFAN-Africa, WHO and UNICEF provided vital support for ICDC to organize three Code implementation training courses in French, for countries in West and Central Africa. The first took place in early 1993 in Burkina Faso and had a major impact on Code implementation in the twelve countries that participated. Prior to the Code training, UNICEF and l'Association pour la Promotion de l'Alimentation Infantile Burkinabé, (APAIB) had been lobbying actively the government of Burkina Faso to adopt a national measure to regulate the marketing of breastmilk substitutes. During the opening of the training course, the representative of the Government of Burkina Faso made a commitment to adopt a national decree to implement the Code; less than one year later, Burkina Faso adopted a national decree regulating the marketing of breastmilk substitutes. Among the countries that participated in the training, Cameroon and Senegal adopted decrees in 1993 and 1994 respectively. DR-Congo, Cote d'Ivoire, Gabon and Ghana completed draft decrees between 1993 and 1995. A few years later, Benin and Niger also adopted decrees on the marketing of breastmilk substitutes.

By 1999, the pace of activity had slowed down. In that year, l'Association pour l'Alimentation Infantile au Gabon, ICDC, IBFAN-Africa, WHO and UNICEF organized a second regional Code training course in Gabon. Of the 8 countries that participated, Burkina Faso and Niger had already issued national decrees but wanted to gain skills to make those decrees effective in their countries. Cote d'Ivoire, Guinea, Togo and Gabon had decrees in draft form. Mauritania and the Central Africa Republic had not previously participated in a Code implementation training course or taken action to implement the Code. Other countries in the region have also benefited from Code implementation training courses. In 2000, Cape Verde, Sao Tome and Principe and Guinea Bissau participated in a course in Mozambique for Portuguese speaking countries. In intervening years, delegates from English-speaking countries in the region including Ghana, Nigeria and the Gambia sent delegations either to an ICDC annual Code training course in Malaysia or to other regional courses in English such as the 1998 training that took place in Kenya for Anglophone Africa. ICDC also supported the training of a pediatrician from Chad who became a strong advocate for Code implementation. With assistance from UNICEF and WHO, Chad has been able to develop a draft law. The region has also benefited from training courses that have focused on monitoring skills such as the monitoring training course conducted by ICDC for West Africa in 2003 hosted by the National Nutrition Agency of Ghana.

6.4. Successes and lessons learned

6.4.1. Ghana

In West and Central Africa, Ghana stands out as a true success story in national implementation of the International Code and provides with a good number of lessons to be learned. The experience in Ghana shows, among other things, that national implementation of the International Code requires championship, coordination of a number of stakeholders and sectors and perseverance. In Ghana, a number of years of information, advocacy, lobbying and consultation were needed before the Breastfeeding Promotion Regulation was adopted in 2000. Having the Ghana Infant Nutrition Action Network (GINAN) and UNICEF as steady and active players throughout the entire process was crucial to Ghana's ultimate success in adopting the regulation. Not only did these institutions initiate the process by organizing a campaign in the 1980s to sensitize relevant individuals and organizations about the International Code and the need to regulate the marketing of breastmilk substitutes in the country, but they continually informed and lobbied government officials, health professionals and manufacturers and distributors and provided timely and professional feed-back to the various draft laws that were considered over the years.

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A Code drafting committee was established in 1989. Later that year, a first draft was presented at a national workshop with all key stakeholders. Over the next three years, drafts were finalized and the drafting committee lobbied for enactment. In 1992, the Ghana

parliament passed the Food and Drugs Law under which it would eventually adopt the Breastfeeding Promotion Regulation. The regulation, however, was delayed because in 1994 the new Baby Friendly Health Facilities Initiative Authority took over the review of the draft. The draft regulation was finally forwarded for action to the Minister of Health. However, it was put on hold again until the Food and Drugs Board was established in 1997. At this time, the draft was again circulated to all concerned parties. The Baby Friendly Health Facilities Initiative Authority finally sought cabinet approval in 1999. At this point, the Attorney General's Department worked with the Code Implementation Committee to re-draft and review the regulation. Various advocacy seminars for the media, parliamentarians and Food and Drugs Board were held to lobby and advocate for the enactment of the regulation. All these efforts yielded the expected gains when the Breastfeeding Promotion Regulation was finally passed on May 9, 2000.

However, the adoption of the regulation was not the end of the process. One year after the adoption of the regulation, an amendment backed by the infant food industry was proposed. This amendment would have weakened some of the provisions in the regulation such as restrictions on donations of breastmilk substitutes and product information materials to health care facilities. Supporters of the amendment argued that donations were necessary in light of the number of mothers infected with HIV. GINAN and other partners were able to garner enough support to have the amendment defeated[46]. The involvement of all stakeholders throughout the process was important for each concerned party to have its views heard and be informed about what was required of them. Having a steady an authoritative voice throughout the drafting and adoption process was crucial as the process was often delayed and could have been abandoned without GINAN and UNICEF's commitment.

The experience in Ghana also proves that officials who are in charge of enforcing the provisions of national legislation need to have strong knowledge on infant feeding, nutrition, and child survival issues and understand well how the International Code relates to these issues. One of the challenges in enforcing the law in Ghana was the promotion of breastmilk substitutes in health facilities. The Regulation allows that technical information on breastmilk substitutes be given to health workers. However, as the line between information and promotion can be thin, promotion messages get sometimes passed on to health workers and from them to mothers and families. Ghanaians closely involved with the regulations have also concluded from their experience that a clearly defined scope is essential for a national legislation on the marketing of breastmilk substitutes to be effective.

Another lesson that can be learned from Ghana's experience is the importance of establishing an independent monitoring body that can submit its findings and recommendations to a designated government enforcement agency that has the capacity to impose penalties. The National Breastfeeding Promotion Regulations Coordinating Committee was inaugurated in 2004. ICDC, with UNICEF's support, conducted a monitoring training course for the Ghana Food and Drugs Board, which oversees the monitoring committee. Since then, the committee coordinates monitoring exercises in the country and determines whether and how Code regulations are being violated. Through this enforcement capability, the government has been able to stop certain shipments of infant formula from entering Ghana because the labels included pictures that are specifically prohibited under the regulations.

Three additional lessons to be learned from the experience in Ghana are:

- *A clearly defined scope is essential for a national legislation on the marketing of breastmilk substitutes to be effective;*
- *Officials who are in charge of enforcing the provisions of national legislation need to have strong knowledge on infant feeding, nutrition, and child survival issues and understand well how the International Code relates to these issues;*
- *It is essential to establish an independent monitoring body that can submit its findings and recommendations to a designated government enforcement agency that has the capacity to impose penalties.*

6.4.2. Nigeria

Nigeria is another country that has adopted strong regulations pursuant to an earlier legislative Act. Like in Ghana, a lesson to be learned from Nigeria is that the process can be drawn out with intervening governments and agencies, but perseverance pays off in the end. The Government of Nigeria was one of the first in the region to implement many of the provisions of the International Code. Decree No. 41 on the marketing of breastmilk substitutes was adopted in 1990. However, this Decree could not be implemented for nearly ten years because it lacked provisions related to monitoring and enforcement. In 1999, the government amended the Decree and designated the National Agency for Food and Drug Administration and Control (NAFDAC) as the agency responsible to enforce compliance with the Decree.

NAFDAC recognized, however, that it was not prepared to carry out this new role as its staff was not familiar with the history and provisions of the International Code and were not trained to recognize violations of the Decree. Moreover, the agency did not have a protocol for monitoring marketing violations. To overcome these limitations, NAFDAC organized a training workshop for its officers with the support of UNICEF. By the end of the workshop, the agency staff was familiar with the purpose and provisions of the Decree and was able to identify violations.

The agency staff also realized that to be truly effective the Decree would need to be further modified. In 2003, Nigeria sent a team of three professionals to participate in a Code Training course held by ICDC in Penang, Malaysia. In 2006, the agency issued detailed regulations that defined more clearly the scope and required product registration. The regis-

tration can be revoked if the products are advertised or otherwise promoted. The regulations also detail the penalties that would be imposed for violations.

The Director General of NAFDAC used the occasion of World Breastfeeding Week 2006 to launch the new regulations as well as the monitoring survey questionnaire that the agency developed to monitor compliance with the regulations. UNICEF has provided essential support to making the regulations successful in the form of technical support for drafting the regulations, training of NAFDAC staff on the implementation of the legislative framework, developing and field testing the monitoring survey questionnaire, developing a training manual, and in-depth training of 100 physicians and nurses about the International Code and Nigeria's implementing regulations.

Lessons to be learned from the experience in Nigeria are:

- *Effective implementation of the International Code at the national level requires that the national legislative framework for the marketing of breastmilk substitutes include provisions related to monitoring and enforcement;*
- *The designation of the National Agency for Food and Drug Administration and Control (NAFDAC) as the agency responsible for enforcing compliance with the International Code has been a crucial step in the implementation of the national legislative framework for the marketing of breastmilk substitutes;*
- *Adequate training of NAFDAC staff and the development of standardized and field-tested monitoring survey tools have been essential for NAFDAC to carry out effectively its enforcement role;*
- *Enforcement becomes easier and effective when – like in Nigeria - national regulations detail the penalties that will be imposed for Code violations, including the suspension of product registration when breastmilk substitutes are advertised or otherwise promoted.*

6.4.3. DR-Congo

DR-Congo has adopted recently a law regulating the marketing of breastmilk substitutes in line with the International Code. The law was first proposed in 2002. However, due to the politically unstable situation in the country, the law was not signed until 2006. On the occasion of *International Breastfeeding Week*, which in 2006 focused on the International Code of Marketing of Breastmilk Substitutes, the law was published in the Official Journal in May 2006. DR-Congo is applying the lessons learned in Ghana and Nigeria, and is taking steps to ensure that the marketing of breastmilk substitutes in the country is in compliance with the recently adopted legislative framework. Moreover, the enactment of the marketing law is placed in the context of a multi-pronged plan of action to strengthen policies and programs for the protection, promotion and support of breastfeeding.

The national plan of action for breastfeeding protection, promotion and support includes the establishment of multisectoral breastfeeding committees at national, provincial and local levels. The committees will monitor the implementation of the plan of action, with a major focus on revitalizing efforts to protect, promote and support improved breastfeeding practices (particularly early initiation of breastfeeding, colostrum feeding, avoidance of prelacteal feeding, exclusive breastfeeding for the first six months of life and continued breastfeeding with adequate and safe complementary foods from 6 to 24 months) as some of the past achievements were lost when breastfeeding programming was interrupted for a long time due to political and social instability.

This renewed effort to boost the protection, promotion and support of improved breastfeeding practices will be implemented through concerted program action at the community level (through community-based resource persons/support groups and NGO-supported programs), the health facility level (in hospitals, maternities and mother-and-child health services) and the public media (television, radio and printed journals).

The Government, with the support of UNICEF and other child survival and development partners will re-launch the *Baby Friendly Hospital Initiative*, once its current implementation is assessed and challenges and opportunities for future action are identified. In this context, a consultation workshop will be held to identify the most cost-effective ways to sensitize the general public, the private sector and program planners and service providers in the health sector about the rationale and scope of the newly endorsed legislative framework on the marketing of breastmilk substitutes. Priority attention will be given to put an end to the provision of: a) free supplies of breastmilk substitutes to health facilities; and b) private sector's "information and education" support to health providers, as both practices continue to influence negatively health workers' advice and support to mothers on breastfeeding.

- *A national law regulating the marketing of breastmilk substitutes in DR-Congo was published in the Official Journal on the occasion of International Breastfeeding Week, which in 2006 focused on the Code of Marketing of Breastmilk Substitutes.*

Lessons to be learned from the experience in DR-Congo are:

- *The enactment of the marketing law is placed in the context of a multi-pronged plan of action to strengthen policies and programs for the protection, promotion and support of improved breastfeeding practices.*
- *The plan is implemented through concerted program action at the community level (through community-based resource persons/support groups and NGO-supported programs), the health facility level (in hospitals, maternities and mother-and-child health services) and the public media (television, radio and printed journals).*

- *In the interface between the Baby Friendly Hospital Initiative and the national legislation on the marketing of breastmilk substitutes, priority attention is given to put an end to the provision of: a) free supplies of breastmilk substitutes to health facilities; and b) private sector's "information and education" support to health providers, as both practices continue to influence negatively health workers' advice and support to mothers on breastfeeding.*

6.4.4. Cote d'Ivoire

Côte d'Ivoire has a long history of taking action to improve infant and young child feeding practices, has taken advantage of international declarations and initiatives on child feeding, nutrition and survival, and has worked in close collaboration with UNICEF, WHO, IBFAN and other agencies to advance such initiatives. However, Cote d'Ivoire has not yet adopted legislation to implement the International Code. Nevertheless, important lessons can be learned from the process that the country is implementing.

Côte d'Ivoire was one of the first countries to participate in a pilot program for the *Baby Friendly Hospital Initiative* in 1991. Similarly, it was one of the first countries to adopt a decree to end the practice of free and low cost supplies of breastmilk substitutes in health care facilities. In 1993, delegates from Cote d'Ivoire attended the first Code implementation training course organized for West and Central African countries in Burkina Faso. In 1994, the Ministry of Health proposed a draft decree regulating the marketing of breastmilk substitutes in Côte d'Ivoire. However, the draft Decree did not advance. In 1997, as part of the National Policy to Promote and Protect Breastfeeding, the Ministry of Health began anew the process of drafting national legislation; however, the National Assembly rejected the draft in 1998. Later analysis determined that the draft had been introduced too quickly to Assembly Members, probably without appropriate explanation of its rationale and the scope of its provisions. Sub-optimal information led to the belief that the proposed legislative framework would prohibit the sale of products within its scope and that it would have negative consequences for the national economy[47].

In 2003, on the occasion of World Breastfeeding Week, the Ministry of Health, with the support of UNICEF and WHO, rekindled the process of implementing the International Code at the national level. The Ministry of Health organized a consultative workshop and invited representatives from a wide range of sectors including the Ministry of Trade, health professionals, pharmacists, representatives of professional associations, medical representatives, and representatives from three infant formula manufacturers. The objective of the consultation was to reanalyze and redraft the law that had been proposed in 1998. Despite some difficulties in achieving consensus due to the inclusion in the working groups of representatives from infant the food industry, a new draft law resulted from the consultation workshop.

One year later, the Ministry of Health organized a follow-up workshop to confirm and finalize the terms of the draft law. Unfortunately, political instability and continuing changes in the make-up of the government left the draft law on the back burner and Côte d'Ivoire remains one of the few countries in the region that has not yet adopted a national law to regulate the marketing of breastmilk substitutes.

This is a worrisome situation, particularly in light of the fact that the prevalence of HIV in Côte d'Ivoire is higher than in most of the countries in West and Central Africa. Public health professionals feel that there is a need to adapt the strategies for the endorsement and enactment of national legislation to regulate the marketing of breastmilk substitutes; such new strategy needs to include championship at the highest level possible, including within the Office of the Prime Minister and the House of Parliament. In the current situation of instability, the priorities of the Government and its humanitarian and development partners tend to shift for what are seen as emergency priorities and the regulation on the marketing of breastmilk substitutes falls between the cracks. Some public health and child survival professionals feel that in a context of 'no war, no peace' a few benefit form the *status quo* situation on the Code. Most public health professional believe that in such a situation children, families and communities definitely lose, including children, families and communities affected by HIV-AIDS.

Côte d'Ivoire has a long history of taking action to improve infant and young child feeding. However, it has not adopted legislation to regulate the marketing of breastmilk substitutes.

Lessons to be learned from the experience in Côte d'Ivoire are:

- *Proper communication with all concerned parties about the rationale and scope of the proposed legislative framework facilitates the drafting and adoption process.*
- *Lack of information sharing throughout the process can lead to the belief that the proposed legislative framework will prohibit the sale of products within its scope, with negative consequences for the national economy.*
- *There is a need to adapt the strategies for the endorsement and enactment of national legislation to regulate the marketing of breastmilk substitutes; such new strategy needs to include championship at the highest level possible, including within the Office of the Prime Minister and the House of Parliament.*
- *Some public health and child survival professionals feel that in a context of 'no war, no peace' a few benefit form the status quo situation on the Code. Most public health professional believe that in such a situation children, families and communities lose, including children, families and communities affected by HIV-AIDS.*

6.5. Building momentum for the future

Over the last 25 years, countries in West and Central Africa have made remarkable progress in implementing the International Code of Marketing of Breastmilk Substitutes. The number of countries in the region that have implemented the International Code by a national legislative framework that includes all or most of the provision of the International Code has grown to twelve in 2006, with at least seven additional countries with a law in draft form. However, substantial efforts are still needed for full implementation of the International Code in the region.

Countries in the region can take advantage of several recent international initiatives on child feeding, nutrition and survival to stimulate policy and program action for the regulation of the marketing of breastmilk substitutes at the national level. In the past, international initiatives and instruments such as the *Baby Friendly Hospital Initiative*, the *Innocenti Declaration* and the *Convention on the Rights of the Child* have served to stimulate improvements at the national level in the areas of infant and young child feeding and Code implementation. In this vein, the WHO/UNICEF *Global Strategy for Infant and Young Child Feeding*, the *Framework for Priority Action on HIV and Infant Feeding*, and the *Africa Union Framework for Child Survival* are all opportunities and instruments to advance action in favor of the full implementation of the International Code in West and Central Africa.

In the first few years of the new millennium, WHO and UNICEF developed jointly the *Global Strategy for Infant and Young Child Feeding* through a process of consultation with experts, regional institutions and national governments. The *Global Strategy* was adopted by the World Health Assembly in 2002. A key focus of the strategy is the urgent implementation of the four targets of the *Innocenti Declaration*. Implementing the International Code is one of those four targets and is considered a crucial step for improving infant and young child feeding, nutrition, survival and development. Other operational targets for governments included in the *Global Strategy* are to ensure that exclusive breastfeeding is protected, promoted and supported for six months, with continued breastfeeding up to two years and beyond; to promote timely, adequate and safe complementary foods and feeding practices; and to provide guidance on feeding infants and young children in exceptionally difficult circumstances such as those born to HIV-positive mothers, those living in emergency situations and low birth-weight newborns.

Adopting and enforcing a legislative framework to regulate the marketing of breastmilk substitutes is also one of the five priority areas for government action included in the 2003 *Framework for Priority Action on HIV and Infant Feeding* developed jointly by UNICEF, WHO, UNFPA and UNAIDS.

More recently, in 2005 UNICEF, WHO and a number of other international organizations met in Florence (Italy) to celebrate the 15 year anniversary of the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*. The participants adopted a new declaration on infant and young child feeding entitled the *Innocenti Declaration 2005*. The new declaration recognizes the important achievements in infant and young child feeding over the last 15 years, but also takes note of the continuing threat to child feeding, nutrition and survival posed by inappropriate feeding practices. The 2005 declaration calls for action from governments, manufacturers and distributors of products within the scope of the International Code, multilateral and bilateral organizations, international financial institutions, and public interest non-governmental organizations. The Declaration calls for universal implementation of the International Code along with achievement of the three complementary targets of the 1995 *Innocenti Declaration*. The 2005 declaration also adds five new operational targets aimed at achieving an environment that enables mothers, families and other caregivers to make informed decisions about optimal feeding, which is defined as exclusive breastfeeding for six months followed by the introduction of appropriate complementary feeding and continuation of breastfeeding for up to two years of age or beyond. The 2006 World Health Assembly endorsed the Call for Action of the 2005 *Innocenti Declaration* (World Health Assembly Resolution WHA59.21, 2006) and the United Nations Standing Committee on Nutrition endorsed the Declaration in March 2006[48].

At the more tangible level, efforts have continued to advance Code implementation in West and Central African countries. For example, in 2006, UNICEF and WHO supported IBFAN-ICDC to conduct a training in Burkina Faso on national implementation of the International Code. As five of the nine participating countries had already adopted national decrees on the marketing of breastmilk substitutes, the training course focused both on drafting of national legislative frameworks and on ways to make national frameworks effective through information, education, monitoring, and enforcement.

Also in 2006, *Code Watch: 25 Years of Protecting Breastfeeding* was chosen as the theme for World Breastfeeding Week to coincide with the 25th anniversary of the adoption of the International Code. The week with its Code-related theme was a catalyst for action at the national level. For example, in Nigeria, the Ministry of Health officially launched new regulations on the marketing of foods for infants and young children as well as a monitoring survey questionnaire that NAFDAC - the implementing agency - will use for enforcing the regulations. DR-Congo used the occasion to publish in the Official Journal a national law regulating the marketing of breastmilk substitutes and to re-launch policy and program action for breastfeeding protection, promotion and support.

For West and Central Africa, the momentum achieved over the last 25 years needs to continue and be intensified. In countries where a law has been adopted, resources need to be channelled to law enforcement. Government officials need to be trained to be able to monitor compliance with the International Code and

monitoring and reporting tools need to be developed. Additionally, health workers need to be informed about the provisions of the law in order to ensure that they are supported in their day-to-day practice and within the health care system. Media outreach must be developed and supported to inform the general public, infant food manufacturers, distributors and detailers about the law. Countries with a law still in draft form need to be supported to advance progress to legally adopted measures. Special efforts are needed to determine why some countries have still taken no action to implement the Code.

A guiding principle in advancing the implementation of the International Code in West and Central Africa is the need for an integrated approach. Adopting legislation to regulate the marketing of breastmilk substitutes will not, by itself, improve infant feeding practices. Governments, UN-agencies, humanitarian and development NGOs, health professionals, media professionals, civil society and individuals need to also work towards revitalizing facility-based, community-based and media-based protection, promotion and support to breastfeeding– particularly early initiation of breastfeeding and exclusive breastfeeding through the first six months of life – as part of Africa-wide efforts to improve child feeding, nutrition and survival and reach Millennium Development Goals 1 and 4 for the reduction of child malnutrition and mortality.

For West and Central African countries, the momentum achieved over the last 25 years in national implementation of the International Code needs to continue and be intensified. A guiding principle in advancing the implementation of the International Code in West and Central Africa is the need for an integrated approach. Adopting legislation to regulate the marketing of breastmilk substitutes will not, by itself, improve infant feeding practices. Governments, UN-agencies, humanitarian and development NGOs, health professionals, media professionals, civil society and individuals need to also work towards revitalizing facility-based, community-based and media-based protection, promotion and support to breastfeeding– particularly early initiation of breastfeeding and exclusive breastfeeding through the first six months of life – as part of Africa-wide efforts to improve child feeding, nutrition and survival and reach Millennium Development Goals 1 and 4 for the reduction of child malnutrition and mortality.

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